Medicare B CONNECTION
medicare.fcso.com
FIRST COAST SERVICE OPTIONS, INC.
A Newsletter for MAC Jurisdiction N Providers
January 2018

In this issue

2018 Medicare travel allowance for collection of specimens

Provider type affected

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

What you need to know

Change request (CR) 10448 revises the payment of travel allowances when billed on a per mileage basis using Health Care Common Procedure Coding System (HCPCS) code P9603 and when billed on a flat-rate basis using HCPCS code P9604 for 2018. Make sure your billing staff is aware of these changes.

Background

Medicare Part B allows payment for a specimen collection fee and travel allowance, when medically necessary, for a laboratory technician to draw a specimen from either a nursing home patient or homebound patient under Section 1833(h)(3) of the Social Security Act (the Act). Payment for these services is made based on the clinical laboratory fee schedule (CLFS).

The travel codes allow for payment either on a per mileage basis for code P9603 or on a flat rate per trip basis for P9604. Payment of the travel allowance is made only if a specimen collection fee is also payable. The travel allowance is intended to cover the estimated travel costs of collecting a specimen including the laboratory technician's salary and travel expenses. Your MAC has the discretion to choose either a mileage basis or a flat rate, and how to set each type of allowance. Many MACs established local policy to pay based on a flat rate basis only.

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

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

See **TRAVEL**, page 42

Contents

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

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

About the Medicare B Connection

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

Important notifications that require communication in between publications will be posted to the First Coast Medicare provider education website at *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.

CMS clarifies proper use of modifier 59

Note: *This article was revised January 3, 2018, to conform with the latest modifier 59 article on the NCCI website. The key update was the addition of information regarding the XE, XS, XP, and XU modifiers. This information was previously published in the June 2014 Medicare B Connection, pages 6-9.*

Provider type affected

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

Provider action needed

This special edition article is being provided by the Centers for Medicare & Medicaid Services (CMS) to clarify the proper use of modifier 59. The article only clarifies existing policy. Make sure that your billing staffs are aware of the proper use of modifier 59.

Background

The Medicare National Correct Coding Initiative (NCCI) includes procedure-to-procedure (PTP) edits that define when two Healthcare Common Procedure Coding System (HCPCS)/ *Current Procedural Terminology* (CPT®) codes should not be reported together either in all situations or in most situations.

For PTP edits that have a correct coding modifier indicator (CCMI) of "0," the codes should never be reported together by the same provider for the same beneficiary on the same date of service. If they are reported on the same date of service, the column one code is eligible for payment and the column two code is denied.

For PTP edits that have a CCMI of "1," the codes may be reported together only in defined circumstances which are identified on the claim by the use of specific NCCI-associated modifiers. (Refer to the *National Correct Coding Initiative Policy Manual for Medicare Services*, Chapter 1, for general information about the NCCI program, PTP edits, CCMIs, and NCCI-associated modifiers. This manual is available in the download section at *https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html*.

One function of NCCI PTP edits is to prevent payment for codes that report overlapping services except in those instances where the services are "separate and distinct." Modifier 59 is an important NCCI-associated modifier that is often used incorrectly.

The *CPT*® *Manual* defines modifier 59 as follows:

"**Distinct Procedural Service:** Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. **Note**: Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25."

Modifier 59 and other NCCI-associated modifiers **should not be used** to bypass a PTP edit unless the proper criteria for use of the modifier are met. Documentation in the medical record must satisfy the criteria required by any NCCI-associated modifier that is used.

1. **Modifier 59 is used appropriately for different anatomic sites during the same encounter only when procedures which are not ordinarily performed or encountered on the same day are performed on different organs, or different anatomic regions, or in limited situations on different, non-contiguous lesions in different anatomic regions of the same organ.**

One of the common uses of modifier 59 is for surgical procedures, non-surgical therapeutic procedures, or diagnostic procedures that are performed at different anatomic sites, are not ordinarily performed or encountered on the same day, and that cannot be described by one of the more specific anatomic NCCI-associated modifiers – i.e., RT, LT, E1-E4, FA, F1-F9, TA, T1-T9, LC, LD, RC, LM, or RI. (See examples 1, 2, and 3.) From an NCCI perspective, the definition of different anatomic sites includes different organs or, in certain instances, different lesions in the same organ. However, NCCI edits are typically created to prevent the inappropriate billing of lesions and sites that should not be considered to be separate and distinct. Modifier 59 should only be used to identify clearly independent services that represent significant departures from the usual situations described by the NCCI edit. The treatment of contiguous structures in the same organ or anatomic region **does not** constitute treatment of different anatomic sites. For example:

- Treatment of the nail, nail bed, and adjacent soft tissue distal to and including the skin overlying the distal interphalangeal joint on the same toe or finger constitutes treatment of a single anatomic site. (See example 4.)
- Treatment of posterior segment structures in the eye constitutes treatment of a single anatomic site. (See example 5.)
- Arthroscopic treatment of structures in adjoining areas of the same shoulder constitutes treatment of a single anatomic site. (See example 6.)

See **MODIFIER**, page 6

MODIFIER

from page 5

2. Modifier 59 is used appropriately when the procedures are performed in different encounters on the same day.6

Another common use of modifier 59 is for surgical procedures, non-surgical therapeutic procedures, or diagnostic procedures that are performed during different patient encounters on the same day and that cannot be described by one of the more specific NCCI-associated modifiers – i.e., 24, 25, 27, 57, 58, 78, 79, or 91. (See example 7) As noted in the CPT® definition, modifier 59 should only be used if no other modifier more appropriately describes the relationship of the two procedure codes.

3. Modifier 59 is used inappropriately if the basis for its use is that the narrative description of the two codes is different.

One of the common misuses of modifier 59 is related to the portion of the definition of modifier 59 allowing its use to describe a "different procedure or surgery." The code descriptors of the two codes of a code pair edit usually represent different procedures, even though they may be overlapping. The edit indicates that the two procedures should not be reported together if performed at the same anatomic site and same patient encounter as those procedures would not be considered to be "separate and distinct." The provider should not use modifier 59 for such an edit based on the two codes being "different procedures." (See example 8.) However, if the two procedures are performed at separate anatomic sites or at separate patient encounters on the same date of service, modifier 59 may be appended to indicate that they are different procedures on that date of service. Additionally, there may be limited circumstances sometimes identified in the *National Correct Coding Initiative Policy Manual* for Medicare Services (available in the downloads section at *https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html*) when the two codes of an edit pair may be reported together with modifier 59 when performed at the same patient encounter or at the same anatomic site.

4. Other specific appropriate uses of modifier 59

There are three other limited situations in which two services may be reported as separate and distinct because they are separated in time and describe non-overlapping services even though they may occur during the same encounter, i.e.:

a. Modifier 59 is used appropriately for two services described by timed codes provided during the same encounter only when they are performed sequentially. There is an appropriate use for modifier 59 that is applicable only to codes for which the unit of service is a measure of time (e.g., per 15 minutes, per hour). If two timed services are provided in time periods that are separate and distinct and not interspersed with each other (i.e., one service is completed before the subsequent service begins), modifier 59 may be used to identify the services. (See example 9.)

b. Modifier 59 is used appropriately for a diagnostic procedure which precedes a therapeutic procedure only when the diagnostic procedure is the basis for performing the therapeutic procedure. When a diagnostic procedure precedes a surgical procedure or non-surgical therapeutic procedure and is the basis on which the decision to perform the surgical procedure is made, that diagnostic test may be considered to be a separate and distinct procedure as long as (a) it occurs before the therapeutic procedure and is not interspersed with services that are required for the therapeutic intervention; (b) it clearly provides the information needed to decide whether to proceed with the therapeutic procedure; and (c) it does not constitute a service that would have otherwise been required during the therapeutic intervention. (See example 10.) If the diagnostic procedure is an inherent component of the surgical procedure, it should not be reported separately.

c. Modifier 59 is used appropriately for a diagnostic procedure which occurs subsequent to a completed therapeutic procedure only when the diagnostic procedure is not a common, expected, or necessary follow-up to the therapeutic procedure. When a diagnostic procedure follows the surgical procedure or non-surgical therapeutic procedure, that diagnostic procedure may be considered to be a separate and distinct procedure as long as (a) it occurs after the completion of the therapeutic procedure and is not interspersed with or otherwise commingled with services that are only required for the therapeutic intervention, and (b) it does not constitute a service that would have otherwise been required during the therapeutic intervention. If the post-procedure diagnostic procedure is an inherent component or otherwise included (or not separately payable) post-procedure service of the surgical procedure or non-surgical therapeutic procedure, it should not be reported separately.

d. Use of modifier 59 does not require a different diagnosis for each HCPCS/CPT® coded procedure. Conversely, different diagnoses are not adequate criteria for use of modifier 59. The HCPCS/CPT® codes remain bundled unless the procedures are performed at different anatomic sites or separate patient encounters or meet one of the other three scenarios described above.

e. Modifiers XE, XS, XP, and XU are effective January 1, 2015. These modifiers were developed to provide greater reporting specificity in situations where modifier 59 was previously reported and may be

See **MODIFIER**, page 7

MODIFIER

from page 6

utilized in lieu of modifier 59 whenever possible. (Modifier 59 should only be utilized if no other more specific modifier is appropriate.) Although NCCI will eventually require use of these modifiers rather than modifier 59 with certain edits, providers may begin using them for claims with dates of service on or after January 1, 2015. The modifiers are defined as follows:

- XE – "Separate encounter, A service that is distinct because it occurred during a separate encounter" This modifier should only be used to describe separate encounters on the same date of service.
- XS – "Separate Structure, A service that is distinct because it was performed on a separate organ/ structure"
- XP – "Separate Practitioner, A service that is distinct because it was performed by a different practitioner"
- XU – "Unusual Non-Overlapping Service, The use of a service that is distinct because it does not overlap usual components of the main service"

Examples of modifier 59 usage

Following are some examples developed to help guide physicians and providers on the proper use of modifier 59 (**Please remember that Medicare policy is that modifier 59 is used appropriately for different anatomic sites during the same encounter only when procedures which are not ordinarily performed or encountered on the same day are performed on different organs, or different anatomic regions, or in limited situations on different, non-contiguous lesions in different anatomic regions of the same organ.)**:

Example 1: Column 1 code /column 2 code - 17000/11100

- CPT® code 17000 – Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), all benign or premalignant lesions (eg, actinic keratoses) other than skin tags or cutaneous vascular proliferative lesions; first lesion
- CPT® Code 11100 – Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion

Modifier 59 may be reported with code 11100 if the procedures are performed at different anatomic sites on the same side of the body and a specific anatomic modifier is not applicable. If the procedures are performed on different sides of the body, modifiers RT and LT or another pair of anatomic modifiers should be used, not modifier 59.

Example 2: Column 1 code/column 2 code 47370/76942

- CPT® code 47370 – Laparoscopy, surgical, ablation of one or more liver tumor(s); radiofrequency
- CPT® code 76942 – Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation

CPT® code 76942 should not be reported and modifier 59 should not be used if the ultrasonic guidance is for needle placement for the laparoscopic liver tumor ablation procedure. Code 76942 may be reported with modifier 59 if the ultrasonic guidance for needle placement is unrelated to the laparoscopic liver tumor ablation procedure.

Example 3: Column 1 code/column 2 code 93453/76000

- CPT® Code 93453 – Combined right and left heart catheterization including intraprocedural injections(s) for left ventriculography, imaging supervision and interpretation, when performed
- CPT® Code 76000 – Fluoroscopy (separate procedure), up to one hour physician time, other than 71023 or 71034 (eg, cardiac fluoroscopy)

CPT® code 76000 should not be reported and Modifier 59 should not be used for fluoroscopy that is used in conjunction with a cardiac catheterization procedure. Modifier 59 may be reported with code 76000 if the fluoroscopy is performed for a procedure unrelated to the cardiac catheterization procedure.

Example 4: Column 1 code /column 2 code - 11055/11720

- CPT® code 11055 - Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); single lesion
- CPT® code 11720 – Debridement of nail(s) by any method(s); one to five

CPT® codes 11720 and 11055 should not be reported together for services performed on skin distal to and including the skin overlying the distal interphalangeal joint of the same toe. Modifier 59 should not be used if a nail is debrided on the same toe on which a hyperkeratotic lesion of the skin on or distal to the distal interphalangeal joint is pared. Modifier 59 may be reported with code 11720 if one to five nails are debrided and a hyperkeratotic lesion is pared on a toe other than one with a debrided toenail or the hyperkeratotic lesion is proximal to the skin overlying the distal interphalangeal joint of a toe on which a nail is debrided.

Example 5: Column 1 code / column 2 code - 67210/67220

- CPT® code 67210 – Destruction of localized lesion of retina (eg, macular edema, tumors), 1 or more sessions; photocoagulation
- CPT® code 67220 – Destruction of localized lesion of choroid (eg, choroidal neovascularization); photocoagulation (eg, laser), 1 or more sessions

CPT® code 67220 should not be reported and Modifier 59 should not be used if both procedures are performed during the same operative session because the retina and choroid are contiguous structures of the same organ.

Example 6: Column 1 code / column 2 code - 29827/29820

- CPT® code 29827 – Arthroscopy, shoulder, surgical; with rotator cuff repair

See **MODIFIER**, page 8

MODIFIER

from page 7

- CPT® code 29820 – Arthroscopy, shoulder, surgical; synovectomy, partial

CPT® code 29820 should not be reported and modifier 59 should not be used if both procedures are performed on the same shoulder during the same operative session because the shoulder joint is a single anatomic structure. If the procedures are performed on different shoulders, modifiers RT and LT should be used, not modifier 59.

Example 7: Column 1 code /column 2 code - 93015/93040

- CPT® code 93015 – Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision, with interpretation and report
- CPT® code 93040 – Rhythm ECG, one to three leads; with interpretation and report

Modifier 59 may be reported if the rhythm ECG is performed at a different encounter than the cardiovascular stress test. If a rhythm ECG is performed during the cardiovascular stress test encounter, CPT® code 93040 should not be reported and Modifier 59 should not be used. **Modifier 59 is used appropriately when the procedures are performed in different encounters on the same day.**

Example 8: Column 1 Code/Column 2 code - 34833/34820

- CPT® code 34833 - Open iliac artery exposure with creation of conduit for delivery of endovascular prosthesis or for establishment of cardiopulmonary bypass, by abdominal or retroperitoneal incision, unilateral (List separately in addition to code for primary procedure)
- CPT® code 34820 - Open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision, unilateral (List separately in addition to code for primary procedure)

CPT® code 34833 is followed by a *CPT® Manual* instruction that states: "(Do not report 34833 in conjunction with 33364, 33953, 33954, 33959, 33962, 33969, 33984, 34820 when performed on the same side)." Although the CPT® code descriptors for 34833 and 34820 describe different procedures, they should not be reported together for the same side. Modifier 59 should not be appended to either code to report the two procedures for the same side of the body. If the two procedures were performed on different sides of the body, they may be reported with modifiers LT and RT as appropriate. **However, modifier 59 is used inappropriately if the basis for its use is that the narrative description of the two codes is different.**

Example 9: Column 1 code /column 2 code - 97140/97530

- CPT® code 97140 – Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes
- CPT® code 97530 – Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes

Modifier 59 may be reported if the two procedures are performed in distinctly different 15 minute time blocks. For example, one service may be performed during the initial 15 minutes of therapy and the other service performed during the second 15 minutes of therapy. Alternatively, the therapy time blocks may be split. For example, manual therapy might be performed for 10 minutes, followed by 15 minutes of therapeutic activities, followed by another 5 minutes of manual therapy. CPT® code 97530 should not be reported and modifier 59 should not be used if the two procedures are performed during the same time block. **Modifier 59 is used appropriately when two timed procedures are performed in different blocks of time on the same day.**

Example 10: Column 1 code /column 2 code - 37220/75710

- CPT® code 37220 – Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty
- CPT® code 75710 – Angiography, extremity, unilateral, radiological supervision and interpretation.

Modifier 59 may be reported with CPT® code 75710 if a diagnostic angiography has not been previously performed and the decision to perform the revascularization is based on the result of the diagnostic angiography. The *CPT® Manual* defines additional circumstances under which diagnostic angiography may be reported with an interventional vascular procedure on the same artery. **Modifier 59 is used appropriately for a diagnostic procedure which precedes a therapeutic procedure only when the diagnostic procedure is the basis for performing the therapeutic procedure.**

See **MODIFIER**, page 9

MODIFIER

from page 8

Additional information

The CMS web page on the National Correct Coding Initiative Edits is available at *https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html* on the CMS website. There is a modifier 59 article on this website also.

The *CPT® Manual* includes the definition of modifier 59, as well as CPT® codes used with modifier 59. The manual is available at *https://www.ama-assn.org/ama* on the American Medical Association (AMA) website.

You may want to review *MLN Matters®* article *MM8863* that alerts providers that CMS is establishing four new HCPCS modifiers to define subsets of modifier 59, distinct procedural services.

Document history

Date of change	Description
June 2, 2014	Initial article released.
May 27, 2015	This article was revised to provide a reference to *MLN Matters®* article *SE1503* that advises physicians, providers and suppliers submitting bills to Medicare that additional guidance and education on the appropriate use of the new X modifiers will be introduced in a gradual, controlled fashion by CMS and that providers may continue to use modifier -59 after January 1, 2015, in any instance in which it was correctly used before January 1, 2015. All other information is unchanged.

Date of change	Description
January 3, 2018	Article updated to conform with latest modifier 59 article on the NCCI website.

MLN Matters® Number: SE1418 *Revised*
Related Change Request (CR) #: N/A
Article Release Date: January 3, 2018
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

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.*

Ambulatory Surgical Center

January 2018 update of the ASC payment system

Provider type affected

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

What you need to know

Change request (CR) 10441 informs MACs about updates to the ASC payment system for January 2018. Be sure your billing staffs are aware of these changes.

Background

CR 10441 includes changes to and billing instructions for various payment policies implemented in the January 2018 ASC payment system update and also includes updates to the Healthcare Common Procedure Coding System (HCPCS).

This notification includes 2018 payment rates for separately payable drugs and biologicals, including descriptors for newly created Level II HCPCS codes for drugs and biologicals (ASC DRUG files), and the 2018 ASC payment rates for covered surgical and ancillary services (ASCFS file). No ASC code pair file is being issued with this notice.

ASC payment rates under the ASC payment system are generally established using payment rate information in the hospital outpatient prospective payment system (OPPS) or the Medicare physician fee schedule (MPFS). The payment files associated with CR 10441 reflect the most recent changes to 2018 OPPS and 2018 MPFS payments.

The changes in CR 10441 are as follows:

1. a. New device pass-through policies

Section 1833(t)(6)(B) of the Social Security Act (the Act) requires that, under the OPPS, categories of devices be eligible for transitional pass-through payments for at least two, but not more than three years. Section 1833(t)(6)(B)(ii)(IV) of the Act requires that the Centers for Medicare & Medicaid Services (CMS) creates additional categories for transitional pass-through payment of new medical devices not described by existing or previously existing categories of devices. This policy was implemented in the 2008 revised ASC payment system. Therefore, additional payments may be made to the ASC for covered ancillary services, including certain implantable devices with pass-through status under the OPPS.

Effective January 1, 2018, there are no device categories eligible for pass-through payment. However, an existing device described by HCPCS code C2623 (*Catheter, transluminal angioplasty, drug coated, non laser*) was recently approved by Food and Drug Administration (FDA) for a new indication, specifically the treatment of patients with Dysfunctional Arteriovenous (AV) fistulae.

Accordingly, in this January 2018 update, devices described by HCPCS code C2623 are eligible for pass-through status retroactive to August 25, 2017, when the device is billed with *Current Procedural Terminology* (CPT®) code 36902 (*Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report; with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty*) or CPT® code 36903 (*Insertion of needle and/or catheter into dialysis circuit and insertion of stent in dialysis segment, with imaging including radiological supervision and interpretation*).This device pass through status will be applied retroactively from August 25, 2017, through December 31, 2017.

1. b. Device offset from payment for device category

Section 1833(t)(6)(D)(ii) of the Act requires that CMS deduct from pass-through payments for devices an amount that reflects the portion of the Ambulatory Payment Classifications (APC) payment amount. With respect to device code C2623, CMS has previously determined that the costs associated with C2623 are not reflected in the APC payment amount. Therefore, CMS is not applying a device offset to the retroactive pass-through payments for C2623. Retroactive pass-through payments for services furnished on August 25, 2017, through December 31, 2017, without deduction, will only apply when HCPCS code C2623 is billed with CPT® codes 36902 or 36903.

2. New separately payable procedure code, effective January 1, 2018

Effective January 1, 2018, new HCPCS code C9748 has been created as described in Table 1.

Table 1 – New separately payable procedure code, effective January 1, 2018

HCPCS code	Short descriptor	Long descriptor	ASC PI
C9748	Prostatic rf water vapor tx	Transurethral destruction of prostate tissue; by radiofrequency water vapor (steam) thermal therapy	G2

See **ASC**, page 11

ASC

from page 10

3. Drugs, biologicals, and radiopharmaceuticals

a. New 2018 HCPCS codes and dosage descriptors for certain drugs, biologicals, and radiopharmaceuticals

For 2018, several new HCPCS codes have been created for reporting drugs and biologicals in the ASC payment system, where there have not previously been specific codes available. These new codes are listed in Table 2.

Table 2 – New 2018 HCPCS codes and dosage descriptors for certain drugs, biologicals, and radiopharmaceuticals

HCPCS code	Short descriptor	Long descriptor	ASC PI
C9014	Injection, cerliponase alfa	Injection, cerliponase alfa, 1 mg	K2
C9015	C-1 esterase, haegarda	Injection, c-1 esterase inhibitor (human), Haegarda, 10 units	K2
C9016	Inj, triptorelin ext rel	Injection, triptorelin extended release, 3.75 mg	K2
C9024	Inj, daunorubicin-cytarabine	Injection, liposomal, 1 mg daunorubicin and 2.27 mg cytarabine	K2
C9028	Inj. inotuzumab ozogamicin	Injection, inotuzumab ozogamicin, 0.1 mg	K2
C9029	Injection, guselkumab	Injection, guselkumab, 1 mg	K2
J0606	Inj, etelcalcetide, 0.1 mg	Injection, etelcalcetide, 0.1 mg	K2
J1555	Inj cuvitru, 100 mg	Injection, immune globulin (cuvitru), 100 mg	K2
J7211	Inj, kovaltry, 1 i.u.	Injection, factor viii, (antihemophilic factor, recombinant), (kovaltry), 1 i.u.	K2
J7345	Aminolevulinic acid, 10% gel	Aminolevulinic acid hcl for topical administration, 10% gel, 10 mg	K2
J9203	Gemtuzumab ozogamicin 0.1 mg	Injection, gemtuzumab ozogamicin, 0.1 mg	K2
Q2040	Tisagenlecleucel car-pos t		K2

b. Other changes to 2018 HCPCS and CPT® codes for certain drugs, biologicals, and radiopharmaceuticals

Many HCPCS and CPT® codes for drugs, biologicals, and radiopharmaceuticals have undergone changes in their HCPCS and CPT® code descriptors that will be effective in 2018. In addition, several temporary HCPCS C-codes have been deleted, effective December 31, 2017, and replaced with permanent HCPCS codes in 2018. ASCs should pay close attention to accurate billing for units of service consistent with the dosages contained in the long descriptors of the 2018 HCPCS and CPT® codes.

Table 3 notes those drugs, biologicals, and radiopharmaceuticals that have undergone changes in their HCPCS/CPT® code, their long descriptor, or both. Each product's 2017 HCPCS/CPT® code and long description is included.

Table 3 – Other 2018 HCPCS and CPT® code changes for certain drugs, biologicals, and radiopharmaceuticals

2017 HCPCS code	2017 long descriptor	2018 HCPCS code	2018 long descriptor
C9490	Injection, bezlotoxumab, 10 mg	J0565	Injection, bezlotoxumab, 10 mg
C9484	Injection, eteplirsen, 10 mg	J1428	Injection, eteplirsen, 10 mg
C9486	Injection, granisetron extended release, 0.1 mg	J1627	Injection, granisetron, extended-release, 0.1 mg
Q9986	Injection,	J1726	Injection,
C9489	Injection, nusinersen, 0.1 mg	J2326	Injection, nusinersen, 0.1 mg
C9494	Injection, ocrelizumab, 1 mg	J2350	Injection, ocrelizumab, 1 mg

See **ASC**, page 12

ASC

from page 11

2017 HCPCS code	2017 long descriptor	2018 HCPCS code	2018 long descriptor
Q9989	Ustekinumab, for Intravenous Injection, 1 mg	J3358	Ustekinumab, for intravenous injection, 1 mg
C9140	Injection, Factor VIII (antihemophilic factor, recombinant) (Afstyla), 1 I.U.	J7210	Injection, factor viii, (antihemophilic factor, recombinant), (Afstyla), 1 i.u.
C9483	Injection, atezolizumab, 10 mg	J9022	Injection, atezolizumab, 10 mg
C9491	Injection, avelumab, 10 mg	J9023	Injection, avelumab, 10 mg
C9485	Injection, olaratumab, 10 mg	J9285	Injection, olaratumab, 10 mg

c. Drugs and biologicals with payments based on average sales price (ASP), effective January 1, 2018

For 2018, payment for non-pass-through drugs, biologicals and therapeutic radiopharmaceuticals continues to be made at a single rate of ASP + six percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical. In addition, in 2018, a single payment of ASP + six percent continues to be made for pass-through drugs, biologicals and radiopharmaceuticals is made to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items. Payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available.

Effective January 1, 2018, payment rates for many drugs and biologicals have changed from the values published in the 2018 OPPS/ASC final rule with comment period as a result of the new ASP calculations based on sales price submissions from the third quarter of 2017. In cases where adjustments to payment rates are necessary, CMS is not publishing the updated payment rates in CR 10441.

However, all ASC payable drugs and biologicals, effective January 1, 2018, including those that were updated as a result of the new ASP calculations are in the January 2018 ASC Addendum BB at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html*.

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

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

Suppliers who think they may have received an incorrect payment for drugs and biologicals impacted by these corrections may request contractor adjustment of the previously processed claims.

e. Biosimilar biological product payment policy

Effective January 1, 2018, the payment rate for biosimilars approved for payment in the ASC payment system will be the same as the payment rate in the OPPS and physician office setting, calculated as the ASP of the biosimilar(s) described by the HCPCS code + six percent of the ASP of the reference product. Payment will be made at the single ASP + six percent rate.

As a reminder, ASC claims for separately paid biosimilar biological products are required to include the modifier that identifies the manufacturer of the specific product. The modifier does not affect payment determination, but is used to distinguish between biosimilar products that appear in the same HCPCS code, but are made by different manufacturers. Any changes to the billing requirements for biosimilar biological products will be issued to ASCs in a future transmittal.

f. Skin-substitute assignments to high-cost and low-cost groups for 2018

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

The skin substitute products are divided into two groups:

1) High-cost skin substitute products, and

2) Low-cost skin substitute products for packaging purposes.

Table 4 lists the skin-substitute products and their assignment as either a high-cost or a low-cost skin substitute product, when applicable. ASCs should not separately bill for packaged skin substitutes (ASC PI=N1). Note that:

- High-cost skin-substitute products should only be used in combination with the performance of one of the skin application procedures described by CPT® codes 15271-15278.
- Low-cost skin-substitute products should only be used in combination with the performance of one of the skin application procedures described by HCPCS code C5271-C5278.
- All OPPS pass-through skin-substitute products (ASC PI=K2) should be billed in combination with one of the skin application procedures described by CPT® code 15271-15278.

Note: All of the skin substitute products listed in this table

See **ASC**, page 13

ASC

from page 12

are packaged and should not be separately billed by ASCs.

Table 4 — Skin-substitute assignments to high-cost and low-cost groups for 2018

HCPCS code	2018 Short descriptor	ASC PI	2018 high/low assignment
C9363	Integra meshed bil wound mat	N1	High
Q4100	Skin substitute, nos	N1	Low
Q4101	Apligraf	N1	High
Q4102	Oasis wound matrix	N1	Low
Q4103	Oasis burn matrix	N1	High
Q4104	Integra bmwd	N1	High
Q4105	Integra drt or omnigraft	N1	High
Q4106	Dermagraft	N1	High
Q4107	Graftjacket	N1	High
Q4108	Integra matrix	N1	High
Q4110	Primatrix	N1	High
Q4111	Gammagraft	N1	Low
Q4115	Alloskin	N1	Low
Q4116	Alloderm	N1	High
Q4117	Hyalomatrix	N1	Low
Q4121	Theraskin	N1	High
Q4122	Dermacell	N1	High
Q4123	Alloskin	N1	High
Q4124	Oasis tri-layer wound matrix	N1	Low
Q4126	Memoderm/ derma/tranz/ integup	N1	High
Q4127	Talymed	N1	High
Q4128	Flexhd/ allopatchhd/ matrixhd	N1	High
Q4131	Epifix or epicord	N1	High
Q4132	Grafix core, grafixpl core	N1	High
Q4133	Grafix prime grafix pl prime	N1	High
Q4134	Hmatrix	N1	Low
Q4135	Mediskin	N1	Low
Q4136	Ezderm	N1	Low
Q4137	Amnioexcel or biodexcel, 1cm	N1	High
Q4138	Biodfence dryflex, 1cm	N1	High
Q4140	Biodfence 1cm	N1	High
Q4141	Alloskin ac, 1cm	N1	High
Q4143	Repriza, 1cm	N1	High
Q4146	Tensix, 1 cm	N1	High
Q4147	Architect ecm px fx 1 sq cm	N1	High
Q4148	Neox rt or clarix cord	N1	High
Q4150	Allowrap ds or dry 1 sq cm	N1	High
Q4151	Amnioband, guardian 1 sq cm	N1	High
Q4152	Dermapure 1 square cm	N1	High
Q4153	Dermavest, plurivest sq cm	N1	High
Q4154	Biovance 1 square cm	N1	High
Q4156	Neox 100 or clarix 100	N1	High
Q4157	Revitalon 1 square cm	N1	High
Q4158	Neox 100 or clarix 100	N1	High
Q4159	Neox 100 or clarix 100	N1	High
Q4160	Neox 100 or clarix 100	N1	High
Q4161	Bio-Connekt per square cm	N1	High
Q4163	Woundex, bioskin, per sq cm	N1	High
Q4164	Helicoll, per square cm	N1	High
Q4165	Keramatrix, per square cm	N1	Low
Q4166	Cytal, per square cm	N1	Low
Q4167	Truskin, per square cm	N1	Low
Q4169	Artacent wound, per square cm	N1	High
Q4170	Cygnus, per square cm	N1	Low
Q4172*	Puraply or puraply am	N1	High

See **CLFS**, page 14

ASC

from page 13

HCPCS code	2018 Short descriptor	ASC PI	2018 high/low assignment
Q4173	Palingen or palingen xplus	N1	High
Q4175	Miroderm	N1	High
Q4176*	Neopatch, per sq centimeter	N1	Low
Q4178*	Floweramniopatch, per sq cm	N1	Low
Q4179*	Flowerderm, per sq cm	N1	Low
Q4180*	Revita, per sq cm	N1	Low
Q4181*	Amnio wound, per square cm	N1	Low
Q4182*	Transcyte, per sq centimeter	N1	Low

Note: HCPCS codes Q4176, Q4178, Q4179, Q4180, Q4181, and Q4182 were assigned to the low-cost group in 2018 OPPS/ASC final rule with comment period. Pass-through status for HCPCS code Q4172 ended December 31, 2017.

4. Section 4011 of the 21st Century Cures Act

Section 4011 of the 21st Century Cures Act created a new subsection (t) in Section 1834 of the Act that requires CMS to make available to the public a searchable Internet website that compares estimated payment and beneficiary liability for an appropriate number of items and services paid under the OPPS and the ASC payment system. Consistent with this statute, CMS plans to first make this website available during 2018.

CMS believes that making available a comparison for all services that receive separate payment under both the OPPS and ASC payment system would be most useful to the public, with regards to displaying the comparison for an "appropriate number of such items and services." CMS believes that displaying the national unadjusted payments and copayment amounts will allow the user to make a meaningful comparison between the systems for items and services paid under both systems. CMS may consider providing payment and copayment comparisons at the locality or provider level for future years.

Along with the comparison information that CMS will make available to the public in accordance with the requirements of Section 4011, CMS also plans to include a disclaimer statement that notes some of the payment policy differences in each care setting and describes the limitations of the comparison tool, to provide users with some context for why there might be potential differences. In the case of the OPPS copayments, CMS plans to include an additional indicator where the service is likely to be capped at the Part A inpatient deductible, based on the unadjusted copayments, under the OPPS coinsurance rules.

5. July ASCFS technical record correction

CMS is including a revised July ASCFS record to provide

a technical correction to the record for 0474T, position 38, on the ASCFS record layout. The original indicator was incompatible with this code. No additional instructions are being provided to MACs at this time.

6. Coverage determinations

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

Additional information

The official instruction, CR 10441, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3939CP.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
January 2, 2018	Initial article released.

MLN Matters® Number: MM10441
Related CR Release Date: December 22, 2017
Related CR Transmittal Number: R3939CP
Related Change Request (CR) Number: 10441
Effective Date: January 1, 2018
Implementation Date: January 2, 2018

Drugs & Biologicals

April 2018 quarterly ASP Medicare Part B drug pricing files and revisions to prior quarterly pricing files

Provider type affected

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

Provider action needed

Change request (CR) 10447 instructs MACs to download and implement the April 2018 and, if released, the revised January 2018, October 2017, July 2017, and April 2017 ASP drug pricing files for Medicare Part B drugs via the Centers for Medicare & Medicaid Services (CMS) data center (CDC). Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after April 2, 2018, with dates of service April 1, 2018, through June 30, 2018. Make sure that your billing staffs are aware of these changes.

Background

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

- File: April 2018 ASP and ASP NOC -- Effective for dates of service of April 1, 2018, through June 30, 2018
- File: January 2018 ASP and ASP NOC -- Effective for dates of service of January 1, 2018, through March 31, 2018
- File: October 2017 ASP and ASP NOC -- Effective for dates of service of October 1, 2017, through December 31, 2017
- File: July 2017 ASP and ASP NOC -- Effective for dates of service of July 1, 2017, through September 30, 2017
- File: April 2017 ASP and ASP NOC -- Effective for dates of service of April 1, 2017, through June 30, 2017

For any drug or biological not listed in the ASP or NOC drug pricing files, your MACs will determine the payment allowance limits in accordance with the policy described in the *Medicare Claims Processing Manual* Chapter 17, Section 20.1.3 at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c17.pdf*.

For any drug or biological not listed in the ASP or NOC drug pricing files that is billed with the KD modifier, MACs will determine the payment allowance limits in accordance with instructions for pricing and payment changes for infusion drugs furnished through an item of durable medical equipment on or after January 1, 2017, associated with the passage of the 21st Century Cures Act which is available at *https://www.gpo.gov/fdsys/pkg/PLAW-114publ255/pdf/PLAW-114publ255.pdf*.

Additional information

The official instruction, CR 10447, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R3947CP.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
January 5, 2018	Initial article released.

MLN Matters® Number: MM10447
Related CR Release Date: January 5, 2018
Related CR Transmittal Number: R3947CP
Related Change Request (CR) Number: 10447
Effective Date: April 1, 2018
Implementation Date: April 2, 2018

Durable Medical Equipment

2018 update for DMEPOS fee schedule

Provider type affected

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

Provider action needed

Change request (CR) 10395 provides the 2018 annual update for the Medicare DMEPOS fee schedule. The instructions include information on the data files, update factors and other information related to the update of the fee schedule. Make sure your billing staffs are aware of these updates.

Background

Section 1834(a), (h), and (i) of the Social Security Act (the Act) requires payment on a fee schedule for certain DMEPOS. Also, payment on a fee-schedule basis is a regulatory requirement at 42 CFR Section 414.102 for parenteral and enteral nutrition (PEN), splints, casts, and Intraocular Lenses (IOLs) inserted in a physician's office.

Section 1834(a)(1)(F)(ii) of the Act mandates adjustments to the fee schedule amounts for certain items furnished on or after January 1, 2016, in areas that are not competitive bid areas, based on information from competitive bidding programs (CBPs) for DME. Section 1842(s)(3)(B) of the Act provides authority for making adjustments to the fee schedule amounts for enteral nutrients, equipment, and supplies (enteral nutrition) based on information from CBPs. Regulations at 42 CFR Section 414.210(g) established the methodologies for adjusting DMEPOS fee schedule amounts using information from CBPs. Recent program instructions on these changes are available in Transmittal 3551, CR 9642, dated June 23, 2016 (MM9642 is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM9642.pdf*), and Transmittal 3416, CR 9431, dated November 23, 2015 (MM9431 is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM9431.pdf*).

The DMEPOS and parenteral and enteral nutrition (PEN) fee schedule files contain HCPCS codes that are subject to the adjusted fee schedule amounts as well as codes that are not subject to the fee schedule CBP adjustments. Fee schedule amounts that are adjusted using information from CBPs will not be subject to the annual DMEPOS covered item update, but will be updated pursuant to 42 CFR Section 414.210(g)(8) when information from the CBPs is updated.

Pursuant to 42 CFR Section 414.210(g)(4), for items where the single payment amounts (SPAs) from CBPs no longer in effect are used to adjust fee schedule amounts, the SPAs are increased by the percentage changes in the consumer price index for all urban consumers (CPI-U) from the last year of the applicable CBP to the current year. Information on the update factor for 2018 is included below.

The ZIP code associated with the address used for pricing a DMEPOS claim determines the rural fee schedule payment applicability for codes with rural and non-rural adjusted fee schedule amounts. ZIP codes for non-continental metropolitan statistical areas (MSAs) are not included in the DMEPOS rural ZIP code file. The DMEPOS rural ZIP code file is updated on a quarterly basis, as necessary. Regulations at 42 CFR 414.202 define a rural area to be a geographical area represented by a postal ZIP code where at least 50 percent of the total geographical area of the ZIP code is estimated to be outside any MSA. A rural area also included any ZIP code within an MSA that is excluded from a competitive bidding area established for that MSA.

The DMEPOS fee schedule file contains fee schedule amounts for non-rural and rural areas. Also, the PEN fee schedule file includes state fee schedule amounts for enteral nutrition items and national fee schedule amounts for parenteral nutrition items.

The DMEPOS and PEN fee schedules and the rural ZIP code public use files (PUFs) will be available for state Medicaid agencies, managed care organizations, and other interested parties at *www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched*.

New codes added

- New DMEPOS codes added to the HCPCS file, effective January 1, 2018, where applicable, are:
- E0953 and E0954 in the inexpensive/routinely purchased (IN) payment category
- L3761, L7700, L8625, L8694, and Q0477, which are all in the prosthetics and orthotics (PO) payment category.

For gap-filling pricing purposes, deflation factors are

See **DME**, page 17

DME

from page 16

applied before updating to the current year. The deflation factors for 2017 by the payment category are:

- 0.447 for oxygen
- 0.450 for capped rental
- 0.451 for prosthetics and orthotics
- 0.572 for surgical dressings
- 0.623 for parental and enteral nutrition
- 0.953 for splints and casts
- 0.937 for intraocular lenses

Codes deleted

No HCPCS codes will be deleted from the DMEPOS fee schedule files effective January 1, 2018.

Specific coding and pricing issues

Effective January 1, 2018, new off-the-shelf orthotic (OTS) code L3761 - Elbow orthosis (EO), with adjustable position locking joint(s) prefabricated off-the-shelf - is included in the fee schedule file. Code L3760 was split into two codes: The existing code revised, effective January 1, 2018, to only describe devices customized to fit a specific patient by an individual with expertise, and a new code describing OTS items (L3761).

The fee schedule amount for existing code L3760 will be applied to new code L3761 effective January 1, 2018. The cross-walking of fee schedule amounts for a single code that is split into two codes for distinct complete items is in accordance with the instructions stated in Chapter 3, Section 60.3.1 of the *Medicare Claims Processing Manual*. An update will be made to the list of orthotic codes that are designated as OTS at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/OTS_Orthotics.html* to reflect added code L3761.

As part of this update, a corrected calculation is applied to the adjusted fee schedule amounts for codes A4619, E0147, and E0580. The fee schedule adjustment methodology at 42 CFR 414.210(g) was incorrectly applied to these codes, and therefore corrections to the adjusted fee schedule amounts for these codes have been made.

Effective January 1, 2018, the replacement external sound processor (HCPCS code L8691) is split into two codes in order to appropriately identify devices where the actuator is a separate component from the sound processor, microphones, and battery. The two codes are a revised L8691 and a new L8694 transducer/actuator code.

Effective January 1, 2018, the existing fee schedules for L8691 are revised to remove payment for the separate transducer/actuator component. Suppliers billing for replacement sound processors that do not separate the sound processor and the actuator should use both L8691 and L8694 to describe the replaced items. Suppliers billing for replacement sound processors that separate the sound processor and the actuator components should use either or both L8691 and L8694 as appropriate to describe the sound processor component(s).

The replacement ventricular assist device (VAD) power module code Q0479 is split in order to separately identify the patient cable. Effective January 1, 2018, HCPCS code Q0477 identifies a replacement patient cable. Thus, the fees for Q0479 are revised to reflect the establishment of the new patient cable code.

The Centers for Medicare & Medicaid Services (CMS) is also adjusting the fee schedule amounts for shoe modification codes A5503 through A5507 in order to reflect more current allowed service data. Section 1833(o)(2)(C) of the Act required that the payment amounts for shoe modification codes A5503 through A5507 be established in a manner that prevented a net increase in expenditures when substituting these items for therapeutic shoe insert codes (A5512 or A5513). To establish the fee schedule amounts for the shoe modification codes, the base fees for codes A5512 and A5513 were weighted based on the approximated total allowed services for each code for items furnished during the second quarter of calendar year 2004.

For 2018, CMS is updating the weighted average insert fees used to establish the fee schedule amounts for the shoe modification codes with more current allowed service data for each insert code. The base fees for A5512 and A5513 will be weighted based on the approximated total allowed services for each code for items furnished during the calendar year 2016. The fee schedule amounts for shoe modification codes A5503 through A5507 are being revised to reflect this change, effective January 1, 2018.

As part of this file update, the jurisdiction for HCPCS code E0781 is revised from 'J' to 'D'.

HCPCS code Q0477 (Power Module Patient Cable for Use with Electric or Electric/Pneumatic Ventricular Assist Device, Replacement Only) is being added to the HCPCS file, effective January 1, 2018, to describe a replacement accessory for Ventricular Assist Devices (VADs). Similar to the other VAD supplies and accessories coded at Q0478 thru Q0495, Q0497-Q0502, and Q0504 thru Q0509, CMS has determined the reasonable useful lifetime for code Q0477 to be one year. Therefore, CMS will deny claims for Q0477 before the lifetime of these items has expired. Suppliers and providers will need to add modifier RA to claims for code Q0477 in cases where the battery is being replaced because it was lost, stolen, or irreparably damaged.

Fees for the 'KU' modifier when billed with wheelchair codes E0953 and E0954 are included in the January 2018 file for billing when these items are furnished in connection with Group 3 complex rehabilitative power wheelchairs.

Diabetic testing supplies

The fee schedule amounts for non-mail order diabetic testing supplies (DTS) (without KL modifier) for codes A4233, A4234, A4235, A4236, A4253, A4256, A4258, and A4259 are not updated by the annual covered item update. In accordance with Section 636(a) of the American Taxpayer Relief Act of 2012, the fee schedule amounts for these codes were adjusted in 2013 so that they are

See **DME**, page 18

DME

from page 17

equal to the single payment amounts (SPAs) for mail order DTS established in implementing the national mail order CBP under Section 1847 of the Act. The national mail-order recompete DTS SPAs are available at *https://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home*.

The non-mail order DTS amounts on the fee schedule file will be updated each time the SPAs are updated. This can happen no less often than every time the mail order CBP contracts are recompeted. The CBP for mail order diabetic supplies is effective July 1, 2016, to December 31, 2018. The program instructions reviewing these changes are included in Transmittal 2709, Change request (CR) 8325, dated May 17, 2013, and Transmittal 2661, CR 8204, dated February 22, 2013. You can review related article MM8325 at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8325.pdf* and MM8204 at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8204.pdf*.

2018 fee schedule update factor of 1.1 percent

For 2018, an update factor of 1.1 percent is applied to certain DMEPOS fee schedule amounts. In accordance with the statutory Sections 1834(a)(14) of the Act, certain DMEPOS fee schedule amounts are updated for 2018 by the percentage increase in the CPI- U for the 12-month period ending June 30, 2017, adjusted by the change in the economy-wide productivity equal to the 10-year moving average of changes in annual economy-wide private non-farm business multi-factor productivity (MFP). The MFP adjustment is 0.5 percent and the CPI-U percentage increase is 1.6 percent. Thus, the 1.6 percentage increase in the CPI-U is reduced by the 0.5 percentage increase in the MFP resulting in a net increase of 1.1 percent for the update factor.

2018 update to the labor payment rates

The 2018 allowed payment amounts for HCPCS labor payment codes K0739, L4205, and L7520 are in the table below. Since the percentage increase in the CPI- U for the 12-month period ending with June 30, 2017, is 1.6 percent, this change is applied to the 2017 labor payment amounts to update the rates for 2018.

State	K0739	L4205	L7520
AK	$28.74	$32.75	$38.53
AL	$15.26	$22.74	$30.87
AR	$15.26	$22.74	$30.87
AZ	$18.87	$22.71	$37.98
CA	$23.41	$37.33	$43.49
CO	$15.26	$22.74	$30.87
CT	$25.48	$23.25	$30.87
DC	$15.26	$22.71	$30.87
DE	$28.09	$22.71	$30.87
FL	$15.26	$22.74	$30.87
GA	$15.26	$22.74	$30.87
HI	$18.87	$32.75	$38.53
IA	$15.26	$22.71	$36.95
ID	$15.26	$22.71	$30.87
IL	$15.26	$22.71	$30.87
IN	$15.26	$22.71	$30.87
KS	$15.26	$22.71	$38.53
KY	$15.26	$29.11	$39.47
LA	$15.26	$22.74	$30.87
MA	$25.48	$22.71	$30.87
MD	$15.26	$22.71	$30.87
ME	$25.48	$22.71	$30.87
MI	$15.26	$22.71	$30.87
MN	$15.26	$22.71	$30.87
MO	$15.26	$22.71	$30.87
MS	$15.26	$22.74	$30.87
MT	$15.26	$22.71	$38.53
NC	$15.26	$22.74	$30.87
ND	$19.02	$32.67	$38.53
NE	$15.26	$22.71	$43.04
NH	$16.39	$22.71	$30.87
NJ	$20.58	$22.71	$30.87
NM	$15.26	$22.74	$30.87
NV	$24.31	$22.71	$42.07
NY	$28.09	$22.74	$30.87
OH	$15.26	$22.71	$30.87
OK	$15.26	$22.74	$30.87
OR	$15.26	$22.71	$44.38
PA	$16.39	$23.39	$30.87
PR	$15.26	$22.74	$30.87
RI	$18.19	$23.41	$30.87
SC	$15.26	$22.74	$30.87
SD	$17.06	$22.71	$41.27
TN	$15.26	$22.74	$30.87
TX	$15.26	$22.74	$30.87
UT	$15.30	$22.71	$48.07
VA	$15.26	$22.71	$30.87
VI	$15.26	$22.74	$30.87
VT	$16.39	$22.71	$30.87
WA	$24.31	$33.31	$39.58
WI	$15.26	$22.71	$30.87
WV	$15.26	$22.71	$30.87
WY	$21.28	$30.31	$43.04

See **DME**, page 19

DME

from page 18

2018 national monthly fee schedule amounts for stationary oxygen equipment

CMS is implementing the 2017 monthly fee schedule payment amounts for stationary oxygen equipment (HCPCS codes E0424, E0439, E1390, and E1391), effective for claims with dates of service from January 1, 2018, through December 31, 2018. As required by statute, the addition of the separate payment classes for oxygen generating portable equipment (OGPE) and stationary and portable oxygen contents must be annually budget neutral. Medicare expenditures must account for these separate oxygen payment classes.

Therefore, the fee schedule amounts for stationary oxygen equipment are reduced by a certain percentage each year to balance the increase in payments made for the additional separate oxygen payment classes. For dates of service January 1, 2018, through December 31, 2018, the monthly fee schedule payment amounts for stationary oxygen equipment range from approximately $66 to $76 incorporating the budget neutrality adjustment factor.

When updating the stationary oxygen equipment amounts, corresponding updates are made to the fee schedule amounts for HCPCS codes E1405 and E1406 for oxygen and water vapor enriching systems. Since 1989, the payment amounts for codes E1405 and E1406 have been established based on a combination of the Medicare payment amounts for stationary oxygen equipment and nebulizer codes E0585 and E0570, respectively.

2018 maintenance and servicing payment amount for certain oxygen equipment

CMS is also updating for 2018 the payment amount for maintenance and servicing for certain oxygen equipment. Payment for claims for maintenance and servicing of oxygen equipment was instructed in Transmittal 635, CR 6792, dated February 5, 2010, and Transmittal 717, CR 6990, dated June 8, 2010.(You can review related articles MM6792 at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6792.pdf* and MM6990 at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6990.pdf*.) To summarize, payment for maintenance and servicing of certain oxygen equipment can occur every six months beginning six months after the end of the 36th month of continuous use or end of the supplier's or manufacturer's warranty, whichever is later for either HCPCS code E1390, E1391, E0433, or K0738, billed with the "MS" modifier. Payment cannot occur more than once per beneficiary, regardless of the combination of oxygen concentrator equipment and/or transfilling equipment used by the beneficiary, for any six-month period.

Per 42 CFR 414.210(e)(5)(iii), the 2010 maintenance and servicing fee for certain oxygen equipment was based on 10 percent of the average price of an oxygen concentrator. For 2011 and subsequent years, the maintenance and servicing fee is adjusted by the covered item update for DME as set forth in §1834(a)(14) of the Act. Thus, the 2017 maintenance and servicing fee is adjusted by the 1.1 percent MFP-adjusted covered item update factor to yield a 2018 maintenance and servicing fee of $70.74 for oxygen concentrators and transfilling equipment.

Additional information

The official instruction, CR 10395, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3931CP.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
January 5, 2018	Initial article released.

MLN Matters® Number: MM10395
Related CR Release Date: December 1, 2017
Related CR Transmittal Number: R3931CP
Related Change Request (CR) Number: 10395
Effective Date: January 1, 2018
Implementation Date: January 2, 2018

2018 DMEPOS HCPCS jurisdiction list

Provider type affected

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

Provider action needed

Change request (CR) 10416 updates the list of Healthcare Common Procedure Coding System (HCPCS) codes for the MACs and DME MACs. Please make sure your billing staffs are aware of these updates.

What you need to know

The Centers for Medicare & Medicaid Services (CMS) annually updates a spreadsheet that contains a list of the HCPCS codes for DME MACs and Part B MACs jurisdictions to reflect codes that have been added or discontinued (deleted) each year. The jurisdiction list is an Excel file and is available at *https://www.cms.gov/Center/Provider-Type/Durable-Medical-Equipment-DME-Center.html*.

The file is also available as an attachment to CR 10416.

Additional information

The official instruction, CR 10416, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-andGuidance/Guidance/Transmittals/2018Downloads/R3950CP.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
January 12, 2018	Initial article released.

MLN Matters® Number: MM10416
Related Change Request (CR) Number: 10416
Related CR Release Date: January 12, 2018
Effective Date: January 1, 2018
Related CR Transmittal Number: R3950CP
Implementation February 13, 2018

2018 DMEPOS jurisdiction listing

This article is informational and is based on change request (CR) 10416 that notifies providers that the spreadsheet containing an updated list of the healthcare common procedure coding system (HCPCS) codes for durable medical equipment Medicare administrative contractor (DME MAC) or Part B MAC jurisdictions is updated annually to reflect codes that have been added or discontinued (deleted) each year.

The spreadsheet is helpful to billing staff by showing the appropriate Medicare contractor to be billed for HCPCS appearing on the spreadsheet. The spreadsheet for the 2017 jurisdiction list is attached to CR 10416 at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R3950CP.pdf. Note that deleted codes are valid for dates of service on or before the date of deletion and updated codes are in bold.

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

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

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

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

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

HCPCS	Description	Jurisdiction
A0021 - A0999	Ambulance services	Part B MAC
A4206 - A4209	Medical, surgical, and self-administered injection supplies	Part B MAC if incident to a physician's service (not separately payable). If other, DME MAC.
A4210	Needle free injection device	DME MAC
A4211	Medical, surgical, and self-administered injection service	Part B MAC if incident to a physician's (not separately payable). If other, DME MAC.
A4212	Non coring needle or stylet with or without catheter	Part B MAC

See **LISTING**, page 21

LISTING

from page 20

HCPCS	Description	Jurisdiction
A4213 - A4215	Medical, surgical, and self-administered injection supplies	Part B MAC if incident to a physician's service (not separately payable). If other, DME MAC.
A4216 - A4218	Saline	Part B MAC if incident to a physician's service (not separately payable). If other, DME MAC.
A4220	Refill kit for implantable pump	Part B MAC
A4221 - A4236	Self-administered injection and diabetic supplies	DME MAC
A4244 - A4250	Medical, surgical, and self-administered injection supplies	Part B MAC if incident to a physician's service (not separately payable). If other, DME MAC.
A4252 - A4259	Diabetic supplies	DME MAC
A4261	Cervical cap for contraceptive use	Part B MAC
A4262 - A4263	Lacrimal duct implants	Part B MAC
A4264	Contraceptive implant	Part B MAC
A4265	Paraffin	Part B MAC if incident to a physician's service (not separately payable). If other, DME MAC.
A4266 - A4269	Contraceptives	Part B MAC
A4270	Endoscope sheath	Part B MAC
A4280	Accessory for breast prosthesis	DME MAC
A4281 - A4286	Accessory for breast pump	DME MAC
A4290	Sacral nerve stimulation test lead	Part B MAC
A4300 - A4301	Implantable catheter	Part B MAC
A4305 - A4306	Disposable drug delivery system	Part B MAC if incident to a physician's service (not separately payable). If other, DME MAC.
A4310 - A4358	Incontinence supplies/ urinary supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the Part B MAC. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME MAC.
A4360 - A4435	Urinary supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the Part B MAC. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME MAC.
A4450 - A4456	Tape; adhesive remover	Part B MAC if incident to a physician's service (not separately payable), or if supply for implanted prosthetic device. If other, DME MAC.
	Enema bag/ system	DME MAC
	Surgical dressing holders	Part B MAC if incident to a physician's service (not separately payable). If other, DME MAC.
A4465 - A4467	Non-elastic binder and garment, strap, covering	DME MAC
A4470	Gravlee jet washer	Part B MAC
A4480	Vabra aspirator	Part B MAC
A4481	Tracheostomy supply	Part B MAC if incident to a physician's service (not separately payable). If other, DME MAC.
A4483	Moisture exchanger	DME MAC
A4490 - A4510	Surgical stockings	DME MAC

See **LISTING**, page 22

LISTING

from page 21

HCPCS	Description	Jurisdiction
A4520	Diapers	DME MAC
A4550	Surgical trays	Part B MAC
A4553 - A4554	Underpads	DME MAC
A4555 - A4558	Electrodes; lead wires; conductive paste	Part B MAC if incident to a physician's service (not separately payable). If other, DME MAC.
A4559	Coupling gel	Part B MAC if incident to a physician's service (not separately payable). If other, DME MAC.
A4561 - A4562	Pessary	Part B MAC
	Sling	Part B MAC
A4570	Splint	Part B MAC
A4575	Topical hyperbaric oxygen chamber, disposable	DME MAC
A4580 - A4590	Casting supplies & material	Part B MAC
A4595	TENS supplies	Part B MAC if incident to a physician's service (not separately payable). If other, DME MAC.
A4600	Sleeve for intermittent limb compression device	DME MAC
	Lithium replacement batteries	DME MAC
A4604	Tubing for positive airway pressure device	DME MAC
A4605	Tracheal suction catheter	DME MAC
A4606	Oxygen probe for oximeter	DME MAC
A4608	Transtracheal oxygen catheter	DME MAC
A4611 - A4613	Oxygen equipment batteries and supplies	DME MAC
A4614	Peak flow rate meter	Part B MAC if incident to a physician's service (not separately payable). If other, DME MAC.
A4615 - A4629	Oxygen & tracheostomy supplies	Part B MAC if incident to a physician's service (not separately payable). If other, DME MAC.
A4630 - A4640	DME supplies	DME MAC
A4641 - A4642	Imaging agent; contrast material	Part B MAC
A4648	Tissue marker, implanted	Part B MAC
A4649	Miscellaneous surgical supplies	Part B MAC if incident to a physician's service (not separately payable), or if supply for implanted prosthetic device or implanted DME. If other, DME MAC.
A4650	Implantable radiation dosimeter	Part B MAC
A4651 - A4932	Supplies for ESRD	DME MAC (not separately payable)
A5051 - A5093	Additional ostomy supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the Part B MAC. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME MAC.
A5102 - A5200	Additional incontinence and ostomy supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the Part B MAC. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME MAC.
A5500 - A5513	Therapeutic Shoes	DME MAC
A6000	Non-contact wound warming cover	DME MAC

See **LISTING**, page 23

LISTING

from page 22

HCPCS	Description	Jurisdiction
	Surgical dressing	Part B MAC if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other, DME MAC.
A6025	Silicone gel sheet	Part B MAC if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other, DME MAC.
A6154 - A6411	Surgical dressing	Part B MAC if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other, DME MAC.
A6412	Eye patch	Part B MAC if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other, DME MAC.
A6413	Adhesive bandage	Part B MAC if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other, DME MAC.
A6441 - A6512	Surgical dressings	Part B MAC if incident to a physician's service (not separately payable), or if supply for implanted prosthetic device or implanted DME. If other, DME MAC.
A6513	Compression burn mask	DME MAC
A6530 - A6549	Compression gradient stockings	DME MAC
A6550	Supplies for negative pressure wound therapy electrical pump	DME MAC
A7000 - A7002	Accessories for suction pumps	DME MAC
A7003 - A7039	Accessories for nebulizers, aspirators and ventilators	DME MAC
A7040 - A7041	Chest drainage supplies	Part B MAC
A7044 - A7047	Respiratory accessories	DME MAC
A7048	Vacuum drainage supply	Part B MAC
	Tracheostomy supplies	DME MAC
	Protective helmets	DME MAC
A9150	Non-prescription drugs	Part B MAC
A9152 - A9153	Vitamins	Part B MAC
A9155	Artificial saliva	Part B MAC
A9180	Lice infestation treatment	Part B MAC
A9270	Noncovered items or services	DME MAC
A9272	Disposable wound suction pump	DME MAC
A9273	Hot water bottles, ice caps or collars, and heat and/or cold wraps	DME MAC
A9274 - A9278	Glucose monitoring	DME MAC
A9279	Monitoring feature/device	DME MAC
A9280	Alarm device	DME MAC
A9281	Reaching/grabbing device	DME MAC
A9282	Wig	DME MAC
A9283	Foot off-loading device	DME MAC
A9284-A9286	Non-electric spirometer, inversion devices and hygienic items	DME MAC
A9300	Exercise equipment	DME MAC

See **LISTING**, page 24

LISTING

from page 23

HCPCS	Description	Jurisdiction
A9500 - A9700	Supplies for radiology procedures	Part B MAC
A9900	Miscellaneous DME supply or accessory	Part B MAC if used with implanted DME. If other, DME MAC.
A9901	Delivery	DME MAC
A9999	Miscellaneous DME supply or accessory	Part B MAC if used with implanted DME. If other, DME MAC.
B4034 - B9999	Enteral and parenteral therapy	DME MAC
D0120 - D9999	Dental procedures	Part B MAC
E0100 - E0105	Canes	DME MAC
E0110 - E0118	Crutches	DME MAC
E0130 - E0159	Walkers	DME MAC
E0160 - E0175	Commodes	DME MAC
E0181 - E0199	Decubitus care equipment	DME MAC
E0200 - E0239	Heat/cold applications	DME MAC
E0240 - E0248	Bath and toilet aids	DME MAC
E0249	Pad for heating unit	DME MAC
E0250 - E0304	Hospital beds	DME MAC
E0305 - E0326	Hospital bed accessories	DME MAC
E0328 - E0329	Pediatric hospital beds	DME MAC
E0350 - E0352	Electronic bowel irrigation system	DME MAC
E0370	Heel pad	DME MAC
E0371 - E0373	Decubitus care equipment	DME MAC
E0424 - E0484	Oxygen and related respiratory equipment	DME MAC
E0485 - E0486	Oral device to reduce airway collapsibility	DME MAC
E0487	Electric spirometer	DME MAC
E0500	IPPB machine	DME MAC
E0550 - E0585	Compressors/ nebulizers	DME MAC
E0600	Suction pump	DME MAC
E0601	CPAP device	DME MAC
E0602 - E0604	Breast pump	DME MAC
E0605	Vaporizer	DME MAC
E0606	Drainage board	DME MAC
E0607	Home blood glucose monitor	DME MAC
E0610 - E0615	Pacemaker monitor	DME MAC
E0616	Implantable cardiac event recorder	Part B MAC
E0617	External defibrillator	DME MAC
E0618 - E0619	Apnea monitor	DME MAC
E0620	Skin piercing device	DME MAC
E0621 - E0636	Patient lifts	DME MAC
E0637 - E0642	Standing devices/lifts	DME MAC
E0650 - E0676	Pneumatic compressor and appliances	DME MAC
E0691 - E0694	Ultraviolet light therapy systems	DME MAC
E0700	Safety equipment	DME MAC
E0705	Transfer board	DME MAC
E0710	Restraints	DME MAC
E0720 - E0745	Electrical nerve stimulators	DME MAC
E0746	EMG device	Part B MAC
E0747 - E0748	Osteogenic stimulators	DME MAC
E0749	Implantable osteogenic stimulators	Part B MAC
E0755- E0770	Stimulation devices	DME MAC
E0776	IV pole	DME MAC

See **LISTING**, page 25

LISTING

from page 24

HCPCS	Description	Jurisdiction
E0779 - E0780	External infusion pumps	DME MAC
E0781	Ambulatory infusion pump	DME MAC
E0782 - E0783	Infusion pumps, implantable	Part B MAC
E0784	Infusion pumps, insulin	DME MAC
E0785 - E0786	Implantable infusion pump catheter	Part B MAC
E0791	Parenteral infusion pump	DME MAC
E0830	Ambulatory traction device	DME MAC
E0840 - E0900	Traction equipment	DME MAC
E0910 - E0930	Trapeze/ fracture frame	DME MAC
E0935 - E0936	Passive motion exercise device	DME MAC
E0940	Trapeze equipment	DME MAC
E0941	Traction equipment	DME MAC
E0942 - E0945	Orthopedic devices	DME MAC
E0946 - E0948	Fracture frame	DME MAC
E0950 - E1298	Wheelchairs	DME MAC
E1300 - E1310	Whirlpool equipment	DME MAC
E1352 - E1392	Additional oxygen related equipment	DME MAC
E1399	Miscellaneous DME	Part B MAC if implanted DME. If other, DME MAC.
E1405 - E1406	Additional oxygen equipment	DME MAC
E1500 - E1699	Artificial kidney machines and accessories	DME MAC (not separately payable)
E1700 - E1702	TMJ device and supplies	DME MAC
E1800 - E1841	Dynamic flexion devices	DME MAC

HCPCS	Description	Jurisdiction
E1902	Communication board	DME MAC
E2000	Gastric suction pump	DME MAC
E2100 - E2101	Blood glucose monitors with special features	DME MAC
E2120	Pulse generator for tympanic treatment of inner ear	DME MAC
E2201 - E2397	Wheelchair accessories	DME MAC
E2402	Negative pressure wound therapy pump	DME MAC
E2500 - E2599	Speech generating device	DME MAC
E2601 - E2633	Wheelchair cushions and accessories	DME MAC
E8000 - E8002	Gait trainers	DME MAC
G0008 - G0329	Misc. professional services	Part B MAC
G0333	Dispensing fee	DME MAC
G0337 - G0365	Misc. professional services	Part B MAC
G0372	Misc. professional services	Part B MAC

See **LISTING**, page 26

LISTING

from page 25

HCPCS	Description	Jurisdiction
G0378 - G0490	Misc. professional services	Part B MAC
J0120 - J3570	Injection	Part B MAC if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.
J3590	Unclassified biologicals	Part B MAC
J7030 - J7131	Miscellaneous drugs and solutions	Part B MAC if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.
	Clotting factors	Part B MAC
J7180 - J7195	Antihemophilic factor	Part B MAC
J7196 - J7197	Antithrombin III	Part B MAC
J7198	Anti-inhibitor; per I.U.	Part B MAC
J7199 - J72**11**	Other hemophilia clotting factors	Part B MAC
J729**6** - J7307	Contraceptives	Part B MAC
J7308 - J7309	Aminolevulinic acid HCL	Part B MAC
J7310	Ganciclovir, long-acting implant	Part B MAC
J7311 - J7316	Ophthalmic drugs	Part B MAC
J7320 - J7328	Hyaluronan	Part B MAC
J7330	Autologous cultured chondrocytes, implant	Part B MAC
J7336	Capsaicin	Part B MAC
J7340	Carbidopa/ levodopa	Part B MAC if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.
	Ciprofloxacin otic **& topical aminolevulinic acid**	Part B MAC
J7500 - J7599		Part B MAC if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.
J7604 - J7699	Inhalation solutions	Part B MAC if incident to a physician's service. If other, DME MAC.
J7799 -J7999	NOC drugs, other than inhalation drugs	Part B MAC if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.
J8498	Anti-emetic drug	DME MAC
J8499	Prescription drug, oral, non-	Part B MAC if incident to a physician's service. If other, DME MAC.
J8501 - J8999	Oral anti-cancer drugs	DME MAC
J9000 - J9999	Chemotherapy drugs	Part B MAC if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.
K0001 - K0108	Wheelchairs	DME MAC
K0195	Elevating leg rests	DME MAC
K0455	Infusion pump used for uninterrupted administration of epoprostenal	DME MAC
K0462	Loaner equipment	DME MAC
K0552 - K0605	External infusion pump supplies **& continuous glucose monitor**	DME MAC
K0606 - K0609	Defibrillator accessories	DME MAC
K0669	Wheelchair cushion	DME MAC
K0672	Soft interface for orthosis	DME MAC
K0730	Inhalation drug delivery system	DME MAC
K0733	Power wheelchair accessory	DME MAC
K0738	Oxygen equipment	DME MAC
K0739	Repair or nonroutine service for DME	Part B MAC if implanted DME. If other, DME MAC

See **LISTING**, page 27

LISTING

from page 26

HCPCS	Description	Jurisdiction
K0740	Repair or nonroutine service for oxygen equipment	DME MAC
K0743 - K0746	Suction pump and dressings	DME MAC
K0800 - K0899	Power mobility devices	DME MAC
K0900	Custom DME, other than wheelchair	DME MAC
L0112 - L4631	Orthotics	DME MAC
L5000 - L5999	Lower limb prosthetics	DME MAC
L6000 - L7499	Upper Limb Prosthetics	DME MAC
L7510 - L7520	Repair of prosthetic device	Part B MAC if repair of implanted prosthetic device. If other, DME MAC.
L7600 - L8485	Prosthetics	DME MAC
L8499	Unlisted procedure for miscellaneous prosthetic services	Part B MAC if implanted prosthetic device. If other, DME MAC.
L8500 - L8501	Artificial larynx; tracheostomy speaking valve	DME MAC
L8505	Artificial larynx accessory	DME MAC
L8507	Voice prosthesis, patient inserted	DME MAC
L8509	Voice prosthesis, inserted by a licensed health care provider	Part B MAC for dates of service on or after 10/01/2010. DME MAC for dates of service prior to 10/01/2010
L8510	Voice prosthesis	DME MAC
L8511 - L8515	Voice prosthesis	Part B MAC if used with tracheoesophageal voice prostheses inserted by a licensed health care provider. If other, DME MAC

HCPCS	Description	Jurisdiction
L8600 - L8699	Prosthetic implants	Part B MAC
L9900	Miscellaneous orthotic or prosthetic component or accessory	Part B MAC if used with implanted prosthetic device. If other, DME MAC.
M0075 - M0301	Medical services	Part B MAC
P2028 - P9615	Laboratory tests	Part B MAC
Q0035		Part B MAC
Q0081	Infusion therapy	Part B MAC
Q0083 - Q0085	Chemotherapy administration	Part B MAC
Q0091	Smear preparation	Part B MAC
Q0092	Portable X-ray setup	Part B MAC
Q0111 - Q0115	Miscellaneous lab services	Part B MAC
	Ferumoxytol injection	Part B MAC
Q0144	Azithromycin dihydrate	Part B MAC if incident to a physician's service. If other, DME MAC.
Q0161 - Q0181	Anti-emetic	DME MAC
Q0477 - Q0509	Ventricular assist devices	Part B MAC
Q0510 - Q0514	Drug dispensing fees	DME MAC
Q0515	Sermorelin acetate	Part B MAC

See **LISTING**, page 28

LISTING

from page 27

HCPCS	Description	Jurisdiction
Q1004 - Q1005	New technology IOL	Part B MAC
Q2004	Irrigation solution	Part B MAC
Q2009	Fosphenytoin	Part B MAC
Q2017	Teniposide	Part B MAC
	Injectable dermal fillers	Part B MAC
Q2034 - Q2039	Influenza vaccine	Part B MAC
	Cellular	Part B MAC
	Doxorubicin	Part B MAC if incident to a physician's service orused in an implanted infusion pump. If other, DME MAC.
Q2052	IVIG demonstration	DME MAC
Q3001	Supplies for radiology procedures	Part B MAC
Q3014	Telehealth originating site facility fee	Part B MAC
Q3027 - Q3028	Vaccines	Part B MAC
Q3031	Collagen skin test	Part B MAC
Q4001 - Q4051	Splints and casts	Part B MAC
Q4074	Inhalation drug	Part B MAC if incident to a physician's service. If other, DME MAC.
Q4081	Epoetin	Part B MAC
Q4082	Drug subject to competitive acquisition program	Part B MAC
Q4100 - Q41**82**	Skin substitutes	Part B MAC
Q5001 - Q5010	Hospice services	Part B MAC
	Injection	Part B MAC if incident to a physician's service orused in an implanted infusion pump. If other, DME MAC.
Q9950 - Q9954	Imaging agents	Part B MAC
Q9955 - Q9957	Microspheres	Part B MAC
Q9958 - Q9969	Imaging agents	Part B MAC

HCPCS	Description	Jurisdiction
	Supplies for radiology procedures	Part B MAC
R0070 - R0076	Diagnostic radiology services	Part B MAC
V2020 - V2025	Frames	DME MAC
V2100 - V2513	Lenses	DME MAC
V2520 - V2523	Hydrophilic contact lenses	If other, DME MAC. Part B MAC if incident to a physician's service.
V2530 - V2531	Contact lenses, scleral	DME MAC
V2599	Contact lens, other type	Part B MAC if incident to a physician's service. If other, DME MAC.
V2600 - V2615	Low vision aids	DME MAC
V2623 - V2629	Prosthetic eyes	DME MAC
V2630 - V2632	Intraocular lenses	Part B MAC
V2700 - V2780	Miscellaneous vision service	DME MAC
V2781	Progressive lens	DME MAC
V2782 - V2784	Lenses	DME MAC
V2785	Processing--corneal tissue	Part B MAC
V2786	Lens	DME MAC
V2787 - V2788	Intraocular lenses	Part B MAC
V2790	Amniotic membrane	Part B MAC
V2797	Vision supply	DME MAC
V2799	Miscellaneous vision service	Part B MAC if supply for an implanted prosthetic device. If other, DME MAC
V5008 - V5299	Hearing services	Part B MAC
V5336	Repair/ modification of augmentative communicative system or device	DME MAC
V5362 - V5364	Speech screening	Part B MAC

Laboratory/Pathology

January update to new waived tests

Provider type affected

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

Provider action needed

Change request (CR) 10418 informs MACs of new Clinical Laboratory Improvement Amendments of 1988 (CLIA) waived tests approved by the Food and Drug Administration. Since these tests are marketed immediately after approval, the Centers for Medicare & Medicaid Services (CMS) must notify its MACs of the new tests so they can accurately process claims. There are four newly added waived complexity tests. Make sure your billing staffs are aware of these changes.

Background

The Clinical Laboratory Improvement Amendments of 1988 (CLIA) regulations require a facility to be appropriately certified for each test performed. To ensure that Medicare & Medicaid only pay for laboratory tests categorized as waived complexity under CLIA in facilities with a CLIA certificate of waiver, laboratory claims are currently edited at the CLIA certificate level.

CR 10418 describes the latest tests approved by the Food and Drug Administration (FDA) as waived tests under CLIA. The *Current Procedural Terminology* (CPT®) codes for the following new tests must have the modifier QW to be recognized as a waived test. However, the tests mentioned on the first page of the list attached to CR 10418 (that is, CPT® codes: 81002, 81025, 82270, 82272, 82962, 83026, 84830, 85013, and 85651) do not require a QW modifier to be recognized as a waived test.

The CPT® code, effective date, and description for the latest tests approved by the FDA as waived tests under CLIA are as follows:

- 83516QW, October 2, 2017, Quidel Corporation, InflammaDry
- 87809QW, October 3, 2017, Quidel, AdenoPlus Test {Tear Fluid}
- 82274QW, G0328QW, October 13, 2017, Enterix Inc. InSure One – One Day Fecal Immunochemical Test
- 85025QW, November 6, 2017, Sysmex XW-100

The new waived complexity code 85025QW [Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count] was assigned for the detection of hematocrit, hemoglobin, platelet count, red blood cell count, white blood cell count and white blood cell differential performed using the Sysmex XW-100.

The new code 87634 [Infectious agent detection by nucleic acid (DNA or RNA); respiratory syncytial virus, amplified probe technique] was effective 1/1/2018. HCPCS code 87634QW describes the waived testing previously assigned to the code 87801QW. The HCPCS code for the Alere i system respiratory syncytial virus is now assigned the HCPCS code 87634QW.

Additional information

The official instruction, CR 10418, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R3945CP.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
January 5, 2018	Initial article released.

MLN Matters® Number: MM10418
Related CR Release Date: January 5, 2018
Related CR Transmittal Number: R3945CP
Related Change Request (CR) Number: 10418
Effective Date: April 1, 2018
Implementation Date: April 2, 2018

April 2018 changes to the laboratory NCD edit software

Provider type affected

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

What you need to know

This article is based on change request (CR) 10424 which informs MACs about the changes that will be included in the April 2018 quarterly release of the edit module for clinical diagnostic laboratory services. Make sure that your billing staffs are aware of these changes.

Background

CR 10424 announces the changes that will be included in the April 2018 quarterly release of the edit module for clinical diagnostic laboratory services. The national coverage determinations (NCDs) for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee, and the final rule was published November 23, 2001. Nationally uniform software was developed and incorporated in the Medicare shared systems so 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 the *Medicare Claims Processing Manual*, Chapter 16, Section 120.2, 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 10424 communicates requirements to MACs notifying them of changes to the laboratory edit module for laboratory NCD code lists for April 2018. Please access the following link for the NCD spreadsheets included with CR 10424:

https://www.cms.gov/Medicare/Coverage/DeterminationProcess/downloads/April2018.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 10424, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3937CP.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
January 3, 2018	Initial article released.

MLN Matters® Number: MM10424
Related CR Release Date: December 22, 2017
Related CR Transmittal Number: R3937CP
Related Change Request (CR) Number: CR10424
Effective Date: October 1, 2017
Implementation Date: April 2, 2018

Codes subject to and excluded from CLIA edits

Provider type affected

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

Provider action needed

Change request (CR) 10446 informs providers and MACs about the new Healthcare Common Procedure Coding System (HCPCS) codes for 2018 that are subject to and excluded from Clinical Laboratory Improvement Amendments (CLIA) edits. Make sure your billing staffs are aware of these updates.

Background

The HCPCS codes that are considered a laboratory test under CLIA change each year. MACs are informed about the new HCPCS codes that are both subject to CLIA edits and excluded from CLIA edits.

The following HCPCS codes were discontinued December 31, 2017:

- 83499 – Hydroxyprogesterone, 20 (synthetic hormone) level
- 84061 -Phosphatase (enzyme) level for forensic examination
- 86185 -Immunologic analysis for detection of antigen
- 86243 -Measurement of Fc receptor
- 86378 -Migration inhibitory factor
- 86729 -Lympho venereum antibody
- 86822 -Lymphocyte culture primed
- 87277 -Legionella micdadei ag if
- 87470 -Bartonella dna dir probe
- 87477 -Lyme dis dna quant
- 87515 -Hepatitis b dna dir probe
- 88154 -Cytopath c/v select

The following HCPCS codes were added February 1, 2017, and are subject to CLIA edits. These codes require a facility to have either a CLIA certificate of registration (certificate type code 9), a CLIA certificate of compliance (certificate type code 1), or a CLIA certificate of accreditation (certificate type code 3). A facility without a valid, current, CLIA certificate, with a current CLIA certificate of waiver (certificate type code 2) or with a current CLIA certificate for provider-performed microscopy procedures (certificate type code 4) cannot be paid for these tests.

- 0001U -Red blood cell antigen typing, DNA, human erythrocyte antigen gene analysis of 35 antigens from 11 blood groups, utilizing whole blood, common RBC alleles reported
- 0002U -Oncology (colorectal), quantitative assessment of three urine metabolites (ascorbic acid, succinic acid and carnitine) by liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring acquisition, algorithm reported as likelihood of adenomatous polyps
- 0003U -Oncology (ovarian) biochemical assays of five proteins (apolipoprotein A-1, CA 125 II, follicle stimulating hormone, human epididymis protein 4, transferrin), utilizing serum, algorithm reported as a likelihood score

The following HCPCS codes were added May 1, 2017, and are subject to CLIA edits. These codes require a facility to have either a CLIA certificate of registration (certificate type code 9), a CLIA certificate of compliance (certificate type code 1), or a CLIA certificate of accreditation (certificate type code 3). A facility without a valid, current, CLIA certificate, with a current CLIA certificate of waiver (certificate type code 2) or with a current CLIA certificate for provider-performed microscopy procedures (certificate type code 4) cannot be paid for these tests.

- 0004U -Infectious disease (bacterial), DNA, 27 resistance genes, PCR amplification and probe hybridization in microarray format (molecular detection and identification of AmpC, carbapenemase and ESBL coding genes), bacterial culture colonies, report of genes detected or not detected, per isolate
- 0005U -Oncology (prostate) gene expression profile by real-time RT-PCR of 3 genes (ERG, PCA3, and SPDEF), urine, algorithm reported as risk score

The following HCPCS codes were added August 1, 2017, and are subject to CLIA edits. These codes require a facility to have either a CLIA certificate of registration (certificate type code 9), a CLIA certificate of compliance (certificate type code 1), or a CLIA certificate of accreditation (certificate type code 3). A facility without a valid, current, CLIA certificate, with a current CLIA certificate of waiver (certificate type code 2) or with a current CLIA certificate for provider-performed microscopy procedures (certificate type code 4) cannot be paid for these tests.

- 0006U -Prescription drug monitoring, 120 or more drugs and substances, definitive tandem mass spectrometry with chromatography, urine, qualitative report of presence (including quantitative levels, when detected) or absence of each drug or substance with description and severity of potential interactions, with identified substances, per date of service
- 0007U -Drug test(s), presumptive, with definitive confirmation of positive results, any number of drug classes, urine, includes specimen verification including DNA authentication in comparison to buccal DNA, per date of service
- 0008U -Helicobacter pylori detection and antibiotic resistance, DNA, 16S and 23S rRNA, gyrA, pbp1, rdxA and rpoB, next generation sequencing, formalin-fixed paraffin embedded or fresh tissue, predictive, reported as positive or negative for resistance to clarithromycin, fluoroquinolones, metronidazole, amoxicillin, tetracycline and rifabutin

See **CLIA**, page 32

CLIA

from page 31

- 0009U -Oncology (breast cancer), ERBB2 (HER2) copy number by FISH, tumor cells from formalin fixed paraffin embedded tissue isolated using image-based dielectrophoresis (DEP) sorting, reported as ERBB2 gene amplified or non-amplified
- 0010U -Infectious disease (bacterial), strain typing by whole genome sequencing, phylogenetic-based report of strain relatedness, per submitted isolate
- 0011U -Prescription drug monitoring, evaluation of drugs present by LC-MS/MS, using oral fluid, reported as a comparison to an estimated steady-state range, per date of service including all drug compounds and metabolites
- 0012U -Germline disorders, gene rearrangement detection by whole genome next-generation sequencing, DNA, whole blood, report of specific gene rearrangement(s)
- 0013U -Oncology (solid organ neoplasia), gene rearrangement detection by whole genome next-generation sequencing, DNA, fresh or frozen tissue or cells, report of specific gene rearrangement(s)
- 0014U -Hematology (hematolymphoid neoplasia), gene rearrangement detection by whole genome next-generation sequencing, DNA, whole blood or bone marrow, report of specific gene rearrangement(s);
- 0015U -Drug metabolism (adverse drug reactions), DNA, 22 drug metabolism and transporter genes, real-time PCR, blood or buccal swab, genotype and metabolizer status for therapeutic decision support
- 0016U -Oncology (hematolymphoid neoplasia), RNA, BCR/ABL1 major and minor breakpoint fusion transcripts, quantitative PCR amplification, blood or bone marrow, report of fusion not detected or detected with quantitation
- 0017U -Oncology (hematolymphoid neoplasia), JAK2 mutation, DNA, PCR amplification of exons 12-14 and sequence analysis, blood or bone marrow, report of JAK2 mutation not detected or detected

The following HCPCS codes are new for 2018 and are subject to CLIA edits. These codes require a facility to have either a CLIA certificate of registration (certificate type code 9), a CLIA certificate of compliance (certificate type code 1), or a CLIA certificate of accreditation (certificate type code 3). A facility without a valid, current, CLIA certificate, with a current CLIA certificate of waiver (certificate type code 2) or with a current CLIA certificate for provider-performed microscopy procedures (certificate type code 4) cannot be paid for these tests.

- 81105 -Human Platelet Antigen 1 genotyping (HPA-1), ITGB3 (integrin, beta 3 [platelet glycoprotein IIIa], antigen CD61 [GPIIIa]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura) gene analysis, common variant, HPA-1a/b (L33P)
- 81106 -Human Platelet Antigen 2 genotyping (HPA-2), GP1BA (glycoprotein Ib [platelet], alpha polypeptide [GPIba]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura) gene analysis, common variant, HPA-2a/b (T145M)
- 81107 -Human Platelet Antigen 3 genotyping (HPA-3), ITGA2B (integrin, alpha 2b [platelet glycoprotein IIb of IIb/IIIa complex], antigen CD41 [GPIIb]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura) gene analysis, common variant, HPA-3a/b (I843S)
- 81108 -Human Platelet Antigen 4 genotyping (HPA-4), ITGB3 (integrin, beta 3 [platelet glycoprotein IIIa], antigen CD61 [GPIIIa]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura) gene analysis, common variant, HPA-4a/b (R143Q)
- 81109 -Human Platelet Antigen 5 genotyping (HPA-5), ITGA2 (integrin, alpha 2 [CD49B, alpha 2 subunit of VLA-2 receptor] [GPIa]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura) gene analysis, common variant (eg, HPA-5a/b (K505E))
- 81110 -Human Platelet Antigen 6 genotyping (HPA-6w), ITGB3 (integrin, beta 3 [platelet glycoprotein IIIa, antigen CD61] [GPIIIa]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura) gene analysis, common variant, HPA-6a/b (R489Q)
- 81111 -Human Platelet Antigen 9 genotyping (HPA-9w), ITGA2B (integrin, alpha 2b [platelet glycoprotein IIb of IIb/IIIa complex, antigen CD41] [GPIIb]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura) gene analysis, common variant, HPA-9a/b (V837M)
- 81112 -Human Platelet Antigen 15 genotyping (HPA-15), CD109 (CD109 molecule) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura) gene analysis, common variant, HPA-15a/b (S682Y)
- 81120 -IDH1 (isocitrate dehydrogenase 1 [NADP+], soluble) (eg, glioma), common variants (eg, R132H, R132C)
- 81121 -IDH2 (isocitrate dehydrogenase 2 [NADP+], mitochondrial) (eg, glioma), common variants (eg, R140W, R172M)
- 81175 -ASXL1 (additional sex combs like 1, transcriptional regulator) (eg, myelodysplastic syndrome, myeloproliferative neoplasms, chronic myelomonocytic leukemia) gene analysis; full gene sequence
- 81176 -ASXL1 (additional sex combs like 1, transcriptional regulator) (eg, myelodysplastic syndrome, myeloproliferative neoplasms, chronic myelomonocytic leukemia) gene analysis; targeted sequence analysis (eg, exon 12)
- 81230 -CYP3A4 (cytochrome P450 family 3 subfamily A member 4) (eg, drug metabolism) gene analysis, common variant(s) (eg, *2, *22)

See **CLIA**, page 33

CLIA

from page 32

- 81231 -CYP3A5 (cytochrome P450 family 3 subfamily A member 5) (eg, drug metabolism) gene analysis, common variants (eg, *2, *3, *4, *5 *6, *7)
- 81232 -DPYD (dihydropyrimidine dehydrogenase) (eg, 5-fluorouracil/5-FU and capecitabine drug metabolism) gene analysis, common variant(s) (eg, *2A, *4, *5, *6)
- 81238 -F9 (coagulation factor IX) (eg, hemophilia B) full gene sequence
- 81247 -G6PD (glucose-6-phosphate dehydrogenase) (eg, hemolytic anemia, jaundice) gene analysis; common variant(s) (eg, A, A-)
- 81248 -G6PD (glucose-6-phosphate dehydrogenase) (eg, hemolytic anemia, jaundice) gene analysis; known familial variant(s)
- 81249 -G6PD (glucose-6-phosphate dehydrogenase) (eg, hemolytic anemia, jaundice) gene analysis; full gene sequence
- 81258 -HBA1/HBA2 (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis; known familial variant
- 81259 -HBA1/HBA2 (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis; full gene sequence
- 81269 -HBA1/HBA2 (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis; duplication/deletion variants
- 81283 -IFNL3 (interferon, lambda 3) (eg, drug response) gene analysis, rs12979860 variant
- 81328 -SLCO1B1 (solute carrier organic anion transporter family, member 1B1) (eg, adverse drug reaction) gene analysis, common variant(s) (eg, *5)
- 81334 -RUNX1 (runt related transcription factor 1) (eg, acute myeloid leukemia, familial platelet disorder with associated myeloid malignancy) gene analysis, targeted sequence analysis (eg, exons 3-8)
- 81335 -TPMT (thiopurine S-methyltransferase) (eg, drug metabolism) gene analysis, common variants (eg, *2, *3)
- 81346 -TYMS (thymidylate synthetase) (eg, 5-fluorouracil/5-FU drug metabolism) gene analysis, common variant(s) (eg, tandem repeat variant)
- 81361 -HBB (hemoglobin, subunit beta) (eg, sickle cell anemia, beta thalassemia, hemoglobinopathy); common variant(s) (eg, HbS, HbC, HbE)
- 81362 -HBB (hemoglobin, subunit beta) (eg, sickle cell anemia, beta thalassemia, hemoglobinopathy); known familial variant(s)
- 81363 -HBB (hemoglobin, subunit beta) (eg, sickle cell anemia, beta thalassemia, hemoglobinopathy); duplication/deletion variant(s)
- 81364 -HBB (hemoglobin, subunit beta) (eg, sickle cell anemia, beta thalassemia, hemoglobinopathy); full gene sequence
- 81448 -Hereditary peripheral neuropathies panel (eg, Charcot-Marie-Tooth, spastic paraplegia), genomic sequence analysis panel, must include sequencing of at least 5 peripheral neuropathy-related genes (eg, BSCL2, GJB1, MFN2, MPZ, REEP1, SPAST, SPG11, and SPTLC1)
- 81520 -Oncology (breast), mRNA gene expression profiling by hybrid capture of 58 genes (50 content and 8 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a recurrence risk score
- 81521 -Oncology (breast), mRNA, microarray gene expression profiling of 70 content genes and 465 housekeeping genes, utilizing fresh frozen or formalin-fixed paraffin-embedded tissue, algorithm reported as index related to risk of distant metastasis
- 81541 – Oncology (prostate), mRNA gene expression profiling by real-time RTPCR of 46 genes (31 content and 15 housekeeping), utilizing formalin-fixed paraffin embedded tissue, algorithm reported as a disease-specific mortality risk score • 81551 - Oncology (prostate), promoter methylation profiling by real-time PCR of 3 genes (GSTP1, APC, RASSF1), utilizing formalin-fixed paraffin embedded tissue, algorithm reported as a likelihood of prostate cancer detection on repeat biopsy
- 86008 -Allergen specific IgE; quantitative or semiquantitative, recombinant or purified component, each
- 86794 -Zika virus, IgM
- 87634 -Infectious agent detection by nucleic acid (DNA or RNA); respiratory syncytial virus, amplified probe technique
- 87662 -Infectious agent detection by nucleic acid (DNA or RNA); Zika virus, amplified probe technique

The following HCPCS codes are mentioned in change request 10445 (*Quarterly Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment*) as new codes and with the effective date of January 1, 2018. These codes are subject to CLIA edits. The HCPCS codes listed below require a facility to have either a CLIA certificate of registration (certificate type code 9), a CLIA certificate of compliance (certificate type code 1), or a CLIA certificate of accreditation (certificate type code 3). A facility without a valid, current, CLIA certificate, with a current CLIA certificate of waiver (certificate type code 2) or with a current CLIA certificate for provider-performed microscopy procedures (certificate type code 4) must not be permitted to be paid for these tests.

- 0024U -Glycosylated acute phase proteins (GlycA), nuclear magnetic resonance spectroscopy, quantitative GLYCA NUC MR SPECTRSC QUAN

See **CLIA**, page 34

CLIA

from page 33

- 0025U -Tenofovir, by liquid chromatography with tandem mass spectrometry (LCMS/MS), urine, quantitative TENOFOVIR LIQ CHROM UR QUAN
- 0026U -Oncology (thyroid), DNA and mRNA of 112 genes, next-generation sequencing, fine needle aspirate of thyroid nodule, algorithmic analysis reported as a categorical result ("Positive, high probability of malignancy" or "Negative, low probability of malignancy") ONC THYR DNA&MRNA 112 GENES
- 0027U -JAK2 (Janus kinase 2) (eg, myeloproliferative disorder) gene analysis, targeted sequence analysis exons 12-15 JAK2 GENE TRGT SEQ ALYS
- 0028U -CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism) gene analysis, copy number variants, common variants with reflex to targeted sequence analysis CYP2D6 GENE CPY NMR CMN VRNT
- 0029U -Drug metabolism (adverse drug reactions and drug response), targeted sequence analysis (ie, CYP1A2, CYP2C19, CYP2C9, CYP2D6, CYP3A4, CYP3A5, CYP4F2, SLCO1B1, VKORC1 and rs12777823) RX METAB ADVRS TRGT SEQ ALYS
- 0030U -Drug metabolism (warfarin drug response), targeted sequence analysis (ie, CYP2C9, CYP4F2, VKORC1, rs12777823) RX METAB WARF TRGT SEQ ALYS
- 0031U -CYP1A2 (cytochrome P450 family 1, subfamily A, member 2)(eg, drug metabolism) gene analysis, common variants (ie, *1F, *1K, *6, *7) CYP1A2 GENE
- 0032U -COMT (catechol-O-methyltransferase)(drug metabolism) gene analysis, c.472G>A (rs4680) variant COMT GENE
- 0033U -HTR2A (5-hydroxytryptamine receptor 2A), HTR2C (5-hydroxytryptamine receptor 2C) (eg, citalopram metabolism) gene analysis, common variants (ie, HTR2A rs7997012 [c.614-2211T>C], HTR2C rs3813929 [c.-759C>T] and rs1414334 [c.551-3008C>G]) HTR2A HTR2C GENES
- 0034U -TPMT (thiopurine S-methyltransferase), NUDT15 (nudix hydroxylase 15)(eg, thiopurine metabolism), gene analysis, common variants (ie, TPMT *2, *3A, *3B, *3C, *4, *5, *6, *8, *12; NUDT15 *3, *4, *5) TPMT NUDT15 GENES

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

Additional information

The official instruction, CR 10446, issued to your MAC regarding this change is available at

https://www.cms.gov/Regulations-andGuidance/Guidance/Transmittals/2018Downloads/R3949CP.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
January 12, 2018	Initial article released.

MLN Matters® Number: MM10446
Related Change Request (CR) Number: 10446
Related CR Release Date: January 12, 2018
Effective Date: January 1, 2018
Related CR Transmittal Number: R3949CP
Implementation Date: April 2, 2018

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.*

Medicare Physician Fee Schedule Database

Summary of policies in the 2018 MPFS final rule and the telehealth originating site facility fee payment, and CT modifier reduction

Provider type affected

This *MLN Matters*® article is intended for physicians and other providers who submit claims to Medicare administrative contractors (MACs) for services paid under the Medicare physician fee schedule (MPFS) and provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 10393 provides a summary of policies in the 2018 MPFS final rule and announces the telehealth originating site facility fee payment amount and makes other policy changes related to Medicare Part B payment. These changes are applicable to services furnished in 2018. Make sure your billing staffs are aware of these updates.

Background

Section 1848(b)(1) of the Social Security Act (the Act) requires the Secretary of Health and Human Services to establish by regulation a fee schedule of payment amounts for physicians' services for the subsequent year. The Centers for Medicare & Medicaid Services (CMS) issued a final rule November 2, 2017, that updates payment policies and Medicare payment rates for services furnished by physicians and non-physician practitioners (NPPs) that are paid under the MPFS in 2018.

The final rule, CMS-1676-F, also addresses public comments on Medicare payment policies proposed earlier this year. The final rule, *Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2018,* was published in the *Federal Register* November 2, 2017. The key changes are as follows:

Overall payment update and misvalued code target

The overall update to payments under the MPFS based on the finalized 2018 rates will be +0.41 percent. This update reflects the +0.50 percent update established under the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, reduced by 0.09 percent, due to the misvalued code target recapture amount, required under the Achieving a Better Life Experience (ABLE) Act of 2014.

After applying these adjustments and the budget neutrality adjustment to account for changes in relative resource units (RVUs), all required by law, the final 2018 physician fee schedule (PFS) conversion factor is $35.99, an increase to the 2017 PFS conversion factor of $35.89.

Payment rates for non-excepted off-campus provider-based hospital departments paid under the MPFS

Section 603 of the Bipartisan Budget Act of 2015 requires that certain items and services furnished by certain off-campus hospital outpatient provider-based departments are no longer paid under the outpatient prospective payment system (OPPS) beginning January 1, 2017. For 2017, CMS finalized the MPFS as the applicable payment system for most of these items and services.

For 2018, CMS is finalizing a reduction to the current MPFS payment rates for these items and services by 20 percent. CMS currently pays for these services under the MPFS based on a percentage of the OPPS payment rate. Specifically, the final policy will change the MPFS payment rates for these services from 50 percent of the OPPS payment rate to 40 percent of the OPPS rate. CMS believes that this adjustment will provide a more level playing field for competition between hospitals and physician practices by promoting greater payment alignment.

Telehealth originating site facility fee payment amount update

Section 1834(m)(2)(B) of the Act establishes the payment amount for the Medicare telehealth originating site facility fee for telehealth services provided from October 1, 2001, through December 31, 2002, at $20. For telehealth services provided on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee is increased by the percentage increase in the Medicare economic index (MEI) as defined in Section 1842(i)(3) of the Act. The MEI increase for 2017 is 1.2 percent. Therefore, for 2018, the payment amount for Healthcare Common Procedure Coding System (HCPCS) code Q3014 (Telehealth originating site facility fee) is 80 percent of the lesser of the actual charge, or $25.76. (The beneficiary is responsible for any unmet deductible amount and Medicare coinsurance.)

Medicare telehealth services

For 2018, CMS is finalizing the addition of several codes to the list of telehealth services, including:

- HCPCS code G0296 (visit to determine low dose computed tomography (LDCT) eligibility)
- CPT® code 90785 (interactive complexity)
- CPT® codes 96160 and 96161 (health risk assessment)
- HCPCS code G0506 (care planning for chronic care management)
- CPT® codes 90839 and 90840 (psychotherapy for crisis)

See **MPFSDB**, page 36

MPFSDB

from page 35

Additionally, CMS is finalizing its proposal to eliminate the required reporting of the telehealth modifier GT for professional claims in an effort to reduce administrative burden for practitioners. CMS is also finalizing separate payment for CPT® code 99091, which describes certain remote patient monitoring, for 2018. This code is payable in both non-facility and facility settings.

In addition, CMS stated the following in the 2018 MPFS final rule (82 FR 53014):

- CMS is adopting CPT® prefatory guidance that this code should be billed no more than once every 30 days.
- CMS is allowing CPT® code 99091 to be billed once per patient during the same service period as chronic care management (CCM) (CPT® codes 99487, 99489, and 99490), transitional care management (TCM) (CPT® codes 99495 and 99496), and behavioral health integration (BHI) services (CPT® codes 99492, 99493, 99494, and 99484).
- CMS is requiring that the practitioner obtain advance beneficiary consent for the service and document this in the patient's medical record.
- For new patients or patients not seen by the billing practitioner within one year prior to billing CPT® code 99091, CMS requires initiation of the service during a face-to-face visit with the billing practitioner, such as an annual wellness visit or initial preventive physical exam, or other face-to-face visit with the billing practitioner.

Lastly, CMS will consider the stakeholder input received in response to the proposed rule's comment solicitation on how CMS could expand access to telehealth services, within the current statutory authority.

Care management services

CMS is continuing efforts to improve payment within traditional fee-for-service Medicare for CCM and similar care management services to accommodate the changing needs of the Medicare patient population. CMS is finalizing its proposals to adopt CPT® codes for 2018 for reporting several care management services currently reported using Medicare G-codes. Also, CMS is clarifying a few policies regarding CCM in this final rule.

Improvement of payment rates for office-based behavioral health services

CMS is finalizing an improvement in the way MPFS rates are set that will positively impact office-based behavioral health services with a patient. The final policy will increase payment for these important services by better recognizing overhead expenses for office-based face-to-face services with a patient.

Evaluation and management comment solicitation

Most physicians and other practitioners bill patient visits to the MPFS under a relatively generic set of codes that distinguish level of complexity, site of care, and in some cases whether or not the patient is new or established. These codes are called Evaluation and Management (E/M) visit codes. Billing practitioners must maintain information in the medical record that documents that they have reported the appropriate level of E/M visit code. CMS maintains guidelines that specify the kind of information that is required to support Medicare payment for each level.

CMS agrees with continued feedback from stakeholders that these guidelines are potentially outdated and need to be revised. CMS thanks the public for the comments received in response to the proposed rule's comment solicitation on the E/M guidelines and summarizes these comments in the final rule. Commenters suggested that CMS provide additional avenues for collaboration with stakeholders prior to implementing any changes. CMS will consider the best approaches for such collaboration and will take the public comments into account as it considers the issue in future rulemaking.

Prolonged preventive services

CMS is adding new codes for prolonged preventive services. Prolonged preventive services are add-on codes payable by Medicare when billed with an applicable preventive service that is both payable from the MPFS, and both deductible and coinsurance do not apply. For the complete list of codes that may be billed with prolonged preventive services visit *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Medicare-PFS-Preventive-Services.html*.

Payments for imaging services that are X-rays taken using computed radiography

CMS is finalizing policy required by Section 1848(b)(9) of the Act, which requires payments for imaging services that are X-rays taken using computed radiography (including the technical component portion of a global service) furnished during 2018-2022, that would otherwise be made under the MPFS (without application of subparagraph (B)(i) and before application of any other adjustment), be reduced by seven percent.

Solicitations on burden reduction

CMS solicited comments on burden reduction on several issues including E/M, telehealth and remote patient monitoring. CMS appreciates the thoughtful input it received in response to these comment solicitations and will consider their input in future rulemaking.

Cognitive therapy services

CMS will retain the coding and valuation of cognitive therapy services through the creation of HCPCS code G0515 that will mirror CPT® code 97532 deleted for 2018

See **MPFSDB**, page 37

Surgery

Medically unlikely edits and bilateral surgical procedures

***Note**: This article was revised with more details and examples and was re-issued January 17, 2018. Providers who perform bilateral surgical procedures should review the entire article. This information was previously published in the July 2014 Medicare B Connection, pages 7-8.*

Provider type affected

This *MLN Matters*® special edition article is intended for all Medicare fee-for-service (FFS) physicians, non-physician practitioners, providers, and other health care professionals who bill Medicare administrative contractors (MACs) for bilateral surgical procedures for Medicare beneficiaries using the physician fee schedule (PFS).

Provider action needed

The purpose of this article is to inform providers that medically unlikely edits (MUEs) may render certain claim lines for bilateral surgical procedures unpayable. Providers and suppliers that bill using the PFS are reminded that Medicare billing instructions require claims for certain bilateral surgical procedures to be filed using a 50 modifier and one unit of service (UOS).

Make sure your billing staffs examine their process for filing claims for bilateral surgical procedures and services to ensure the 50 modifier is used in accordance with Medicare correct coding and claims submission instructions.

Background

Healthcare Common Procedure Coding System (HCPCS) coding for bilateral surgical procedures differs from CPT® coding guidelines.

Coding claims for surgical procedures performed bilaterally depends on:

- The HCPCS code descriptor,
- The "bilateral indicator" assigned to the HCPCS code (that is, whether special payment rules apply), and
- The nature of the service.

The *National Correct Coding Initiative (NCCI)* manual specifies that modifier 50 is used to report bilateral surgical procedures as a single UOS. The NCCI manual warns that MUE edits based on established CMS policies may limit units of service and are predicated on the assumption that claims are coded in accordance with these Medicare instructions. Consequently, many bilateral procedures have an MUE value of one.

Bilateral indicators only apply to the physician fee schedule (PFS) and not to other Medicare payment systems.

See **MUE**, page 38

MPFSDB

from page 36

instead of valuing CPT® code 97127. CMS will assign status indicator "I" to CPT® code 97127 to indicate that it is "Invalid" for Medicare purposes. HCPCS code G0515 has been added to the therapy code list, see CR 10303 for more information. *MLN Matters*® article MM10303 discusses CR 10303 and it is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm10303.pdf.

Additional information

The official instruction, CR 10393, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3938CP.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 26, 2017	Initial article released.

MLN Matters® Number: MM10393
Related CR Release Date: December 22, 2017
Related CR Transmittal Number: R3938CP
Related Change Request (CR) Number: 10393
Effective Date: January 1, 2018
Implementation Date: January 2, 2018

MUE

from page 37

Bilateral indicators

Bilateral indicator	What does this bilateral indicator mean?
0	**No bilateral payment adjustment** 150% payment adjustment for bilateral procedures does not apply. If procedure is reported with modifier 50 or with modifiers RT and LT, base the payment for the two sides on the lower of: (a) the total actual charge for both sides and (b) 100 percent of the fee schedule amount for a single code. **Example**: The fee schedule amount for code XXXXX is $125. The physician reports code XXXXX-LT with an actual charge of $100 and XXXXX-RT with an actual charge of $100. Payment should be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200). The bilateral adjustment is inappropriate for codes in this category (a) because of physiology or anatomy, or (b) because the code description specifically states that it is a unilateral procedure and there is an existing code for the bilateral procedure.
1	**150 percent bilateral payment adjustment** 150 percent payment adjustment for bilateral procedures applies. If the code is billed with the bilateral modifier or is reported twice on the same day by any other means (e.g., with RT and LT modifiers, or with a two in the units field), base the payment for these codes when reported as bilateral procedures on the lower of: (a) the total actual charge for both sides or (b) 150 percent of the fee schedule amount for a single code. If the code is reported as a bilateral procedure and is reported with other procedure codes on the same day, apply the bilateral adjustment before applying any multiple procedure rules.
2	**Bilateral procedure** 150 percent payment adjustment does not apply. RVUs are already based on the procedure being performed as a bilateral procedure. If the procedure is reported with modifier 50 or is reported twice on the same day by any other means (e.g., with RT and LT modifiers or with a two in the units field), base the payment for both sides on the lower of (a) the total actual charge by the physician for both sides, or (b) 100 percent of the fee schedule for a single code. **Example**: The fee schedule amount for code YYYYY is $125. The physician reports code YYYYY-LT with an actual charge of $100 and YYYYY-RT with an actual charge of $100. Payment should be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200). The RVUs are based on a bilateral procedure because (a) the code descriptor specifically states that the procedure is bilateral, (b) the code descriptor states that the procedure may be performed either unilaterally or bilaterally, or (c) the procedure is usually performed as a bilateral procedure.
3	**No bilateral payment adjustment** The usual payment adjustment for bilateral procedures does not apply. If the procedure is reported with modifier 50 or is reported for both sides on the same day by any other means (e.g., with RT and LT modifiers or with a two in the units field), base the payment for each side or organ or site of a paired organ on the lower of (a) the actual charge for each side or (b) 100 percent of the fee schedule amount for each side. If the procedure is reported as a bilateral procedure and with other procedure codes on the same day, determine the fee schedule amount for a bilateral procedure before applying any multiple procedure rules. Services in this category are generally radiology procedures or other diagnostic tests which are not subject to the special payment rules for other bilateral surgeries.

See **MUE**, page 39

MUE

from page 38

Request for reopening of a claim

For all MUE edit denials, including both MAI of two and three, if the provider identifies a clerical error and the correct value is equal to or less than the MUE, the provider may request a reopening (i.e., a clerical error reopening (CER)) to correct its billing of the claim as an alternative to filing a formal appeal. Providers can request a CER through their Medical administrative contractor. providers are reminded this approach is allowable to redress underpayments resulting from unintentional errors, but it nonetheless delays full payment. For example, if the provider identifies a denial of a bilateral surgical service because it was billed with two UOS instead of being billed with one UOS and a 50 modifier, the provider may request a reopening to correct the coding/billing error, although providers should be aware that reopening requests do not extend the window for filing appeals. More importantly, though, the provider should bring his billing into compliance with CMS instructions, using one UOS and the 50 modifier to avoid future denials and delays in payment.

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/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html* under - How Does It Work.

You may also want to review the following publications:

For information on clerical error reopenings (CERs) consult the *Claims Processing Manual* Pub. 100-04 Chapter 34 and work with your Medicare administrative contractor

For information on MUE adjudication indicators (MAIs) review the Revised Modification to the Medically Unlikely Edit (MUE) Program available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8853.pdf*.

For information on reporting hospital outpatient services using Healthcare Common Procedure Coding System (HCPCS) consult the *Claims Processing Manual* Pub. 100-04 Chapter 4 Section 20.6 - Use of Modifiers.

A podcast transcript on the MUEs at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/2015-05-21-Medically-Unlikely-Edits-Compliant-PodcastTranscript.pdf*.

MLN Matters® article MM6526 "Payment of Bilateral Procedures in a Method II Critical Access Hospital (CAH)" at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6526.pdf*.

Document history

Date of change	Description
January 17, 2018	This article was revised with more details and examples and was re-issued.
June 30, 2014	Initial article released.

MLN Matters® Number: SE1422 *Revised*
Related Change Request (CR) #: N/A
Article Release Date: January 17, 2018
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

Examples of correct coding for bilateral surgical procedures for PFS

Bilateral indicator	Expected units of service if performed bilaterally	Modifier based on laterality	HCPCS code descriptor and *explanation of correct coding*
1	1	50	23515 Open treatment of clavicular fracture, includes internal fixation, when performed. *The code descriptor does not identify this procedure as a bilateral procedure (or unilateral or bilateral), so when performed bilaterally at the same operative session physicians must report the procedure with modifier "-50" as a single line item using one UOS. Do not use modifiers RT and LT when modifier -50 applies.*
2	1		52290 Cystourethroscopy; with ureteral meatotomy, **unilateral or bilateral**. *The code descriptor identifies this procedure as a unilateral or bilateral procedure, so when performed bilaterally at the same operative session report one UOS as a single line item and do not report the procedure with modifier "-50".*

See **MUE**, page 40

MUE

from page 39

Bilateral indicator	Expected units of service if performed bilaterally	Modifier based on laterality	HCPCS code descriptor and *explanation of correct coding*
2	1		64488 Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) **bilateral**; by injections (includes imaging guidance, when performed). *The code descriptor identifies this procedure as a bilateral procedure, so when performed bilaterally at the same operative session report one UOS as a single line item and do not report the procedure with modifier "-50".*

Examples of incorrect coding for bilateral surgical procedures for PFS

Bilateral indicator	Expected units of service if performed bilaterally	Modifier based on laterality	Second modifier	HCPCS code descriptor and *explanation of incorrect coding*
1	1	RT	LT	23515 Open treatment of clavicular fracture, includes internal fixation, when performed. *The code descriptor does not identify this procedure as a bilateral procedure (or unilateral or bilateral), so when performed bilaterally at the same operative session physicians must report the procedure with modifier "-50" as a single line item using one UOS. Do not use modifiers RT and LT when modifier -50 applies.*
2	1		LT	52290 Cystourethroscopy; with ureteral meatotomy, **unilateral or bilateral**. *The code descriptor identifies this procedure as a unilateral or bilateral procedure, so when performed bilaterally at the same operative session report one UOS as a single line item and do not report the procedure with modifier "-50". Do not report the procedure using two line items using RT and LT modifiers.*
2	1	RT		52290 Cystourethroscopy; with ureteral meatotomy, **unilateral or bilateral**. *The code descriptor identifies this procedure as a unilateral or bilateral procedure, so when performed bilaterally at the same operative session report one UOS as a single line item and do not report the procedure with modifier "-50". Do not report the procedure using two line items using RT and LT modifiers.*
2	2			64488 Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) **bilateral**; by injections (includes imaging guidance, when performed). *The code descriptor identifies this procedure as a bilateral procedure, so when performed bilaterally at the same operative session report one UOS as a single line item. Do not report two UOS.*
2	1	50		64488 Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) **bilateral**; by injections (includes imaging guidance, when performed). *The code descriptor identifies this procedure as a bilateral procedure, so when performed bilaterally at the same operative session report one UOS as a single line item. Do not report the procedure with modifier "-50".*

General Coverage

ICD-10 and other coding revisions to national coverage determinations

***Note**: This article was revised January 19, 2018, to reflect a revised change request (CR) 10318 issued January 18. In the article, the CR release date, MAC implementation 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 December 2017 Medicare B Connection, pages 19-20.*

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

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

See **ICD-10**, page 42

ICD-10

from page 41

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
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/R2005OTN.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
January 19, 2018	The article was revised due to a revised CR 10318 issued January 18. In the article, the CR release date, MAC implementation date, transmittal number, and the web address of the CR are revised. All other information remains the same.
November 16, 2017	Initial article released.

MLN Matters® Number: MM10318 *Revised*
Related Change Request (CR) Number: 10318
Related CR Release Date: January 18, 2018
Effective Date: April 1, 2018 - Unless otherwise noted in CR 10318
Related CR Transmittal Number: R2005OTN
Implementation Date: January 29, 2018, 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

TRAVEL

from page 1

The allowance per mile was computed using the Federal mileage rate of $0.545 per mile plus an additional $0.45 per mile to cover the technician's time and travel costs. MACs have the option of establishing a higher per mile rate in excess of the minimum $1.00 per mile if local conditions warrant it. The minimum mileage rate will be reviewed and updated throughout the year, as well as in conjunction with the CLFS, as needed. At no time will the laboratory be allowed to bill for more miles than are reasonable, or for miles that are not actually traveled by the laboratory technician.

The per flat-rate trip basis travel allowance (P9604) for 2018 is $10.00.

Additional information

The official instruction, MM10448, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3942CP.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
January 2, 2018	Initial article released.

MLN Matters® Number: MM10448
Related CR Release Date: December 22, 2017
Related CR Transmittal Number: R3942CP
Related Change Request (CR) Number: 10448
Effective Date: January 1, 2018
Implementation Date: January 22, 2018

Suppression of the standard paper remittance advice in 45 days if also receiving ERA

***Note**: This article was revised December 29, 2017, to reflect the revised change request (CR) 10151 issued December 28, 2017. In the article, the CR release date, transmittal number, and the web address for accessing the CR are revised. All other information remains the same. This information was previously published in the August 2017 Medicare B Connection, page 1.*

Provider type affected

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

Provider action needed

CR 10151 provides notice that beginning January 2, 2018, Medicare's shared system maintainers (SSMs) must eliminate issuance of standard paper remittance advice (SPRs) to those providers/suppliers (or a billing agent, clearinghouse, or other entity representing those providers/suppliers) who also have been receiving electronic remittance advice (ERA) transactions for 45 days or more. The shared system changes to suppress the distribution of SPRs were implemented in January 2006 per CR 3991 (issued August 12, 2005, Transmittal 645). Make sure your billing staffs are aware of the suppression of the SPR.

Background

The SPR is the hard copy version of an ERA. MACs, including durable medical equipment (DME) MACs must be capable of producing SPRs for providers/suppliers who are unable or choose not to receive an ERA. The MACs and the DME MACs suppress distribution of SPRs if an electronic data interchange (EDI) enrolled provider/supplier is also receiving ERAs for more than 31 days for institutional health care claims (837I) and 45 days for DME and professional health care claims (837P). internet-only-manuals (IOMs), *MLN Matters*® article MM4376 provided information to the MACs regarding the receipt of SPR and ERA distribution time lines.

Beginning February 14, 2018, the SSMs shall suppress the delivery of SPR to the MACs EDI enrolled providers/suppliers who are also receiving both the ERA and SPR. In rare situations (such as natural or man-made disasters) exceptions to this policy may be allowed at the discretion of the Centers for Medicare & Medicaid Services (CMS). MACs will not send a SPR/hard copy version to a particular provider/supplier unless this requirement causes hardship and CMS has approved a waiver requested by your MAC.

Note: MM4376 is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM4376.pdf*.

Additional information

The official instruction, CR 10151, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1994OTN.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 29, 2017	This article was revised to reflect the revised CR 10151 issued December 28, 2017. In the article, the CR release date, transmittal number, and the web address for accessing the CR are revised. All other information remains the same.
December 22, 2017	This article was revised to reflect the revised CR 10151 issued December 21, 2017. In the article, the CR release date, transmittal number, and the web address for accessing the CR are revised. All other information remains the same.
August 7, 2017	Initial article released.

MLN Matters® Number: MM10151 *Revised*
Related CR Release Date: December 28, 2017
Related CR Transmittal: R1994OTN
Related Change Request (CR) Number: 10151
Effective Date: January 1, 2018
Implementation Date: January 2, 2018

How unsolicited/voluntary refunds are handled

Medicare contractors receive unsolicited/voluntary refunds (i.e., monies received not related to an open account receivable). Part A contractors generally receive unsolicited/voluntary refunds in the form of an adjustment bill, but may receive some unsolicited/voluntary refunds as checks. Part B contractors generally received checks. Substantial funds are returned to the trust funds each year through such unsolicited/voluntary refunds.

The Centers for Medicare & Medicaid Services reminds providers that:

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

remedies arising from or relating to these or any other claims.

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

Update to CARC and RARC codes for use with MREP 4.6

An updated remittance advice remark code (RARC) and claim adjustment reason code (CARC) “Codes.ini” file is now available for the provider/supplier community to import into their current version of Medicare Remit Easy Print (MREP) software.

The Centers for Medicare & Medicaid Services (CMS) has released a new version of the software that includes this “Codes.ini” file. Users who downloaded the MREP v4.5.1 between January 2, 2018 and January 10, 2018 will not need to import the “Codes.ini” file separately. To download the most current “Codes.ini” file, please follow these steps:

1. Navigate to *CMS’ Medicare Remit Easy Print (MREP) page*
2. Scroll to the bottom of the page
3. Extract the “Codes.ini” file from the *Medicare Remit Easy Print - Version 4.6 [ZIP, 1MB]*
4. After you have extracted the “Codes.ini” file, save it to your computer
5. Follow the instructions outlined in the “Working with MREP Remittances Advices” section - How to Update (Import) the CARC/RARC codes (page 67) of the *Medicare Remit Easy Print User Guide, Version 4.6*

2018 ‘Medicare Part B Participating Physician and Supplier Directory’

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

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

Source: Pub 100-04, Transmittal 3917, CR 10351

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.

Search capability simplifies LCD lookup

Providers in need of a quick and direct method to locate local coverage determinations (LCDs) by procedure code have a simple way to do so by using First Coast Service Options' website search functionality.

Providers can simply enter a procedure code, keyword, or ICD-10 code into the website search bar and search "LCDs only" to find the matching results. This search function replaces the multiple steps currently required by other methods, and lets providers locate the corresponding LCDs by using First Coast's own LCD data.

Click here for more information.

Revisions to LCD

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 to remove *Current Procedural Terminology* (CPT®) codes 80159, 80171, 80173, 80183, 80184, 83992, and 84999 from the "CPT®/ HCPCS Codes" section of the LCD since they represent drug testing of therapeutic intent. The focus of the LCD is on drugs of abuse testing and not on therapeutic effect of drugs.

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*.

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*.

Duplex scan of lower extremity arteries – revision to the Part A and Part B LCD

LCD ID number: L33667 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on an annual review of the local coverage determination (LCD) for duplex scan of lower extremity arteries, it was determined that some of the italicized language in the "Indications and Limitations of Coverage and/or Medical Necessity" section of 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 January 9, 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, please *click here*.

Hemophilia clotting factors – revision to the Part A and Part B LCD

LCD ID number: L33684 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on change request (CR) 10385 (January 2018 integrated outpatient code editor [I/OCE]), the local coverage determination (LCD) for hemophilia clotting factors was revised to reflect that Healthcare Common Procedure Coding System (HCPCS) code J7191 was changed from "Part A and Part B" to "Part B only" in the "CPT®/HCPCS codes" section of the LCD as this code has a Part A status indicator "E2" (Not paid by Medicare when submitted on outpatient claims). Also, HCPCS code J7191 was removed from "Group 1 Paragraph:" under "ICD-10 Codes that Support Medical Necessity" section of the LCD and put in its own group.

Effective date

This LCD revision is 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.

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

Hepatitis B surface antibody and surface antigen – revision to the Part A and Part B LCD

LCD ID number: L34003 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on an annual review of the local coverage determination (LCD) for hepatitis B surface antibody and surface antigen, it was determined that some of the italicized language in the "Indications and Limitations of Coverage and/or Medical Necessity" section of 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 January 9, 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*.

Luteinizing hormone-releasing hormone (LHRH) analogs – revision to the Part A and Part B LCD

LCD ID number: L33685 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on change request 10385 (January 2018 Integrated Outpatient Code Editor [I/OCE]), the local coverage determination (LCD) for luteinizing hormone-releasing hormone (LHRH) analogs was revised to reflect that Healthcare Common Procedure Coding System (HCPCS) code J9219 was changed to indicate "Part B only" in the "CPT®/HCPCS codes" section of the LCD as this code has a Part A status indicator "E2" (Not paid by Medicare when submitted on outpatient claims). In addition, the procedure codes in the "CPT®/HCPCS Codes" section of the LCD were put in groups to be consistent with the groups in the "ICD-10 Codes that Support Medical Necessity" section of the LCD.

Effective date

The LCD revision related to HCPCS code J9219 is effective for services rendered **on or after January 1, 2018.** The LCD revision related to consistency in the groups 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*.

Magnetic resonance angiography (MRA) – revision to the Part A and Part B LCD

LCD ID number: L34372 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on an annual review of the local coverage determination (LCD) for magnetic resonance angiography (MRA), it was determined that some of the italicized language in the "Indications and Limitations of Coverage and/or Medical Necessity" section of 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 January 9, 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*.

Molecular pathology procedures for human leukocyte antigen (HLA) typing – revision to the Part A and Part B LCD

LCD ID number: L34518 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on an annual review of the local coverage determination (LCD) for molecular pathology procedures for human leukocyte antigen (HLA) typing, it was determined that some of the italicized language in the "Documentation Requirements" section of 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 January 9, 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, please *click here*.

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.

Monitored anesthesia care (MAC) for certain interventional pain management services – revision to the Part A and Part B LCD

LCD ID number: L33595 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on an annual review of the local coverage determination (LCD) for monitored anesthesia care (MAC) for certain interventional pain management services, it was determined that some of the italicized language in the "Indications and Limitations of Coverage and/or Medical Necessity" section of 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 January 9, 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*.

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

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

Based on change request 10236 (October 2017 Update of the Hospital Outpatient Prospective Payment System [OPPS]), the local coverage determination (LCD) for noncovered services was revised to move procedure code 0421T from "CPT®/HCPCS Codes – Group 3 Codes:" under the subtitle "Procedures for Part B only" section of the LCD to "CPT®/HCPCS Codes – Group 1 Codes:" under the subtitle "Procedures for Part A and Part B" section of the LCD with the symbol "++" to indicate it is covered if the beneficiary is enrolled in an approved category B investigational device exemption (IDE) study.

Effective date

This LCD revision is effective for claims processed **on or after January 1, 2018**, for services rendered **on or after June 5, 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, please *click here*.

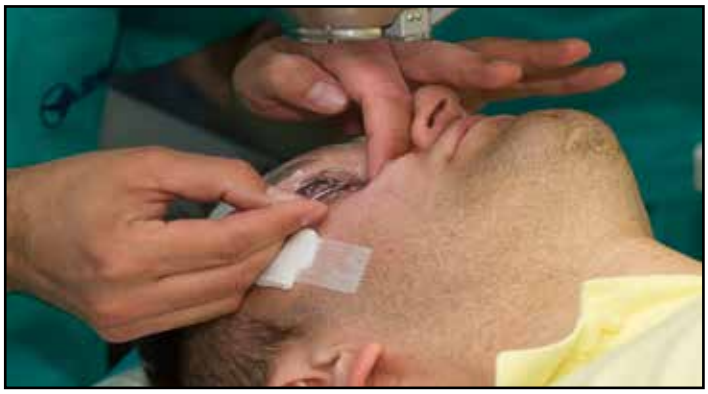
Noncovered services (procedure codes 0449T and 0450T) – revision to the Part A and Part B LCD

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 include multiple published sources from reconsideration requests received in 2017 for *Current Procedural Terminology* (CPT®) codes 0449T and 0450T (insertion of aqueous drainage device, without extraocular reservoir, internal approach, into the subconjunctival space). 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 January 18, 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, please *click here*.

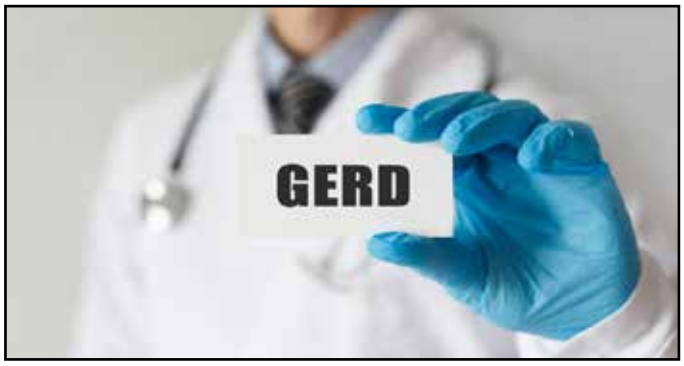
Noncovered procedures - endoscopic treatment of gastroesophageal reflux disease (GERD) – revision to the Part A and Part B LCD

LCD ID number: L33296 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on a local coverage determination (LCD) reconsideration request, the LCD for noncovered procedures - endoscopic treatment of gastroesophageal reflux disease (GERD) was revised to remove *Current Procedural Terminology* (CPT®) code 43210 from the “CPT®/HCPCS Codes” section of the LCD. Also, language related to “Esophyx” was removed from the “Limitations of Coverage” section of the LCD. In addition, the “Sources of Information and Basis for Decision” section of the LCD was updated with eight full text published sources from this reconsideration request for CPT® code 43210 for the Esophyx® system for the treatment of GERD.

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 “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*.

Non-invasive physiologic studies of upper or lower extremity arteries – revision to the Part A and Part B LCD

LCD ID number: L33696 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on an annual review of the local coverage determination (LCD) for non-invasive physiologic studies of upper or lower extremity arteries, it was determined that some of the italicized language in the "Indications and Limitations of Coverage and/or Medical Necessity" section of 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 January 9, 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*.

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

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

The local coverage determination (LCD) for screening and diagnostic mammography was revised to add ICD-10-CM diagnosis codes N63.11-N63.14, N63.21-N63.24, N63.31, N63.32, N63.41, and N63.42 to the "ICD-10 Codes that Support Medical Necessity" section of the LCD for procedure codes 77065, 77066, and G0279.

Effective date

This LCD revision is effective for claims processed **on or after December 29, 2017**, for services rendered **on or after October 1, 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*.

Total calcium – revision to the Part A and Part B LCD

LCD ID number: L34031 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on an annual review of the local coverage determination (LCD) for total calcium, it was determined that some of the italicized language in the "Utilization Guidelines" section of 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 January 9, 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*.

Transcranial magnetic stimulation for major depressive disorder – revision to the Part A and Part B LCD

LCD ID number: L34522 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on an annual review of the local coverage determination (LCD) for transcranial magnetic stimulation for major depressive disorder, it was determined that some of the italicized language in the "Indications and Limitations of Coverage and/or Medical Necessity" section of 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 January 9, 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*.

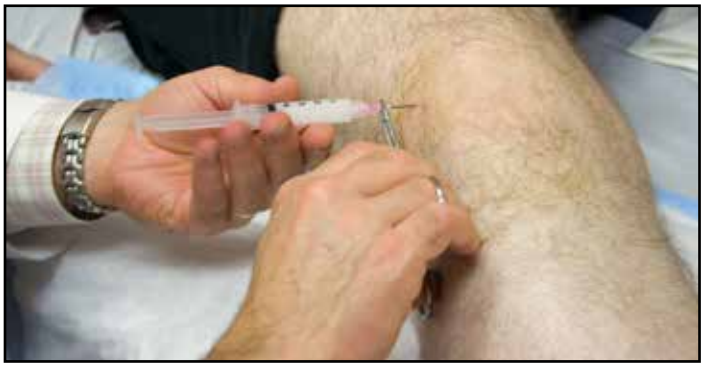
Viscosupplementation therapy for knee – revision to the Part A and Part B LCD

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

Based on change request (CR) 10385 (January 2018 Integrated Outpatient Code Editor [I/OCE]), the local coverage determination (LCD) for viscosupplementation therapy for knee was revised to add Healthcare Common Procedure Coding System (HCPCS) code J7320 to the "CPT®/HCPCS Codes" and "ICD-10 Codes that Support Medical Necessity" sections of the LCD for Part A as the status indicator changed from "E2" (Not paid by Medicare when submitted on outpatient claims) to "K" (Paid under OPPS, separate APC payment).

Effective date

This LCD revision is 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.

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

Additional Information

Susceptibility studies – revision to the Part A and Part B LCD "coding guidelines"

LCD ID number: L33755 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for susceptibility studies "coding guidelines" were revised to clarify that the diagnosis codes listed in national coverage determination (NCD) 190.12 for *Current Procedural Terminology* (CPT®) codes 87086 and 87088 are also allowed for susceptibility studies (CPT® codes 87181-87190).

Effective date

This revision to the "coding guidelines" is effective for claims processed **on or after December 19, 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, please *click here*.

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 January 4, 2018

MLN Connects® for January 4, 2018

View this edition as a PDF

News & Announcements

- CMS Launches Data Submission System for Clinicians in the Quality Payment Program
- CMS Updates Website to Compare Hospital Quality
- Patients over Paperwork: Get Updates on Burden Reduction
- Quality Payment Program: Qualified Registries and QCDRs
- Quality Payment Program Resources
- EHR Incentive Program Hospitals: Use QNet to Attest
- Medicare Diabetes Prevention Program Resources
- Post-Acute Care Quality Reporting Program Section GG Web-based Training
- Hospice Compare Update
- Are You Prepared for a Health Care Emergency?
- Get Your Patients Off to a Healthy Start in 2018

Provider Compliance

- Hospice Election Statements Lack Required Information or Have Other Vulnerabilities – Reminder

Upcoming Events

- Low Volume Appeals Settlement Option Call – January 9
- ESRD QIP: Final Rule for CY 2018 Call – January 23

Medicare Learning Network Publications & Multimedia

- Dementia Care Call: Audio Recording and Transcript – New
- Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians Booklet – Revised

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.

MLN Connects® for January 11, 2018

MLN Connects® for January 11, 2018

View this edition as a PDF

News & Announcements

- CMS Launches Data Submission System for Clinicians in the Quality Payment Program
- CMS Updates Website to Compare Hospital Quality
- Patients over Paperwork: Get Updates on Burden Reduction
- Quality Payment Program: Qualified Registries and QCDRs
- Quality Payment Program Resources
- EHR Incentive Program Hospitals: Use QNet to Attest
- Medicare Diabetes Prevention Program Resources
- Post-Acute Care Quality Reporting Program Section GG Web-based Training
- Hospice Compare Update
- Are You Prepared for a Health Care Emergency?
- Get Your Patients Off to a Healthy Start in 2018

Provider Compliance

- Hospice Election Statements Lack Required Information or Have Other Vulnerabilities – Reminder

Upcoming Events

- Low Volume Appeals Settlement Option Call – January 9
- ESRD QIP: Final Rule for CY 2018 Call – January 23

Medicare Learning Network Publications & Multimedia

- Dementia Care Call: Audio Recording and Transcript – New
- Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians Booklet – Revised

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MLN Connects® for January 18, 2018

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News & Announcements

- 2018 Value Modifier Results and Payment Adjustment Factor
- Final DMEPOS Quality Standards for Therapeutic Shoe Inserts
- Glaucoma Awareness Month: Make a Resolution for Healthy Vision

Provider Compliance

- CMS Provider Minute Video: CT Scans — Reminder

Upcoming Events

- New Medicare Card Project Special Open Door Forum — January 23
- ESRD QIP: Final Rule for CY 2018 Call — January 23
- MIPS Annual Call for Measures and Activities Webinar — February 5
- Comparative Billing Report on Opioid Prescribers Webinar — February 21

Medicare Learning Network Publications & Multimedia

- QRUR Video Presentation — New

- Low Volume Appeals Settlement Call: Audio Recording and Transcript — New
- Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians Web-based Training — Revised
- How to Use the Medicare Coverage Database Booklet — Revised
- Behavioral Health Integration Services Fact Sheet — Revised

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Redeterminations

Medicare Part B Redetermination
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