Medicare B Connection

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A Newsletter for MAC Jurisdiction N Providers

March 2018

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Provider type affected

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

Provider action needed

This article is based on change request (CR) 10494 which directs MACs to mass adjust QMB claims impacted by CR 9911. (An article related to CR 9911 is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm9911.pdf*.) Make sure that your billing staff is aware of these upcoming claims adjustments.

Background

CR 9911 incorporates claim processing system modifications implemented October 2, 2017, to generate QMB information in remittance advices (RAs) and Medicare summary notices. Providers may use RAs to bill state Medicaid agencies and other secondary payers outside the coordination of benefits agreement (COBA) crossover process, but CR 9911 RAs lacked the formatting and specificity that states require to process QMB cost-sharing claims.

To address these issues, December 8, 2017, the Centers for Medicare & Medicaid Services (CMS) temporarily suspended the CR 9911 claim processing system modifications. See “QMB Remittance Advice Issue” at *https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MM9911Update112017.pdf*.

Through CR 10433, CMS will reintroduce QMB information in the RA starting July 2018 and modify CR 9911 to avoid disrupting claim processing by secondary payers. CR 10433 will be effective for claims processed on or after July 2, 2018. A related article is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm10433.pdf*.

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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.

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About the Medicare B Connection

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

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

Ambulatory Surgical Center

April 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) 10530 informs MACs about updates to the ASC payment system for January 2018. Be sure your billing staffs are aware of these changes.

Background

CR 10530 describes changes to billing instructions for various payment policies implemented in the April 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. CMS is also including April 2018 ASC payment rates for covered surgical and ancillary services (ASCFS) update file. No ASC code pair file is being issued.

The changes in CR 10530 are as follows:

1. New separately payable procedure code effective April 1, 2018

Effective April 1, 2018, new HCPCS code C9749 has been created as described in the Table 1.

Table 1 — New separately payable procedure code effective April 1, 2018

HCPCS code	Short descriptor	Long descriptor	ASC PI
C9749	Repair nasal stenosis w/ imp	Repair of nasal vestibular lateral wall stenosis with implant(s)	J8

2. Drugs, biologicals, and radiopharmaceuticals

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

For 2018, payment for non-pass-through drugs, biologicals and therapeutic radiopharmaceuticals continues to be made at a single rate of ASP + 6 percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical. In addition, in 2018, a single payment of ASP + 6 percent continues to be made for pass-through drugs, biologicals and radiopharmaceuticals to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items. Payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. Updated payment rates effective April 1, 2018, and drug price restatements, can be found in the April 2018 update of ASC Addendum BB at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html*.

b. April 2018 HCPCS codes and dosage descriptors for certain drugs, biologicals, and radiopharmaceuticals effective April 1, 2018

Several new HCPCS codes have been created for reporting drugs and biologicals in the ASC payment system effective April 1, 2018, where there have not previously been specific codes available. These new codes are listed in Table 2.

Table 2 — April 2018 HCPCS codes and dosage descriptors for certain drugs, biologicals, and radiopharmaceuticals effective April 1, 2018

HCPCS code	Short descriptor	Long descriptor	ASC PI
C9462	Injection, delafloxacin	Injection, delafloxacin, 1 mg	K2
C9463	Injection, aprepitant	Injection, aprepitant, 1 mg	K2
C9464	Injection, rolapitant	Injection, rolapitant, 0.5 mg	K2
C9465	Injection, Durolane	Hyaluronan or derivative, Durolane, for intra-articular injection, per dose	K2
C9466	Injection, benralizumab	Injection, benralizumab, 1 mg	K2
C9467	Inj rituximab hyaluronidase	Injection, rituximab and hyaluronidase, 10 mg	K2
C9468	Inj, factor ix, Rebinyn	Injection, factor ix (antihemophilic factor, recombinant), glycopegylated, Rebinyn, 1 i.u..	K2
C9469	Inj triamcinolone acetonide	Injection, triamcinolone acetonide, preservative-free, extended-release, microsphere formulation, 1 mg	K2

See **ASC**, page 6

ASC

from page 5

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

Some drugs and biologicals based on ASP methodology may have payment rates that are corrected retroactively. These retroactive corrections typically occur on a quarterly basis. The list of drugs and biologicals with corrected payments rates will be accessible on the CMS website 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 MACs to adjust previously processed claims.

d. Changes to biosimilar biological product HCPCS codes and modifiers

Effective April 1, 2018, CMS is revising the long and short descriptors for HCPCS code Q5101. Table 3 displays the revised descriptors.

Table 3 — Revised descriptors for Q5101

HCPCS code	Short descriptor	Long descriptor	ASC PI
Q5101	Injection, zarxio	Injection, filgrastim-sndz, biosimilar, (zarxio), 1 microgram	K2

In addition, effective April 1, 2018, HCPCS codes Q5103, Injection, infliximab-dyyb, biosimilar, (inflectra), 10 mg, and Q5104 (Injection, infliximab-abda, biosimilar, (renflexis), 10 mg) will replace HCPCS code Q5102 (Inj., infliximab biosimilar). Table 4 (below), describes coding changes, the ASC payment indicator, and effective dates for biosimilar biological product HCPCS codes.

The new biosimilar payment policy also makes the use of modifiers that describe the manufacturer of a biosimilar product unnecessary. Therefore, modifiers ZA, ZB, and ZC will be discontinued for dates of service on or after April 1, 2018. Beginning April 1, 2018, Q5101, when performed, would no longer be required to be billed with a modifier. However, please note that both HCPCS codes Q5101 and Q5102, and the requirement to use applicable biosimilar modifiers remain in effect for dates of service prior to April 1, 2018.

3. 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 10530, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R3996CP.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
March 12, 2018	Initial article released.

MLN Matters® Number: MM10530
Related CR Release Date: March 9, 2018
Related CR Transmittal Number: R3996CP
Related Change Request (CR) Number: 10530
Effective Date: April 1, 2018
Implementation Date: April 2, 2018

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Table 4 — Changes to biosimilar biological product HCPCS codes

HCPCS code	Short descriptor	Long descriptor	ASC PI	Added date	Termination date
Q5102*	Inj., infliximab biosimilar	Injection, infliximab, biosimilar, 10 mg	K2	7/1/16	3/31/18
Q5103	Injection, inflectra	Injection, infliximab-dyyb, biosimilar, (inflectra), 10 mg	K2	4/1/18	
Q5104	Injection, renflexis	Injection, infliximab-abda, biosimilar, (renflexis), 10 mg	K2	4/1/18	

*Note on Q5102: Q5102 was added 7/01/2016, and effective 4/5/2016.

Drugs & Biologicals

April 2018 update of drug and biological code changes

***Note**: This article was revised March 8 to reflect an updated change request (CR). That CR provides additional instructions for the MACs, regarding use of the long descriptors. The CR date, transmittal number and link to the transmittal also changed. All other information is unchanged. This information was previously published in the February 2018 Medicare B Connection, page 6.*

Provider type affected

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

What you need to know

The HCPCS code set is updated on a quarterly basis. CR 10454 informs MACs of the April 2018 updates of specific biosimilar biological product HCPCS code, modifiers used with these biosimilar biologic products and an autologous cellular immunotherapy treatment. Be sure your staffs are aware of these updates.

Background

CR 10454 describes updates associated with the following biosimilar biological product HCPCS codes and modifiers. The April 2018 HCPCS file includes three new HCPCS codes: Q5103, Q5104, and Q2041 Also, the April 2018 HCPCS file includes a revision to the descriptor for HCPCS code Q5101.

Effective for services as of April 1, 2018, The April 2018 HCPCS file includes these revised/new HCPCS codes:

- HCPCS code: Q5101
  - Short description: Injection, zarxio
  - Long description: Injection, filgrastim-sndz, biosimilar, (zarxio), 1 microgram
- HCPCS code: Q5103
  - Short description: Injection, inflectra
  - Long description: Injection, infliximab-dyyb, biosimilar, (inflectra), 10 mg
  - Type of service (TOS) code: 1,P
  - Medicare physician fee schedule database (MPFSDB) status indicator: E
- HCPCS code: Q5104
  - Short description: Injection, renflexis
  - Long description: Injection, infliximab-abda, biosimilar, (renflexis), 10 mg
  - TOS code: 1, P
  - MPFSDB status indicator: E
- HCPCS code:Q2041
  - Short description: Axicabtagene ciloleucel car+
  - Long description: Axicabtagene Ciloleucel, up to 200 million autologous Anti-CD19 CAR T Cells, Including leukapheresis and dose preparation procedures, per infusion
  - TOS code: 1
  - MPFSDB status indicator: E

Effective for claims with dates of service on or after April 1, 2018, HCPCS code Q5102 (which describes both currently available versions of infliximab biosimilars) will be replaced with two codes, Q5103 and Q5104. Thus, Q5102 Injection, infliximab, biosimilar, 10 mg, will be discontinued, effective March 31, 2018.

Also, beginning on April 1, 2018, modifiers that describe the manufacturer of a biosimilar product (for example, ZA, ZB and ZC) will no longer be required on Medicare claims for HCPCS codes for biosimilars. However, please note that HCPCS code Q5102 and the requirement to use biosimilar modifiers remain in effect for dates of service prior to April 1, 2018.

Medicare Part B policy changes for biosimilar biological products were discussed in the 2018 physician fee schedule (PFS) final rule at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1676-F.html*. Effective January 1, 2018, newly approved biosimilar biological products with a common reference product will no longer be grouped into the same billing code. The rule also stated that instructions for new codes for biosimilars that are currently grouped into a common payment code and the use of modifiers would be issued.

Additional information

The official instruction, CR 10454, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R3997CP.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
March 8, 2018	This article was revised to reflect an updated CR. That CR provided additional instructions for the MACs, regarding use of the long descriptors. The CR date, transmittal number and link to the transmittal also changed. All other information is unchanged.
February 2, 2018	Initial article released.

See **DRUG**, page 8

Durable Medical Equipment

April quarterly update for 2018 DMEPOS fee schedule

Provider type affected

This *MLN Matters*® article is intended for providers and suppliers submitting claims to durable medical equipment Medicare administrative contractors (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) 10503 provides the April 2018 Medicare DMEPOS fee schedule quarterly update. It provides specific instructions to your DME MAC for implementing updated oxygen volume adjustments.

When necessary, the DMEPOS fee schedule is updated quarterly, to implement fee schedule amounts for new codes, to correct any fee schedule amounts for existing codes (as applicable) and to apply changes in payment policies. It contains fee schedule amounts for both non-rural and rural areas. Additionally, the parenteral and enteral nutrition (PEN) fee schedule file includes state fee schedule amounts for enteral nutrition items and national fee schedule amounts for parental nutrition items.

There were no Quarter 2, 2018, rural ZIP code changes, so an April 2018 DMEPOS rural ZIP code file will not be furnished as part of this update; and there was no change to the PEN fee schedule file for Quarter 2, 2018, so a new PEN fee schedule file will not be furnished as part of this update.

Background

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

Additionally, Section 1834(a)(1)(F)(ii) of the Act mandates adjustments to the fee schedule amounts for certain items furnished on or after January 1, 2016, in areas that are not competitive bid areas, based on information from Competitive Bidding Programs (CBPs) for DME. Section 1842(s)(3)(B) of the Act provides authority for making adjustments to the fee schedule amount for enteral nutrients, equipment and supplies (enteral nutrition) based on information from CBPs.

The methodologies for adjusting DMEPOS fee schedule amounts under this authority are established at 42 CFR §414.210(g). The DMEPOS and PEN fee schedule files contain Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the adjustments, as well as codes that are not subject to the fee schedule CBP adjustments.

Additional information on adjustments to the fee schedule amounts based on information from CBPs is available in Transmittal 3551, CR 9642, dated June 23, 2016, and Transmittal 3416, CR 9431, dated November 23, 2015. You can find the *MLN Matters*® articles associated with these change requests at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9642.pdf*, and *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9431.pdf*, respectively.

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

The fee schedules public use files (PUFs) will be available for state Medicaid agencies, managed care organizations, and other interested parties shortly after the release of the data files on the CMS website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html*.

K0903

As part of this update, CR 10503 is adding fee schedule amounts for HCPCS code K0903 (For diabetics only, multiple density insert, made by direct carving with CAM technology from a rectified CAD model created from a digitized scan of the patient, total contact with patient's foot, including arch, base layer minimum of 3/16 inch material of shore a 35 durometer (or higher), includes arch filler and other shaping material, custom fabricated, each),

See **DME**, page 9

DRUG

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DME

from page 8

effective for claims with dates of service on or after April 1, 2018. The fees for code K0903 are set based on the fees for code A5513 because inserts carved from a digitized scan of the patient's foot were determined to be comparable to inserts made over a positive model of the patient's foot.

Oxygen volume adjustments

As part of the 2017 April quarterly DMEPOS fee schedule update (Please refer to the associated *MLN Matters*® article at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9988.pdf*), the 'QF' modifier (prescribed amount of oxygen is greater than four liter per minute (LPM) and portable oxygen is prescribed) was added to the DMEPOS fee schedule for use with both stationary and portable oxygen when the oxygen flow rate exceeds four liters per minute (LPM) and portable oxygen is prescribed.

- Section 1834(a)(5)(C) and (D) of the Act requires that when an oxygen flow rate exceeds four LPM, the Medicare payment amount be the higher of
- 50 percent of the stationary payment amount (HCPCS codes E0424, E0439, E1390, or E1391); or
- The portable oxygen add-on amount (HCPCS codes E0431, E0433, E0434, E1392, or K0738); and
- Never both.

The stationary oxygen QF modifier fee schedule amounts represent 100 percent of the stationary oxygen fee schedule amount. The portable oxygen 'QF' fee schedule amounts represent the higher of 1) 50 percent of the monthly stationary oxygen payment amount; or 2) The fee schedule amount for the portable oxygen add-on amount. The 'QF' modifier is billed on both the stationary oxygen and portable oxygen code when the prescribed amount of oxygen is greater than 4 LPM, portable oxygen is prescribed, **and there is no difference in the prescribed flow rate for nighttime and daytime use.**

CR 10503 provides that effective April 1, 2018:

- The 'QF' modifier is revised to read as follows:
  - QF – (PRESCRIBED AMOUNT OF STATIONARY OXYGEN WHILE AT REST EXCEEDS 4 LITERS PER MINUTE (LPM) AND PORTABLE OXYGEN IS ; and
- The following new oxygen volume adjustment modifier is added to the HCPCS file:
  - QB – (PRESCRIBED AMOUNTS OF STATIONARY OXYGEN FOR DAYTIME USE WHILE AT REST AND NIGHTTIME USE DIFFER AND THE AVERAGE OF THE TWO AMOUNTS EXCEEDS 4 LITERS PER MINUTE (LPM) AND PORTABLE OXYGEN IS PRESCRIBED).

Specifically (effective April 1, 2018), the modifier 'QB' should be used in conjunction with claims submitted for stationary oxygen (codes E0424, E0439, E1390, or E1391) and portable oxygen (codes E0431, E0433, E0434, E1392, or K0738) **when the prescribed amount of oxygen for daytime and nighttime differ** and the average of the two amounts is greater than four liters per minute (LPM) and portable oxygen is prescribed. For more information April 1, 2018, changes to the pricing modifiers for oxygen flow rate, please refer to *MLN Matters*® article MM10158, titled "Revised and new modifiers for oxygen flow rate."

Please note that the 'QB' modifier is used in billing to denote when: 1) The average prescribed amount of oxygen is greater than four LPM; 2) Portable oxygen is prescribed; and 3) There is a difference in the prescribed flow rates for nighttime and for daytime use. In these instances, regulations at 42 CFR 414.226(e)(3)(iii) require that an average of the varying nighttime and daytime flow rates is to be used in determining the volume adjustment. Therefore, the 'QB' modifier is used when the average of the nighttime and daytime flow rates exceed four LPM and portable oxygen is prescribed.

In addition, please note that Section 1834(a)(5)(C) and (D) of the Act also applies to the 'QB' modifier. This section of the Act requires that, when the oxygen flow rate exceeds four LPM, the Medicare payment amount is to be: 1) The higher of 50 percent of the stationary payment amount (codes E0424, E0439, E1390, or E1391); or 2) The portable oxygen add-on amount (E0431, E0433, E0434, E1392 or K0738); and 3) Never both.

To facilitate this payment calculation, CR 10503 adds the 'QB' modifier (effective April 1, 2018) to the DMEPOS fee schedule file, for both stationary and portable oxygen.

The stationary oxygen 'QB' modifier fee schedule amounts represent 100 percent of the stationary oxygen fee schedule amount. The portable oxygen 'OB' fee schedule amounts represent the higher of 1) 50 percent of the monthly stationary oxygen payment amount or 2) the fee schedule amount for the portable oxygen add-on amount.

Additional information

The official instruction, CR 10503, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4004CP.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
March 22, 2018	Initial article released.

MLN Matters® Number: MM10503
Related CR Release Date: March 21, 2018
Related CR Transmittal Number: R4004CP
Related Change Request (CR) Number: 10503
Effective Date: April 1, 2018
Implementation Date: April 2, 2018

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Laboratory/Pathology

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

Note**: This article was revised March 15 to reflect an updated change request (CR). That CR removed the list of new codes with a QW modifier that were effective as of April 1, 2018, from the policy section. All other information remains the same. This information was previously published in the February 2018 Medicare B Connection, pages 8-9.* ***Note: Editorial corrections made May 23, 2018, to correct related CR release date and transmittal number.

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) 10445 which informs the MACs about the changes in the April 2018 quarterly update to the clinical laboratory fee schedule (CLFS). Make sure that your billing staffs are aware of these changes.

Background

Effective January 1, 2018, CLFS rates will be based on weighted median private payor rates as required by the Protecting Access to Medicare Act (PAMA) of 2014. For more details, visit PAMA Regulations, at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/PAMA-Regulations.html*. Part B deductible and coinsurance do not apply for services paid under the CLFS.

Access to data file

Internet access to the quarterly CLFS data file will be available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/index.html*. Interested parties, such as the Medicaid State agencies, the Indian Health Service, the United Mine Workers, and the Railroad Retirement Board, should use the Internet to retrieve the quarterly clinical laboratory fee schedule. The file will be available in multiple formats: Excel, text, and comma delimited.

Pricing information

The CLFS includes separately payable fees for certain specimen collection methods (codes 36415, P9612, and P9615). The fees are established in accordance with Section 1833(h)(4)(B) of the Social Security Act.

New codes

The following new codes will be MAC priced, until they are addressed at the annual Clinical Laboratory Public Meeting, which will take place in July, 2018. The following "U" codes shall have HCPCS pricing indicator code - 22 = Price established by A/B MACs Part B (e.G., gap-fills, A/B MACs Part B established panels) instead of pricing indicator - 21 = Price subject to national limitation amount. (code, long descriptor, short descriptor, effective date, type of service (TOS))

0024U Glycosylated acute phase proteins (GlycA), nuclear magnetic resonance spectroscopy, quantitative GLYCA NUC MR SPECTRSC QUAN 1/1/2018 5

0025U Tenofovir, by liquid chromatography with tandem mass spectrometry (LC-MS/MS), urine, quantitative TENOFOVIR LIQ CHROM UR QUAN 1/1/2018 5

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 1/1/18 5

0027U JAK2 (Janus kinase 2) (eg, myeloproliferative disorder) gene analysis, targeted sequence analysis exons 12-15 JAK2 GENE TRGT SEQ ALYS 1/1/18 5

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 1/1/18 5

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

See **LAB**, page 11

LAB

from page 10

METAB ADVRS TRGT SEQ ALYS 1/1/18 5

0030U Drug metabolism (warfarin drug response), targeted sequence analysis (ie, CYP2C9, CYP4F2, VKORC1, rs12777823) RX METAB WARF TRGT SEQ ALYS 1/1/18 5

0031U CYP1A2 (cytochrome P450 family 1, subfamily A, member 2)(eg, drug metabolism) gene analysis, common variants (ie, *1F, *1K, *6, *7) CYP1A2 GENE 1/1/18 5

0032U COMT (catechol-O-methyltransferase)(drug metabolism) gene analysis, c.472G>A (rs4680) variant COMT GENE 1/1/18 5

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 1/1/18 5

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 1/1/18 5

The following new code is effective January 1, 2018:

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

Deleted codes

The following codes are deleted effective January 1, 2018:

Existing code 0004U is to be deleted.

Existing code 0015U is to be deleted.

Existing code 81280 is to be deleted.

Existing code 81281 is to be deleted.

Existing code 81282 is to be deleted.

Code update

Existing code 80410 had an incorrect crosswalk (multiplier of 1 instead of 3) in the annual CLFS file, and is corrected with this CR in the quarterly file, effective January 1, 2018.

Additional information

The official instruction, CR 10445, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/*

Transmittals/2018Downloads/R3999CP.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
March 15, 2018	The article was revised to reflect an updated CR. That CR removed the list of new codes with a QW modifier that were effective as of April 1, 2018, from the policy section.
February 9, 2018	Initial article released.

MLN Matters® Number: MM10445
Related CR Release Date: March 14, 2018
Related CR Transmittal Number: R3999CP
Related Change Request (CR) Number: 10445
Effective Date: January 1, 2018, for new HCPCS codes, otherwise April 1, 2018
Implementation Date: April 2, 2018

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Medicare Physician Fee Schedule

April update to the 2018 Medicare physician fee schedule database

Provider type affected

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

Provider action needed

Change request (CR) 10488 amends payment files issued to MACs based upon the calendar year 2018 Medicare physician fee schedule (MPFS) final rule. Make sure your billings staffs are aware of these changes.

Background

Payment files were issued to contractors based upon the 2018 MPFS final rule, published in the *Federal Register* November 15, 2017, to be effective for services furnished between January 1, 2018, and December 31, 2018. Section 1848(c)(4) of the Social Security Act authorizes the Secretary to establish ancillary policies necessary to implement relative values for physicians' services.

CR 10488 presents a summary of the changes for the April update to the 2018 MPFSDB. Unless otherwise stated, these changes are effective for dates of service on and after January 1, 2018.

CPT®/ HCPCS & Mod	Action
G0516	Change in short descriptor on 4-1-18 to "insert drug implant,>=4"
45399	Global days = YYY
G9976	Procedure status = I
G9977	Procedure status = I
83992	Procedure status = I

The following "Q" codes are effective for services performed on or after April 1, 2018 (see *MLN Matters*® article *MM10454* for additional information):

CPT® code	Short descriptor	Action
Q2041	Axicabtagene ciloleucel car+	Procedure status = E; there are no RVUs
Q5101	Injection, zarxio	Change in short descriptor
Q5102	Inj., infliximab biosimilar	Procedure status = I (invalid); code discontinued 4-1-18 & after
Q5103	Injection, inflectra	Procedure status = E; there are no RVUs
Q5104	Injection, renflexis	Procedure status = E; there are no RVUs

The HCPCS "G" codes listed below have been added to the MPFSDB effective for dates of service on and after April 1, 2018. All of these new codes were communicated through other instructions. Please consult those instructions for the description and other information. In addition, the descriptions are available also at *https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update.html*.

CPT®/ HCPCS & Mod	Action
G9873	Procedure status = X; there are no RVUs; all policy indicators = concept does not apply
G9874	Procedure status = X; there are no RVUs; all policy indicators = concept does not apply
G9875	Procedure status = X; there are no RVUs; all policy indicators = concept does not apply
G9876	Procedure status = X; there are no RVUs; all policy indicators = concept does not apply
G9877	Procedure status = X; there are no RVUs; all policy indicators = concept does not apply
G9878	Procedure status = X; there are no RVUs; all policy indicators = concept does not apply
G9879	Procedure status = X; there are no RVUs; all policy indicators = concept does not apply
G9880	Procedure status = X; there are no RVUs; all policy indicators = concept does not apply
G9881	Procedure status = X; there are no RVUs; all policy indicators = concept does not apply
G9882	Procedure status = X; there are no RVUs; all policy indicators = concept does not apply
G9883	Procedure status = X; there are no RVUs; all policy indicators = concept does not apply
G9884	Procedure status = X; there are no RVUs; all policy indicators = concept does not apply
G9885	Procedure status = X; there are no RVUs; all policy indicators = concept does not apply
G9890	Procedure status = X; there are no RVUs; all policy indicators = concept does not apply
G9891	Procedure status = X; there are no RVUs; all policy indicators = concept does not apply

Providers should be aware MACs do not need to search their files to either retract payment for claims already paid

See **MPFSDB**, page 15

Radiology

Appropriate-use criteria for advanced diagnostic imaging – voluntary participation and reporting period - claim processing requirements – modifier QQ

Provider type affected

This *MLN Matters*® article is intended for physicians, facilities and other practitioners billing Part B services to Medicare administrative contractors (MACs) for advanced diagnostic imaging provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 10481 informs the MACs of the appropriate Healthcare Common Procedure Coding System (HCPCS) modifier (QQ) that may be reported on the same claim line as the *Current Procedural Terminology* (CPT®) code for an advanced diagnostic imaging service that is furnished in an applicable setting and paid for under an applicable payment system.

Background

The Protecting Access to Medicare Act (PAMA) of 2014, Section 218(b), established a new program to increase the rate of appropriate advanced diagnostic imaging services provided to Medicare beneficiaries. Examples of such advanced imaging services include computerized tomography, positron emission tomography, nuclear medicine, and magnetic resonance imaging. Under this program, at the time a practitioner orders an advanced imaging service for a Medicare beneficiary, he/she will be required to consult a qualified Clinical Decision Support Mechanism (CDSM). CDSMs are the electronic portals through which practitioners access appropriate use criteria (AUC) during the patient workup. The CDSM will provide the ordering professional with a determination of whether the order adheres, or does not adhere, to AUC, or if there is no AUC applicable. A list of qualified CDSMs is available at *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Appropriate-Use-Criteria-Program/index.html*.

A consultation must take place for an applicable imaging service ordered by an ordering professional that would be furnished in an applicable setting and paid under an applicable payment system. Please note that the applicable setting is where the imaging service is furnished, not the setting where the imaging service is ordered.

Applicable settings include physician offices, hospital outpatient departments (including emergency departments), ambulatory surgical centers, and any other provider-led outpatient setting determined appropriate by the Secretary of Health and Human Services (at this time, no other settings have been identified). Applicable payment systems include the physician fee schedule (PFS), the hospital outpatient prospective payment system (OPPS), and the ambulatory surgical center payment system.

When this program is more fully implemented (expected January 1, 2020), consultation with a qualified CDSM will be required and detailed information regarding the ordering professional's consultation must be appended to the furnishing professional's claim. This includes the ordering practitioner's national provider identifier (NPI) and documenting which CDSM was consulted (there are multiple qualified CDSMs available). The Centers for Medicare and Medical Services (CMS) does not have guidance at this time regarding what the claim-based reporting requirements will be in 2020. In addition, this program will include exceptions to consulting CDSMs that include:

1. The ordering professional having a significant hardship,
2. Situations in which the patient has an emergency medical condition, or,
3. An applicable imaging service ordered for an inpatient, and for which payment is made under Part A.

Ultimately, this program will result in identified outlier ordering professionals being subject to prior authorization.

Regulatory language for this program is in *42 Code of Federal Regulation* 414.94 titled *Appropriate Use Criteria for Advanced Diagnostic Imaging Services*. In the calendar year 2018 PFS final rule, CMS stated that the program would begin with a voluntary participation period. During this period, ordering professionals may choose to consult qualified CDSMs; and furnishing professionals may choose to report limited consultation information on their Medicare claims.

Effective July 1, 2018, HCPCS modifier QQ (ordering professional consulted a qualified clinical decision support mechanism for this service and the related data was provided to the furnishing professional) is available for this reporting. The modifier may be:

- Used when the furnishing professional is aware of the result of the ordering professional's consultation with a CDSM for that patient,
- Reported on the same claim line as the CPT® code for an advanced diagnostic imaging service furnished in an applicable setting and paid for under an applicable payment system, and,
- Reported on both the facility and professional claim.

You should be aware that, effective for claims with dates of service on or after July 1, 2018, your MACs will accept the new QQ modifier on the same claim line as any CPT® codes that fall within the ranges shown below.

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QQ

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Please note that the QQ modifier may also appear on the same claim line as a CPT® code that falls outside the range; and, until further notice, MACs will continue to pay claims for services within, or outside, the CPT® code range shown below regardless of the presence of the QQ modifier.

Magnetic resonance imaging

70336, 70540, 70542, 70543, 70544, 70545, 70546, 70547, 70548, 70549, 70551, 70552, 70553, 70554, 70555, 71550, 71551, 71552, 71555, 72141, 72142, 72146, 72147, 72148, 72149, 72156, 72157, 72158, 72159, 72195, 72196, 72197, 72198, 73218, 73219, 73220, 73221, 73222, 73223, 73225, 73718, 73719, 73720, 73721, 73722, 73723, 73725, 74181, 74182, 74183, 74185, 75557, 75559, 75561, 75563, 75565, 76498

Computerized tomography

70450, 70460, 70470, 70480, 70481, 70482, 70486, 70487, 70488, 70490, 70491, 70492, 70496, 70498, 71250, 71260, 71270, 71275, 72125, 72126, 72127, 72128, 72129, 72130, 72131, 72132, 72133, 72191, 72192, 72193, 72194, 73200, 73201, 73202, 73206, 73700, 73701, 73702, 73706, 74150, 74160, 74170, 74174, 74175, 74176, 74177, 74178, 74261, 74262, 74712, 74713, 75571, 75572, 75573, 75574, 75635, 76380, 76497,

Single-photon emission computed tomography

76390

Nuclear medicine

78012, 78013, 78014, 78015, 78016, 78018, 78020, 78070, 78071, 78072, 78075, 78099, 78102, 78103, 78104, 78110, 78111, 78120, 78121, 78122, 78130, 78135, 78140, 78185, 78191, 78195, 78199, 78201, 78202, 78205, 78206, 78215, 78216, 78226, 78227, 78230, 78231, 78232, 78258, 78261, 78262, 78264, 78265, 78266, 78267, 78268, 78270, 78271, 78272, 78278, 78282, 78290, 78291, 78299, 78300, 78305, 78306, 78315, 78320, 78350, 78351, 78399, 78414, 78428, 78445, 78451, 78452, 78453, 78454, 78456, 78457, 78458, 78459, 78466, 78468, 78469, 78472, 78473, 78481, 78483, 78491, 78492, 78494, 78496, 78499, 78579, 78580, 78582, 78597, 78598, 78599, 78600, 78601, 78605, 78606, 78607, 78608, 78609, 78610, 78630, 78635, 78645, 78647, 78650, 78660,

78699, 78700, 78701, 78707, 78708, 78709, 78710, 78725, 78730, 78740, 78761, 78799, 78800, 78801, 78802, 78803, 78804, 78805, 78806, 78807, 78811, 78812, 78813, 78814, 78816, 78999

Additional information

The official instruction, CR 10481, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R2040OTN.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
March 2, 2018	Initial article released.

MLN Matters® Number: MM10481
Related CR Release Date: March 2, 2018
Related CR Transmittal Number: R2040OTN
Related Change Request (CR) Number: 10481
Effective Date: July 1, 2018
Implementation Date: July 2, 2018

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Therapy Services

Supervised exercise therapy for symptomatic peripheral artery disease

***Note**: The article was revised March 5, 2018, to reflect a revised change request (CR). The MAC implementation date, CR release date, transmittal numbers and the web addresses of the transmittals were revised. All other information remains the same. Editorial errors have also been corrected in the "Document history" and CR details at the end of the article. This information was previously published in the February 2018 Medicare B Connection, pages 15-17.*

Provider type affected

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

Provider action needed

Change request (CR) 10295 informs MACs that effective May 25, 2017, the Centers for Medicare & Medicaid Services (CMS) issued a national coverage determination (NCD) to cover supervised exercise therapy (SET) for beneficiaries with intermittent claudication (IC) for the treatment of symptomatic peripheral artery disease (PAD). Make sure your billing staffs are aware of these changes.

Background

SET involves the use of intermittent walking exercise, which alternates periods of walking to moderate-to-maximum claudication, with rest. SET has been recommended as the initial treatment for patients suffering from IC, the most common symptom experienced by people with PAD.

Despite years of high-quality research illustrating the effectiveness of SET, more invasive treatment options (such as, endovascular revascularization) have continued to increase. This has been partly attributed to patients having limited access to SET programs. There is currently no NCD in effect.

CMS issued the NCD to cover SET for beneficiaries with IC for the treatment of symptomatic PAD. Up to 36 sessions over a 12-week period are covered if all of the following components of a SET program are met:

The SET program must:

- Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication
- Be conducted in a hospital outpatient setting, or a physician's office
- Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD
- Be under the direct supervision of a physician (as defined in Section 1861(r)(1)) of the Social Security Act (the Act), physician assistant, or nurse practitioner/ clinical nurse specialist (as identified in Section 1861(aa)(5) of the Act)) who must be trained in both basic and advanced life support techniques.

Beneficiaries must have a face-to-face visit with the physician responsible for PAD treatment to obtain the referral for SET. At this visit, the beneficiary must receive information regarding cardiovascular disease and PAD risk factor reduction, which could include education, counseling, behavioral interventions, and outcome assessments.

MACs have the discretion to cover SET beyond 36 sessions over 12 weeks and may cover an additional 36

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MPFSDB

from page 12

or to retroactively pay claims. However, MACs will adjust claims that you bring to their attention.

Additional information

The official instruction, CR 10488, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R3976CP.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
February 16, 2018	Initial article released.

MLN Matters® Number: MM10488
Related Change Request (CR) Number: 10488
Related CR Release Date: February 16, 2018
Effective Date: January 1, 2018
Related CR Transmittal Number: R3976CP
Implementation Date: April 2, 2018

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PAD

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sessions over an extended period of time. MACs shall accept the inclusion of the KX modifier on the claim line(s) as an attestation by the provider of the services that documentation is on file verifying that further treatment beyond the 36 sessions of SET over a 12-week period meets the requirements of the medical policy. SET is non-covered for beneficiaries with absolute contraindications to exercise as determined by their primary attending physician.

Coding requirements for SET

Providers should use *Current Procedural Terminology* (CPT®) 93668 (under peripheral arterial disease rehabilitation) to bill for these services with appropriate International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10) code as follows:

- I70.211 – right leg
- I70.212 – left leg
- I70.213 – bilateral legs
- I70.218 – other extremity
- I70.311 – right leg
- I70.312 – left leg
- I70.313 – bilateral legs
- I70.318 – other extremity
- I70.611 – right leg
- I70.612 – left leg
- I70.613 – bilateral legs
- I70.618 – other extremity
- I70.711 – right leg
- I70.712 – left leg
- I70.713 – bilateral legs
- I70.718 – other extremity

Medicare will deny claim line items for SET services when they do not contain one of the above ICD-10 codes using the following messages:

- Claim adjustment reason code (CARC) 167 – This (these) diagnosis (es) is (are) not covered. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- Remittance advice remark code (RARC) N386: This decision was based on a National Coverage Determination 20.35 (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *https://www.cms.gov/mcd/search.asp*. If you do not have web access, you may contact the contractor to request a copy of the NCD.
- Group code CO (contractual obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

MACs will accept claims for CPT® 93668 only when services are provided in Place of Service (POS) code 11, 19, or 22. MACs will deny claims for SET if services are not provided in POS 11, 19, or 22, using the following remittance messages:

- CARC 58: Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. **Note**: Refer to the 832 Healthcare Policy Identification Segment (loop 2110 Service payment Information REF), if present.
- RARC N386: This decision was based on a National Coverage Determination 20.35 (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *https://www.cms.gov/mcd/search.asp*. If you do not have web access, you may contact the contractor to request a copy of the NCD.
- Group code CO (contractual obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

Institutional claims for SET must be submitted on type of bills (TOB) 13x or 85x. MACs will deny line items on institutional claims that are not submitted on TOB 13x or 85x using the following messages:

- CARC 58: “Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. **Note**: Refer to the 832 Healthcare Policy Identification Segment (loop 2110 Service payment Information REF), if present.
- RARC N386: “This decision was based on a National Coverage Determination 20.35 (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *https://www.cms.gov/mcd/search.asp*. If you do not have web access, you may contact the contractor to request a copy of the NCD.
- Group code CO (contractual obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

Medicare will pay claims for SET services containing CPT® code 93668 on types of bill (TOBs) 13x under OPPS and 85x on reasonable cost, except it will pay claims for SET services containing CPT® 93668 with revenue codes 096x, 097x, or 098x when billed on TOB 85x method II critical access hospitals (CAHs) based on 115 permission of the lesser of the fee schedule amount or the submitted charge.

Medicare will reject claims with CPT® 93668 which exceed 36 sessions within 84 days from the date of the first session when the KX modifier is not included on the claim line OR any SET session provided after 84 days from the date of the first session and the KX modifier is not included on the claim and use the following messages:

- CARC 96: Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is not an

See **PAD**, page 17

PAD

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ALERT.) **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

- RARC N640: Exceeds number/frequency approved/ allowed within time period.
- 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.
- Group code PR (patient responsibility) assigning financial liability to the beneficiary if a claim is received with a GA modifier indicating a signed ABN is on file.

MACs will deny/reject claim lines for SET exceeding 73 sessions using the following codes:

- CARC 119: Benefit maximum for this time period or occurrence has been reached.
- RARC N386: "This decision was based on a National Coverage Determination 20.35 (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *https://www.cms.gov/mcd/search.asp*. If you do not have web access, you may contact the contractor to request a copy of the NCD.
- Group code CO (contractual obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.
- Group code PR (patient responsibility) assigning financial liability to the beneficiary if a claim is received with a GA modifier indicating a signed ABN is on file.

Medicare's common working file (CWF) will display remaining SET sessions on all CWF provider query screens (HIQA, HIQH, ELGH, ELGA, and HUQA). The multi-carrier system desktop tool will also display remaining SET sessions in a format equivalent to the CWF HIMR screen(s).

Additional information

The official instruction, CR 10295, was issued to your MAC via two transmittals. The first updates the *Medicare Claims Processing Manual* and it is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R3992CP.pdf*. The second updates the *NCD Manual* and it is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R205NCD.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
March 5, 2018	The article was revised to reflect a revised CR. The MAC implementation date, CR release date, transmittal numbers and the Web addresses of the transmittals were revised. All other information remains the same.
February 6, 2018	Initial article released.

MLN Matters® Number: MM10295
Related CR Release Date: March 2, 2018
Related CR Transmittal Number: R205NCD and R3992CP
Related Change Request (CR) Number: 10295
Effective Date: May 25, 2017
Implementation Date: April 2, 2018 – MAC edits; July 2, 2018 – full implementation

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General Coverage

ICD-10 and other coding revisions to national coverage determinations

Note: Editorial corrections made May 23, 2018, to correct link to transmittal number.

Provider type affected

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

Provider action needed

Change request (CR) 10473 constitutes a maintenance update of the International Classification of Diseases, Tenth Revision (ICD-10) conversions and other coding updates specific to national coverage determinations (NCDs). These NCD coding changes are the result of newly available codes, coding revisions to NCDs released separately, or coding feedback received. Please follow the link below for the NCD spreadsheets included with this CR:

https://www.cms.gov/Medicare/Coverage/DeterminationProcess/downloads/CR10473.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 10473 makes coding and clarifying adjustments to the following NCDs:

1. NCD20.5 Extracorporeal Immunoadsorption (ECI) Using Protein A Columns
2. NCD110.18 Aprepitant
3. NCD110.21 Erythropoiesis Stimulating Agents (ESAs)
4. NCD150.3 Bone Mineral Density Studies
5. NCD190.1 Histocompatibility Testing
6. NCD190.11 PT/INR
7. NCD210.3 Colorectal Cancer Screening
8. NCD210.4.1 Counseling to Prevent Tobacco Use
9. NCD210.6 Hepatitis B Virus Screening
10. NCD220.4 Mammograms
11. NCD220.6.17 PET for Solid Tumors
12. NCD250.4 Actinic Keratosis (AKs)

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 10473, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R2039OTN.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/*.

See **ICD-10**, page 19

Manual updates to Pub. 100-01, 100-02 and 100-04 to correct errors and omissions

Provider type affected

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

Provider action needed

Stop – impact to you

This article is based on change request (CR) 10512 which informs MACs about an update to the Medicare manuals to correct various minor technical errors and omissions. Those changes are intended only to clarify the existing content and no policy, processing, or system changes are anticipated.

Go – what you need to do

Make sure that your billing staff is aware of these changes. See the *Background* and *Additional information* sections of this article for further details regarding these changes.

Background

CR 10512 updates the Medicare manuals with regard to SNF policy to clarify the existing content. These changes are being made to correct various omissions and minor technical errors. No policy, processing or system changes are anticipated.

Medicare General Information, Eligibility and Entitlement Manual,

Chapter 4: Physician Certification and Recertification of Services

Pub 100-01, Chapter 4, §40.1

This section is revised by adding an appropriate cross-reference.

Pub 100-01, Chapter 4, §40.2

This section is revised by clarifying the discussion of the initial certification's required content, and by adding an appropriate cross-reference.

Chapter 5: Medicare General Information, Eligibility, and Entitlement

Pub 100-01, Chapter 5, §30.2

This section is revised by updating the existing citation to the regulations at 42 CFR 483.75(n), in order to reflect their redesignation at 42 CFR 483.70(j) in the long-term care facility requirements reform final rule (81 FR 68831, October 4, 2016).

Pub 100-01, Chapter 5, §30.3

This section is revised by updating the existing citation to the regulations at 42 CFR 482.66, in order to reflect their redesignation at 42 CFR 482.58 in a final rule that was published May 12, 2014 (79 FR 27155), and by adding an appropriate cross-reference.

Medicare Benefit Policy Manual

Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance

Pub 100-02, Chapter 8, §20.2.3

This section is revised by modifying the language that describes the starting point of the applicable 30-day period, so that it more accurately tracks that of the corresponding statutory authority in §1861(i) of the Social Security Act and the implementing regulations at 42 CFR 409.36.

Pub 100-02, Chapter 8, §30.1

This section is revised by modifying the language so that it no longer pertains to only one particular type of case-mix model, and by adding a reference to the posting of the CMS-designated case-mix classifiers on the SNF PPS website. These changes reflect similar revisions made in the corresponding regulations at 42 CFR 409.30 and 413.345 by the FY 2018 SNF PPS final rule (82 FR 35644-45, August 4, 2017).

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ICD-10

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Document history

Date of change	Description
March 1, 2018	This article was revised to reflect an updated CR. That CR corrected instructions in business requirement 7 (NCD210.3), including the spreadsheet for MACs. The CR release date, transmittal number and link to the transmittal also changed.
February 21, 2018	Initial article released.

MLN Matters® Number: MM10473
Related Change Request (CR) Number: 10473
Related CR Release Date: February 28, 2018
Effective Date: July 1, 2018
Related CR Transmittal Number: R2039OTN
Implementation Date: April 2, 2018, for local MAC edits; July 2, 2018, for shared system edits

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Pub 100-02, Chapter 8, §40.1

This section is revised by updating the existing citation to the regulations at 42 CFR 483.40(e), in order to reflect their redesignation at 42 CFR 483.30(e) in the long-term care facility requirements reform final rule (81 FR 68829, October 4, 2016).

Pub 100-02, Chapter 8, §50.3

This section is revised to correct some cross-references, and to clarify the language describing the nonparticipating portion of the same institution that also includes a participating distinct part.

Pub 100-02, Chapter 8, §50.8.2

This section is revised to correct a cross-reference.

Pub 100-02, Chapter 8, §70.4

The first paragraph of this section is revised to clarify the scope of services for which SNFs can make arrangements with outside sources, and also by adding an appropriate cross-reference.

Medicare Claims Processing Manual

Chapter 1 - General Billing Requirements

Pub 100-04, Chapter 1, §30.1.1.1

This section is revised by updating the existing citation to the regulations at 42 CFR 483.10(b)(5)-(6), in order to reflect their revision and redesignation at 42 CFR 483.10(g)(17)-(18) in the long-term care facility requirements reform final rule (81 FR 68825, 68854, October 4, 2016).

Chapter 6 - SNF Inpatient Part A Billing and SNF Consolidated Billing

Pub 100-04, Chapter 6, §10.1

This section is revised to expand and clarify the discussion of a beneficiary's status as a SNF "resident" for consolidated billing purposes to conform more closely with the corresponding regulations at 42 CFR 411.15(p)(3), as well as by adding some appropriate cross-references, and by updating the existing citation to the regulations at 42 CFR 483.12(a)(2)(i)-(vi), in order to reflect their redesignation at 42 CFR 483.15(c)(1)(i)(A)-(F) in the long-term care facility requirements reform final rule (81 FR 68826, October 4, 2016).

Pub 100-04, Chapter 6, §10.4

This section is revised by updating the existing citation to the regulations at 42 CFR 483.75(h), in order to reflect their redesignation at 42 CFR 483.70(g) in the long-term care facility requirements reform final rule (81 FR 68830, October 4, 2016).

Pub 100-04, Chapter 6, §20.1.2

This section is revised to restore a minor edit that was agreed to during the internal review of CR 9748 but was then inadvertently omitted from the published version.

Pub 100-04, Chapter 6, §20.2.1

The final paragraph of this section is revised to reflect the statutory addition of acute dialysis to the scope of the Part B dialysis benefit and, by extension, to the scope of the dialysis exclusion from SNF consolidated billing as well.

Pub 100-04, Chapter 6, §20.3

This section is revised to clarify the language in a parenthetical phrase.

Pub 100-04, Chapter 6, §20.3.1

This section is revised to clarify that the exclusion of dialysis-related ambulance transports from SNF consolidated billing applies to the entire ambulance roundtrip from the SNF, and to clarify the discussion of a beneficiary's status as a SNF "resident" for consolidated billing purposes. In addition, the existing citation to the regulations at 42 CFR 483.10(b)(6) is updated in order to reflect their revision and redesignation at 42 CFR 483.10(g)(18) in the long-term care facility requirements reform final rule (81 FR 68825, 68854, October 4, 2016).

Pub 100-04, Chapter 6, §40.3.3

This section is revised to clarify the language on counting inpatient days.

Pub 100-04, Chapter 6, §40.3.4

This section is revised to clarify the language on counting inpatient days and the discussion of a beneficiary's status as a SNF "resident" for consolidated billing purposes.

Pub 100-04, Chapter 6, §40.3.5

This section is revised to clarify the language on counting inpatient days and the language that describes the nonparticipating portion of the same institution that also includes a participating distinct part.

Pub 100-04, Chapter 6, §40.3.5.2

This section is revised to clarify the language that describes the nonparticipating portion of the same institution that also includes a participating distinct part.

Chapter 20 - Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

Pub 100-04, Chapter 20, §10.2

In column A ("Conditions"), a cross-reference in item 2 is corrected, and in column B ("Review Action"), the

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next-to-last paragraph in item 2 is revised to clarify the language describing the nonparticipating portion of the same institution that also includes a participating distinct part.

Chapter 30 - Financial Liability Protections

Pub 100-04, Chapter 30, §130.3

Paragraphs A and B of this section are revised to clarify the language describing the nonparticipating portion of the same institution that also includes a participating distinct part.

Pub 100-04, Chapter 30, §130.4

Paragraph A of this section is revised to clarify the language describing the nonparticipating portion of the same institution that also includes a participating distinct part.

Additional information

The official instruction, CR 10512, issued to your MAC regarding this change consists of the following three transmittals:

- Transmittal R114GI updates the *Medicare General Information, Eligibility, and Entitlement Manual* at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R114GI.pdf.
- Transmittal R242BP updates the *Medicare Benefit Policy Manual* at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R242BP.pdf.
- Transmittal R4001CP updates the *Medicare Claims Processing Manual* at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4001CP.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
March 16, 2018	Initial article released.

MLN Matters® Number: MM10512
Related CR Release Date: March 16, 2018
Related CR Transmittal Number: R114GI, R242BP, and R4001CP
Related Change Request (CR) Number: 10512
Effective Date: June 19, 2018
Implementation Date: June 19, 2018

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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.

Modifications to the implementation of the paperwork segment of the esMD system

Provider type affected

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

Provider action needed

Change request (CR) 10397 updates the business requirements to enable MACs to receive unsolicited documentation (also known as paperwork (PWK)) via the electronic submission of medical documentation (esMD) system. CR 10397 is for esMD purposes only. Please make sure your billing staffs are aware of these updates.

Background

CR 10397 also contains attachments that include cover sheets that must be used for electronic, fax, or mail submissions of documentation. There are three cover sheets, one each for Part A and Part B providers, as well as one for durable medical equipment (DME) suppliers. In addition, there are two companion guides attached to CR 10397, one for institutional claims and one for professional claims. A link to CR 10397 is available in the *Additional information* section of this article.

With CR 10397, MACs will modify PWK, also known as unsolicited documentation procedures to include electronic submission(s) via esMD. Also, Medicare systems will accept PWK 02 values "EL" and "FT" for those MACs in a CMS-approved esMD system. This mechanism will suppress initial auto letter generation, if applicable, when PWK 02 is "EL" or "FT," and is present at any level of the claim or line.

Providers will receive communication from MACs via companion documents for 5010 X12 837 to include:

- The value "EL" (electronic) in PWK 02 to represent an esMD submission for sending the documentation using X12 Standards (6020 X12 275)
- The value "FT" (file transfer) in PWK 02 to represent an esMD submission for sending the documentation in PDF format using XDR specifications.

MACs will allow seven calendar "waiting days" (from the date of receipt) for additional information to be submitted when the PWK 02 value is "EL" or "FT."

MACs will use RC client to reject the PWK data submissions as administrative error(s) when the received cover sheet (via esMD) is incomplete or incorrectly filled out as applicable to current edits. Providers can expect to see new generic reason statements introduced to convey these errors as follows (Codes for these statements will be finalized and sent along with the RC implementation guide):

- The date(s) of service on the cover sheet received is missing or invalid.
- The NPI on the cover sheet received is missing or invalid.
- The state where services were provided is missing or invalid on the cover sheet received.
- The Medicare ID on the cover sheet received is missing or invalid.
- The billed amount on the cover sheet received is missing or invalid.
- The contact phone number on the cover sheet received is missing or invalid.
- The beneficiary name on the cover sheet received is missing or invalid.
- The claim number on the cover sheet received is missing or invalid.
- The attachment control number (CAN) on the cover sheet is missing or invalid.

Once again, examples of the cover sheet are included as an attachment to CR 10397.

Additional information

The official instruction, CR 10397, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R2031OTN.pdf*.

The X12 837 companion guides are available at *https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/CompanionGuides.html*.

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
February 16, 2018	Initial article released.

MLN Matters® Number: MM10397
Related CR Release Date: February 16, 2018
Related CR Transmittal Number: R2031OTN
Related Change Request (CR) Number: 10397
Effective Date: July 1, 2018
Implementation Date: July 2, 2018

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April 2018 update to the healthcare provider taxonomy codes

Provider type affected

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

What you need to know

Change request (CR) 10402 directs MACs to obtain the most recent healthcare provider taxonomy codes (HPTCs) code set and use it to update their internal HPTC tables and/or reference files. Make sure your billing staffs are aware of these changes.

Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that covered entities comply with the requirements in the electronic transaction format implementation guides adopted as national standards. The institutional and professional claim electronic standard implementation guides (X12 837-I and 837-P) each require use of valid codes contained in the HPTC set when there is a need to report provider type or physician, practitioner, or supplier specialty for a claim.

You should note that:

1. Valid HPTCs are those codes approved by the National Uniform Claim Committee (NUCC) for current use.
2. Terminated codes are not approved for use after a specific date.
3. Newly approved codes are not approved for use prior to the effective date of the code set update in which each new code first appears.
4. Specialty and/or provider type codes issued by any entity other than the NUCC are not valid.
5. Medicare would be guilty of non-compliance with HIPAA if MACs accepted claims that contain invalid HPTCs.

The HPTC set is maintained by the National Uniform Claim Committee (NUCC) for standardized classification of health care providers. The NUCC updates the code set twice a year with changes effective April 1 and October 1. The HPTC list is available for view or for download from the NUCC website at *http://www.nucc.org/index.php/code-sets-mainmenu-41/provider-taxonomy-mainmenu-40*.

Although the NUCC generally posts their updates on the WPC web page three months prior to the effective date, changes are not effective until April 1 or October 1, as indicated in each update. The changes to the code set include the addition of a new code and addition of definitions to existing codes. When reviewing the HCPT code set online, revisions made since the last release are identifiable by these color codes:

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

Additional information

The official instruction, MM10402, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R3977CP.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
February 16, 2018	Initial article released.

MLN Matters® Number: MM10402
Related Change Request (CR) Number: 10402
Related CR Release Date: February 16, 2018
Effective Date: July 1, 2018
Related CR Transmittal Number: R3977CP
Implementation Date: July 2, 2018

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

Provider type affected

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

What you need to know

Change request (CR) 10489 updates the remittance advice remark codes (RARC) and claims adjustment reason code (CARC) lists and instructs Medicare shared system maintainers (SSMs) to update Medicare Remit Easy Print (MREP) and PC Print. Be sure your staff are aware of these changes and obtain the updated MREP and PC Print software if they use that software.

Background

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

The Centers for Medicare & Medicaid Services (CMS) instructs MACs to conduct updates based on the code update schedule that results in publication three times per year – around March 1, July 1, and November 1. This recurring update notification applies to Chapter 22, Sections 40.5, 60.1, and 60.2 of the *Medicare Claims Processing Manual*."

The shared system maintainers (SSMs) have the responsibility to implement code deactivation, making sure that any deactivated code is not used in original business messages and allowing the deactivated code in derivative messages. SSMs must make sure that Medicare does not report any deactivated code on or after the effective date for deactivation as posted on the Washington Publishing Company (WPC) website. If any new or modified code has an effective date past the implementation date specified in CR 10489, MACs must implement on the date specified on the WPC website, available at: *https://wpc-edi.com/Reference/*.

A discrepancy between the dates may arise as the WPC website is only updated three times per year and may not match the CMS release schedule. For this recurring CR, the MACs and the SSMs must get the complete list for both CARC and RARC from the WPC website to obtain the comprehensive lists for both code sets and determine the changes that are included on the code list since the last code update, CR 10270 (see *MLN Matters*® article *MM10270*).

Additional information

The official instruction, CR 10489, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R3980CP.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
February 16, 2018	Initial article released.

MLN Matters® Number: MM10489
Related Change Request (CR) Number: 10489
Related CR Release Date: February 16, 2018
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Related CR Transmittal Number: R3980CP
Implementation Date: July 2, 2018

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MSI reminder announcement: There is still time to evaluate our services

There is still time to share your experiences about the services we provide. Please complete the MAC Satisfaction Indicator (MSI) survey. These survey results will help us find ways to better serve you. *https://cfigroup.qualtrics.com/jfe/form/SV_0iaaiJ6oOWShLIF?MAC_BRNC=9&MAC=JN–First_Coast*

Form CMS-855O Processing Guide

***Note**: Editorial correction made May 23, 2018, to correct the Related Change Request Number.*

Provider type affected

This *MLN Matters*® article is intended for eligible ordering, certifying physicians, and other eligible professionals who order or certify items or services for Medicare beneficiaries.

Provider action needed

Change request (CR) 10355 adds, to the *Medicare Program Integrity Manual*, a supplementary guide that educates physicians and other eligible professionals on the preparation and submission of the Centers for Medicare & Medicaid Services form (CMS)-855O. The CR does not involve any legislative or regulatory policies

Background

Most physicians and eligible professionals (as defined in section 1848(K)(3)(B) of the Social Security Act) enroll in the Medicare program to be reimbursed for the covered services they furnish to Medicare beneficiaries. However, with the implementation of Section 6405 of the Affordable Care Act, the Centers for Medicare & Medicaid Services (CMS) requires certain physicians and eligible professionals to enroll in the Medicare program not for reimbursement for furnishing services, but rather for the sole purpose of ordering, or certifying, items or services for Medicare beneficiaries.

The providers who may enroll in Medicare solely for the purpose of ordering and certifying include those who are:

- Doctors of medicine or osteopathy
- Doctors of dental medicine
- Doctors of dental surgery
- Doctors of podiatric medicine
- Doctors of optometry
- Physician assistants
- Certified clinical nurse specialists
- Nurse practitioners
- Clinical psychologists
- Certified nurse midwifes
- Clinical social workers
- Licensed residents (as defined in 42 C.F.R. section 413.75(b)) in an approved medical residency program
- Retired physicians who are licensed

These providers can enroll for the sole purpose of ordering or certifying items or services for Medicare beneficiaries by completing the Form CMS-855O via paper or the Internet-based Provider Enrollment, Chain and Ownership System (PECOS) process. To obtain additional information on Internet-based PECOS, refer to *https://www.cms.gov/Medicare/Provider- Enrollment-and-Certification/MedicareProviderSupEnroll/InternetbasedPECOS.html*.

CR10355 adds a new supplemental guide to the *Medicare Program Integrity Manual* titled: *Processing the CMS-855O Medicare Enrollment Application – Enrollment for Eligible Ordering, Certifying Physicians, and Other Eligible Professionals*. This supplementary guide has been developed to educate providers and suppliers on the preparation and submission of the form CMS-855O.

Additional information

The official instruction, CR 10355, issued to your MAC regarding this change, is available at *https://www.cms.gov/Regulations-and- Guidance/Guidance/Transmittals/2018Downloads/R773PI.pdf*. You will find the Form CMS- 855O Processing Guide as an attachment to this CR.

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
February 23, 2018	Initial article released.

MLN Matters® Number: MM10355
Related CR Release Date: February 23, 2018
Related CR Transmittal Number: R773PI
Related Change Request (CR) Number: 10355
Effective Date: March 23, 2018
Implementation Date: March 23, 2018

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ADJUSTMENTS

from page 1

Under CR 10494, MACs will initiate non-monetary mass adjustments for claims impacted by CR 9911 QMB RA changes, which include claims that were paid after October 2, 2017 and up to December 31, 2017, and that have not been voided or replaced. MACs will issue replacement RAs without the CR 9911 changes and re-process QMB cost-sharing claims by secondary payers by December 20, 2018, for Part B/MAC claims and by September 20, 2018, for Part A/MAC and durable medical equipment MAC claims.

Providers may use the new RAs to resubmit state Medicaid QMB cost-sharing claims that states initially failed to pay due to CR 9911 QMB RA changes. To avoid duplicate claims, providers should not resubmit claims that secondary payers successfully processed through direct claim submission or the COBA process.

Note that although mass-adjusted claims may not cross over, this solution targets affected providers who attempted to bill supplemental payers directly using CR 9911 QMB RAs because their QMB cost-sharing claims either did not cross over or crossed over to supplemental payers but failed to process. The goal is to produce replacement Medicare RAs that providers can submit to supplemental payers to coordinate benefits as necessary.

Make sure your billing staff is aware of these changes.

Additional information

The official instruction, CR 10494, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R2042OTN.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
March 22, 2018	Initial article released.

MLN Matters® Number: MM10494
Related CR Release Date: March 16, 2018
Related CR Transmittal Number: R2042OTN
Related Change Request (CR) Number: 10494
Effective Date: December 20, 2018, for Part B MAC claims and September 20, 2018, for Part A and DME MAC claims
Implementation Date: December 20, 2018, for Part B MAC claims and September 20, 2018, for Part A and DME MAC claims

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Quarterly provider update

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

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

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

Reinstating the QMB indicator in the Medicare fee-for-service claim processing system from CR 9911

Note**: A correction was made to the "Provider type affected" section to include DME MACs and the "Background" section to include pharmacies. This information was previously published in the February 2018 Medicare B Connection, pages 24-25.* ***Note: Editorial corrections made May 23, 2018, to the "Provider type affected" section to include DME MACs and the "Background" section to include pharmacies.

Provider type affected

This *MLN Matters®* article is intended for providers and suppliers who submit claims to Part A/B and durable medical equipment (DME) Medicare administrative contractors (MACs).

What you need to know

Effective with CR 10433, the Centers for Medicare & Medicaid Services (CMS) will reintroduce qualified Medicare beneficiary (QMB) information in the Medicare remittance advice (RA) and Medicare summary notice (MSN). CR 9911 modified the fee-for-service (FFS) systems to indicate the QMB status and zero cost-sharing liability of beneficiaries on RAs and MSNs for claims processed on or after October 2, 2017. On December 8, 2018, CMS suspended CR 9911 to address unforeseen issues preventing the processing of QMB cost-sharing claims by states and other secondary payers outside of the coordination of benefits agreement (COBA) process. CR 10433 remediates these issues by including revised "alert" remittance advice remark codes (RARC) in RAs for QMB claims without adopting other RA changes that impeded claim processing by secondary payers. CR 10433 reinstates all changes to the MSNs under CR 9911. Please make sure your billing staff is aware of these changes.

Background

Federal law bars Medicare providers and suppliers, including pharmacies, from billing an individual enrolled in the QMB program for Medicare Part A and Part B cost-sharing under any circumstances. (See Sections 1902(n)(3)(B), 1902(n)(3)(C), 1905(p)(3), 1866(a)(1)(A), and 1848(g)(3)(A) of the Social Security Act.) The QMB program is a State Medicaid benefit that assists low-income Medicare beneficiaries with Medicare Part A and Part B premiums and cost-sharing, including deductibles, coinsurance, and copays. In 2016, 7.5 million individuals (more than one out of eight beneficiaries) were enrolled in the QMB program.

Providers and suppliers, including pharmacies, may bill state Medicaid agencies for Medicare cost-sharing amounts. However, as permitted by Federal law, states may limit Medicare cost-sharing payments, under certain circumstances. Be aware, persons enrolled in the QMB program have no legal liability to pay Medicare providers for Medicare Part A or Part B cost-sharing.

System changes to assist providers under CR 9911

To help providers more readily identify the QMB status of their patients, CR 9911 introduced a QMB indicator in the claim processing system for the first time. CR 9911 is part of the CMS ongoing effort to give providers tools to comply with the statutory prohibition on collecting Medicare A/B cost-sharing from QMBs.

Through CR 9911, CMS indicated the QMB status and zero cost-sharing liability of beneficiaries in the RA and MSN for claims processed on or after October 2, 2017. In particular, CR 9911 changed the MSN to include new messages for QMB beneficiaries and reflect $0 cost-sharing liability for the period they are enrolled in QMB. In addition, CMS modified the RA to include new alert RARCs to notify providers to refrain from collecting Medicare cost-sharing because the patient is a QMB (N781 is associated with deductible amounts and N782 is associated with coinsurance).

Additionally, CR 9911 changed the display of patient responsibility on the RA by replacing claim adjustment group code "patient responsibility" (PR) with group code "other adjustment" (OA). CMS zeroed out the deductible and coinsurance amounts associated with claim adjustment reason code (CARC) 1 (deductible) and/or 2 (coinsurance) and used CARC 209 – ("Per regulatory or other agreement, the provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to the patient if collected. (Use only with group code OA).") However, the changes to the display of patient liability in the RAs for QMB claims caused unforeseen issues affecting the processing of QMB cost-sharing claims directly submitted by providers to states and other payers secondary to Medicare. Providers rely on RAs to bill state Medicaid Agencies and other secondary payers outside the Medicare COBA claims crossover process. States and other secondary payers generally require RAs that separately display the Medicare deductible and coinsurance amounts with the claim adjustment group code "PR" and associated CARC codes and could not process claims involving the RA changes from CR 9911. Barriers to the processing of secondary claims have additional implications for institutional providers that claim bad debt under the Medicare program since they must obtain a Medicaid remittance advice to seek reimbursement for unpaid deductibles and coinsurance as a Medicare bad debt for QMBs.

To address these issues, on December 8, 2017, CMS suspended the CR 9911 system changes causing the claim processing systems to suspend the RA and MSN changes for QMB claims under CR 9911.

See **INDICATOR**, page 28

INDICATOR

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Reintroduction of QMB information in the MA and MSN under CR 10433

Effective with CR 10433, the claim processing systems will reintroduce QMB information in the RA without impeding claim processing by secondary payers.

The RA for QMB claims will retain the display of patient liability amounts needed by secondary payers to process QMB cost-sharing claims.

All Medicare's FFS systems will discontinue the practice of outputting claim adjustment group code OA with CARC 209 in place of CARCs 1 and 2, as well as CARCs 66, 247, and 248, on the ERAs and on SPRs, as applicable.

The shared systems shall include the revised alert RARCs N781 and N782 in association with CARCs 1 and/or 2 on the RA. These RARCs designate that the beneficiary is enrolled in the QMB program and may not be billed for Medicare cost sharing amounts. Additionally, for QMB claims, the Part A and B shared systems shall include the revised alert RARC N781 in association with CARC 66 (blood deductible). The revised alert RARCs are as follows:

- N781 - Alert: Patient is a Medicaid/ Qualified Medicare Beneficiary. Review your records for any wrongfully collected deductible. This amount may be billed to a subsequent payer.
- N782 – Alert: Patient is a Medicaid/ Qualified Medicare Beneficiary. Review your records for any wrongfully collected coinsurance. This amount may be billed to a subsequent payer.

CR 9911 changes to the MSN by including QMB messages and reflecting $0 cost-sharing liability for the period beneficiaries are enrolled in QMB.

Additional information

The official instruction, CR 10433, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R3993CP.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
March 13, 2018	This article was revised to reflect an updated CR. That CR added CARCs 66, 247, and 248. DME MACs were added to the *Providers affected* section and the QMB enrollment numbers were also updated under *Background* to reflect 2016 statistics. Pharmacies were also included in *Background*. The CR date, transmittal number and link to the transmittal also changed. All other information is unchanged.
February 28, 2018	This article was revised to correct a date in the *What you need to know* Section. The date should have been December 8, 2017." All other information is unchanged.
February 2, 2018	Initial article released.

MLN Matters® Number: MM10433
Related CR Release Date: March 6, 2018
Related CR Transmittal Number: R3993CP
Related Change Request (CR) Number: 10433
Effective Date: July 1, 2018
Implementation Date: For claims processed on or after July 2, 2018

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Your Feedback Matters

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

Prohibition on billing dually eligible individuals enrolled in the QMB program

Note**: This article was revised March 22, 2018, to include updated information about the remittance advice (RA) and Medicare summary notice (MSN) for all Medicare fee-for-service (FFS) QMB claims. It also includes new statistics on the number of beneficiaries enrolled in QMB. All other information remains the same. This information was last published in the December 2017 Medicare B Connection, pages 22-24.* ***Note: Editorial corrections made May 23, 2018, to correct release date of revised article and correct verbiage and links in the "Background" and "Additional information" sections.

Provider types affected

This article pertains to all Medicare providers and suppliers, including pharmacies that serve beneficiaries enrolled in original Medicare or a Medicare advantage (MA) plan.

Provider action needed

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

Implement key measures to ensure compliance with QMB billing requirements. Use HIPAA eligibility transaction system (HETS) (effective November 2017), CMS' eligibility-verification system, and the provider RA (July 2018) to identify beneficiaries' QMB status and exemption from cost-sharing prior to billing. Starting July 2018, look for QMB alerts messages in the remittance advice for FFS claims to verify QMB after claim processing. Refer to the *Background* and *Additional information* sections for further details and important steps to promote compliance.

Background

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

Billing of QMBs is prohibited by federal law

Federal law bars Medicare providers and suppliers from billing an individual enrolled in the QMB program for Medicare Part A and Part B cost-sharing under any circumstances (see Sections 1902(n)(3)(B), 1902(n)(3)(C), 1905(p)(3), 1866(a)(1)(A), and 1848(g)(3)(A) of the Social Security Act [the Act]). The QMB program is a state Medicaid benefit that assists low-income Medicare beneficiaries with Medicare Part A and Part B premiums and cost-sharing, including deductibles, coinsurance, and copays. In 2016, 7.5 million individuals (more than one out of eight beneficiaries) were enrolled in the QMB program.

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

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

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

Inappropriate billing of QMB individuals persists

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

Ways to promote compliance with QMB billing rules

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

1. Establish processes to routinely identify the QMB status of your Medicare patients prior to billing for items and services.
   - Use Medicare eligibility data provided to Medicare providers, suppliers, and their authorized billing agents (including clearinghouses and third party vendors) by CMS' HETS (effective November 2017) to verify a beneficiary's QMB status and exemption from cost-sharing charges. Ask your third party eligibility-verification vendors how their products reflect the new QMB information from HETS. For more information on HETS, visit *https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/index.html*.

See **QMB**, page 30

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- In July 2018, CMS will reintroduce QMB information in the Medicare RA that original Medicare providers and suppliers can use to identify the QMB status of beneficiaries. Refer to the *Additional information* section for educational materials on recent changes that impact RAs for Medicare FFS QMB claims.
- MA providers and suppliers should also contact the MA plan to learn the best way to identify the QMB status of plan members both before and after claims submission.

2. Providers and suppliers may also verify beneficiaries' QMB status through state online Medicaid eligibility systems in the state in which the person is a resident or by asking beneficiaries for other proof, such as their Medicaid identification card or documentation of their QMB status. Ensure that billing procedures and third-party vendors exempt individuals enrolled in the QMB program from Medicare charges and that you remedy billing problems should they occur. If you have erroneously billed individuals enrolled in the QMB program, recall the charges (including referrals to collection agencies) and refund the invalid charges they paid.
3. Determine the billing processes that apply to seeking payment for Medicare cost-sharing from the states in which the beneficiaries you serve reside. Different processes may apply to original Medicare and MA services provided to individuals enrolled in the QMB program. For original Medicare claims, nearly all states have electronic crossover processes through the Medicare Benefits Coordination & Recovery Center (BCRC) to automatically receive Medicare-adjudicated claims.
   - If a claim is automatically crossed over to another payer, such as Medicaid, it is customarily noted on the Medicare RA.

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

Important reminders concerning QMB billing requirements

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

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

Additional information

For more information on this process, refer to Section HI 00801.140 of the *Social Security Administration Program Operations Manual System*.

Refer to these educational materials for information on recent changes that impact RAs and MSNs for Medicare FFS QMB claims:

- *MLN Matters® article MM9911*, discusses the claim processing system modifications implemented October 2, 2017, to generate QMB information in the RAs and MSNs.
- On December 8, 2017, the claim processing system modifications made October 2, 2017, were temporarily suspended due to unintended issues that affected processing QMB cost-sharing claims by states and other payers secondary to Medicare. For more information, refer to *QMB remittance advice issue*.
- *MLN Matters® article 10494* describes how Medicare administrative contractors (MACs) will issue replacement RAs for QMB claims paid on or after October 2, 2017, through December 31, 2017, that have not been voided or replaced. MACs will issue replacement RAs by December 20, 2018, for Part B claims and by September 20, 2018, for Part A/durable medical equipment claims.
- *MLN Matters® article MM10433* discusses how CMS will reintroduce QMB information in the RA starting July 2018 and modify to CR 9911 to avoid disrupting claim processing by secondary payers.

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

See **QMB**, page 31

QMB

from page 30

Document history

Date of change	Description
March 22, 2018	The article was revised to indicate that CMS will reintroduce QMB information in the Medicare remittance advice (RA) and Medicare summary notice (MSN) for all claims processed on or after July 2, 2018. CMS initially included QMB information in RAs and MSNs for claims processed on or after October 2, 2017, but suspended those changes December 8, 2017, to address unforeseen issues preventing the processing of QMB cost-sharing claims by states and other secondary payers outside of the coordination of benefits agreement (COBA) process. All other information remains the same.
December 4, 2017	The article was revised to indicate that December 8, 2017, CMS will suspend modifications to the provider remittance advice and the Medicare summary notice for QMB claims made October 2, 2017. The article was also revised to show the HETS QMB release was implemented in November 2017. Finally, the article was changed to clarify that QMBs cannot elect to pay Medicare cost-sharing but may need to pay a small Medicaid copay in certain circumstances. All other information remains the same.
November 3, 2017	Article revised to show the HETS QMB release will be in November 2017. All other information remains the same.
October 18, 2017	The article was revised to indicate that the provider remittance advice and the Medicare summary notice for beneficiaries identifies the QMB status of beneficiaries and exemption from cost-sharing for Part A and B claims processed on or after October 2, 2017, and to recommend how providers can use these and other upcoming system changes to promote compliance with QMB billing requirements. All other information remains the same.
August 23, 2017	The article was revised to highlight upcoming system changes that identify the QMB status of beneficiaries and exemption from Medicare cost-sharing, recommend key ways to promote compliance with QMB billing rules, and remind certain types of providers that they may seek reimbursement for unpaid deductible and coinsurance amounts as a Medicare bad debt.
May 12, 2017	This article was revised May 12, 2017, to modify language pertaining to billing beneficiaries enrolled in the QMB program. All other information is the same.
January 12, 2017	This article was revised to add a reference to *MLN Matters*® article *MM9817*, which instructs Medicare administrative contractors to issue a compliance letter instructing named providers to refund any erroneous charges and recall any existing billing to QMBs for Medicare cost sharing.
February 4, 2016	The article was revised February 4, 2016, to include updated information for 2016 and a correction to the second sentence in paragraph 2 under *Important Clarifications Concerning QMB Balance Billing Law*.
February 1, 2016	The article was revised to include updated information for 2016 and a clarifying note regarding eligibility criteria in the table.
March 28, 2014	The article was revised to change the name of the coordination of benefits contractor (COBC) to BCRC.

MLN Matters® Number: SE1128 *Revised*
Related Change Request (CR) #: N/A
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Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

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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

Bone mineral density studies – revision to the Part A and Part B LCD

LCD ID number: L36356 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on change request (CR) 10473 (ICD-10 and Other Coding Revisions to National Coverage Determination [NCDs]), the bone mineral density studies local coverage determination (LCD) was revised to add ICD-10-CM diagnosis code Z79.811* for *Current Procedural Terminology* (CPT®) codes 77080 and 77085. In addition, based on CR 8691, this LCD was revised to add ICD-10-CM diagnosis codes E34.2 and N95.9 to the "ICD-10 Codes that Support Medical Necessity" section of the LCD for Healthcare Common Procedure Coding System (HCPCS)/CPT® codes G0130, 77078, 77080, 77081, 77085, and 76977.

Effective date

The LCD revision related to CR 10473 is effective for claims processed **on or after April 2, 2018**, for services rendered **on or after October 1, 2015**.

The LCD revision related to CR 8691 is effective for services rendered **on or after October 1, 2015**.

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*.

Diagnostic colonoscopy – revision to Part A and Part B LCD

LCD ID number: L33671 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on an external inquiry the local coverage determination (LCD) for diagnostic colonoscopy was revised to remove ICD-10-CM diagnosis codes Z12.10, Z12.11, Z12.13, Z80.0, Z83.71 - Z83.79, Z85.038, Z85.048, and Z86.010 from the "ICD-10 Codes that Support Medical Necessity" section of the LCD. We want to clarify that these ICD-10-CM diagnoses are not appropriate for billing with a diagnostic colonoscopy *Current Procedural Terminology* (CPT®) code. For coding purposes a screening colonoscopy must be coded as Healthcare Common Procedure Coding System (HCPCS) codes G0105 (Colorectal cancer screening; colonoscopy on individual at high risk) or G0121 (Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk). For screening colonoscopies, please refer to First Coast Service Options Inc. colorectal cancer screening LCD (L36355).

Effective date

This LCD revision is effective for services rendered **on or after May 17, 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, please *click here*.

Find out first: Subscribe to First Coast *eNews*

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

Fundus photography – revision to Part A and Part B LCD

LCD ID number: L33670 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on an annual review of the fundus photography local coverage determination (LCD), it was determined that the italicized language in the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD does not represent direct quotation from the Centers for Medicare & Medicaid Services (CMS) sources. Therefore, this LCD is being revised to assure consistency with the CMS manual language.

Effective date

This LCD revision is effective for services rendered **on or after March 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*.

Label and off-label coverage of outpatient drugs and biologicals – revision to the Part B LCD

LCD ID number: L33915 (Florida, Puerto Rico/ U.S. Virgin Islands)

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

Effective date

The revision of this LCD is effective for services rendered **on or after March 15, 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*.

Correct your claims on the 'SPOT'

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

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 an annual review the local coverage determination (LCD)/"coding guidelines" article for luteinizing hormone-releasing hormone (LHRH) analogs was revised to update the dosage information for Healthcare Common Procedure Coding System (HCPCS) code J3315 (triptorelin pamoate). Also, the "Sources of Information and Basis for Decision" section of the LCD was updated.

Effective date

This LCD revision is effective for services rendered **on or after March 15, 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, please *click here*.

Noncovered services – revision to Part A and Part B LCD

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

The local coverage determination (LCD) for noncovered services was revised based on an LCD reconsideration request. The quality of the evidence reviewed for the peri-prostatic transperineal placement of a hydrogel biodegradable material was strong for establishing that it resulted in a reduction of radiation dose delivered to the anterior rectum and that it is a safe, low risk procedure. In conclusion, for being a low risk procedure that could have theoretical benefits for beneficiaries, the Jurisdiction N (JN) Medicare Administrative Contractor (MAC) made the determination to remove Current Procedural Terminology (CPT®) code 55874 from the "CPT®/HCPCS Codes – Group 1 Codes:" under the subtitle "Procedures for Part A and Part B" section of the LCD, and Healthcare Common Procedure Coding System (HCPCS) code L8699 (Prosthetic implant, not otherwise specified [when used for hydrogel application of a spacer to increase the distance between the prostate and anterior rectal wall]) was removed from the "CPT®/HCPCS Codes – Group 5 Paragraph/Codes:" under the subtitle "Procedures for Part B only" section of the LCD. Removal of a service or procedure from the Noncovered Services LCD is not a positive coverage statement. Claims for such services assuming all other requirements of the program are met would always need to meet the medically reasonable and necessary threshold for coverage.

Effective date

The LCD revision is effective for services rendered **on or after March 8, 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*.

Online Medicare refreshers

The *Medicare Learning Network*® (MLN) Products Web-Based Training (WBT) courses are designed for self-paced training via the Internet.

These WBT courses provide information on a broad range of Medicare topics for health care professionals and their staff. Many of these courses offer continuing education credits.

Click here to explore the wide away of training opportunities.

Paravertebral facet joint blocks – revision to the Part A and Part B LCD

LCD ID number: L33930 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on an annual review of the paravertebral facet joint blocks local coverage determination (LCD), it was determined that the italicized language in the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD does not represent direct quotation from the Centers for Medicare & Medicaid Services (CMS) sources. Therefore, this LCD is being revised to assure consistency with the CMS manual language.

Effective date

This LCD revision is effective for services rendered **on or after March 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*.

Peripheral nerve blocks – revision to the Part B LCD

LCD ID number: L33933 (Florida, Puerto Rico/ U.S. Virgin Islands)

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

Effective date

The revision of this LCD is effective for services rendered **on or after March 15, 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*.

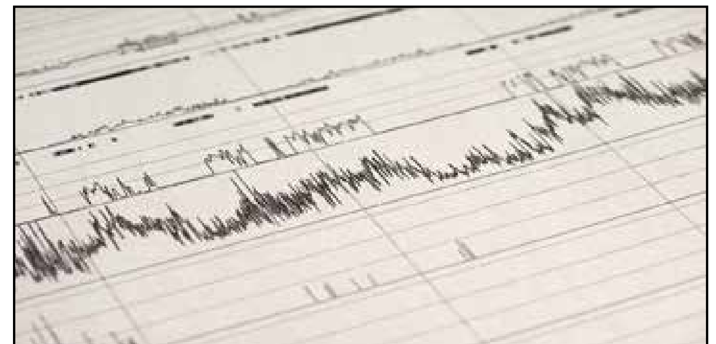
Polysomnography and sleep testing – revision to the Part A and Part B LCD

LCD ID number: L33405 (Florida, Puerto Rico/ U.S. Virgin Islands)

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

Effective date

The revision of this LCD is effective for services rendered **on or after March 15, 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*.

Radiation therapy for T1 basal cell and squamous cell carcinomas of the skin – revision to the Part A and Part B LCD

LCD ID number: L33538 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on an annual review of the radiation therapy for T1 basal cell and squamous cell carcinomas of the skin local coverage determination (LCD), it was determined that the italicized language in the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD does not represent direct quotation from the Centers for Medicare & Medicaid Services (CMS) sources. Therefore, this LCD is being revised to assure consistency with the CMS manual language.

Effective date

This LCD revision is effective for services rendered **on or after March 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*.

Screening and diagnostic mammography – revision to the Part A and Part B coding guidelines article (A54846)

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

Based on an annual review of the screening and diagnostic mammography local coverage determination (LCD) coding guidelines article, it was determined that the italicized language does not represent direct quotation from the Centers for Medicare & Medicaid Services (CMS) sources listed in the LCD. Therefore, the coding guidelines article is being revised to assure consistency with the CMS manual language.

Effective date

This revision to the LCD coding guidelines article is effective for services rendered **on or after March 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*.

Surgical management of morbid obesity – revision to the Part A and Part B LCD

LCD ID number: L33411 (Florida, Puerto Rico/ U.S. Virgin Islands)

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

Effective date

The revision of this LCD is effective for services rendered **on or after March 15, 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*.

Therapy services billed by physicians/nonphysician practitioners – revision to the Part B LCD

LCD ID number: L33961 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for therapy services billed by physicians/nonphysician practitioners were revised based on Section 50202 of the Bipartisan Budget Act, which repeals Medicare provisions affecting the outpatient therapy caps. This section requires that Medicare claims no longer be subject to the therapy cap. Therefore, the "Documentation Requirements" section of the LCD was revised to remove language related to the therapy cap.

Effective date

This LCD revision is effective for claims processed **on or after February 23, 2018**, 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*.

Therapy and rehabilitation services – revision to the Part A and Part B LCD

LCD ID number: L33413 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for therapy and rehabilitation services was revised based on Section 50202 of the Bipartisan Budget Act, which repeals Medicare provisions affecting the outpatient therapy caps. This section requires that Medicare claims no longer be subject to the therapy cap. Therefore, the "Indications and Limitations of Coverage and/or Medical Necessity," "CPT®/HCPCS Codes," and "ICD-10 Codes that Support Medical Necessity" sections of the LCD were revised to remove language related to the therapy cap. Also, based on the Centers for Medicare and Medicaid Services (CMS) change request (CR) 10318 (national coverage determination (NCD) 270.1), the LCD was revised to add non-pressure chronic ulcers as covered for Healthcare Common Procedure Coding System (HCPCS) code G0281 in the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD.

Effective date

The LCD revision based on Section 50202 of the Bipartisan Budget Act is effective for claims processed **on or after February 23, 2018**, for services rendered **on after January 1, 2018**. The LCD revision based on CR 10318 is effective for claims processed **on or after April 2, 2018,** 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*.

Confirm First Coast's receipt of your redetermination

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

Additional Information

Clarification on the implementation of change request (CR) 10318, transmittal 2005 titled, "ICD-10 and Other Coding Revisions to National Coverage Determinations (NCDs)"

The Centers for Medicare & Medicaid Services (CMS) has received multiple inquiries related to instructions in change request (CR) 10318 for national coverage determinations (NCDs) 110.21 and 80.11 and wants to clarify as follows.

CR 10318, transmittal 2005 titled, "ICD-10 and Other Coding Revisions to National Coverage Determinations (NCDs)" that was released January 18, 2018 (a correction to the initial CR 10318, transmittal 1975, dated November 9, 2017), contains the latest coding instructions to the CMS NCDs. Business requirement (BR) 10 specifically addresses coding changes for NCD 110.21 (Erythropoiesis Stimulating Agents (ESAs) in Cancer) and BR 21-21.2 specifically address coding changes for NCD 80.11 (Vitrectomy).

CMS is in the process of re-reviewing the coding changes for NCD 110.21. Until this review is complete and CMS makes a final determination, the A/B Medicare administrative contractors (MACs) will not implement the edits contained in CR 10318. The A/B MACs will also reprocess any claims that were processed in error from January 1, 2018 to the present, that were processed with the additional codes included in CR 10318 as not payable with the EC modifier.

Regarding the vitrectomy NCD (see *NCD Manual* Section 80.11) implementation instructions to remove certain diagnosis codes per CR 10318, CMS instructs the A/B MACs to not implement this editing. The CMS carefully reviews all coding revisions. While the review of the Vitrectomy NCD is no exception, CMS realizes that a large number of diagnosis codes were removed and that has caused some concern among stakeholders. We appreciate all the stakeholders' comments that notified CMS of the effect of the coding changes. As a result, CMS is in the process of a subsequent review of the codes marked for removal in CR 10318.

In the interim, codes included in the covered diagnosis list prior to CR 10318 are coverable. The CMS MACs have been notified of this decision. Any claims you and/or the MACs believe were processed in error as a result of CR 10318 will be reprocessed. Furthermore, if you were advised by a MAC to hold NCD 80.11 claims until further notice, please be assured you can submit those claims and they will be processed without regard to CR 10318.

Once CMS has completed their re-review of coding for NCD 80.11 and if changes to CR 10318 are warranted, they will release a subsequent CR as well as directions to its MACs indicating that decision, complete with specific implementation instructions.

Your feedback matters

Your opinion is important to us. If you haven't already completed the MAC Satisfaction Indicator (MSI) survey, please take a moment to complete it now. Share your experience with the services we provide. It will take about 10 minutes. You can access the survey by clicking here.

Upcoming provider outreach and educational events

Topic:Psychiatric and psychotherapy services (B)

Date: Tuesday, May 15
Time: 11:30 a.m.-1:00 p.m.
Type of Event: Webcast

https://medicare.fcso.com/Events/0402691.asp

Topic: Medicare Part B changes and regulations

Date: Wednesday, June 13
Time: 11:30 a.m.-1:00 p.m.
Type of Event: Webcast

https://medicare.fcso.com/Events/0402681.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 February 22, 2018

MLN Connects® for February 22, 2018
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News & Announcements

- Low Volume Appeals Settlement Process

Provider Compliance

- Payment for Outpatient Services Provided to Beneficiaries Who Are Inpatients of Other Facilities — Reminder

Upcoming Events

- Low Volume Appeals Settlement Option Update Call — March 13
- Open Payments: The Program and Your Role Call — March 14
- Dementia Care: Person-Centered Care Planning and Practice Recommendations Call — March 20
- CMS National Provider Enrollment Conference — April 24 and 25

Medicare Learning Network Publications & Multimedia

- CMS Provider Minute Video: Utilizing Your MAC to Prepare for CERT Review — New
- Low Volume Appeals Settlement Call: Audio Recording and Transcript — New
- Provider Compliance Tips for Hospital Beds and Accessories Fact Sheet — New
- Provider Compliance Tips for Infusion Pumps and Related Drugs Fact Sheet — New
- Provider Compliance Tips for Nebulizers and Related Drugs Fact Sheet — New
- Provider Compliance Tips for Laboratory Tests – Blood Counts Fact Sheet — New
- Provider Compliance Tips for Diabetic Test Strips Fact Sheet — Revised
- Overview of the Repetitive Scheduled Non-emergent Ambulance Prior Authorization Model MLN Matters® Article — Revised
- Telehealth Services Booklet — Revised
- Medicare Enrollment for Institutional Providers Booklet — Revised
- PECOS for Physicians and NPPs Booklet — Revised
- DMEPOS Information for Pharmacies Fact Sheet — Reminder
- DMEPOS Accreditation Fact Sheet — Reminder
- Mass Immunizers and Roster Billing Booklet — Reminder

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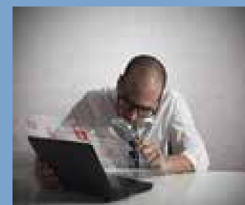
Where do I find...

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



Medicare expired legislative provisions extended and other Bipartisan Budget Act of 2018 provisions

On February 9, 2018, President Trump signed into law the Bipartisan Budget Act of 2018. This new law includes several provisions related to Medicare payment.

With regard to payment for outpatient therapy services, the law repeals application of the Medicare outpatient therapy caps but retains the former cap amounts as a threshold above which claims must include the KX modifier as a confirmation that services are medically necessary as justified by appropriate documentation in the medical record; and retains the targeted medical review process, but at a lower threshold amount. It also extends several recently expired Medicare legislative provisions affecting health care providers and beneficiaries, including the Medicare physician fee schedule work geographic adjustment floor, add-on payments for ambulance services and home health rural services, changes to the payment adjustment for low volume hospitals, and the Medicare dependent hospital program.

In addition, with regard to Section 53111 – Medicare Payment Update for Skilled Nursing Facilities, the Centers for Medicare & Medicaid Services has received questions from stakeholders about the impact of the FY 2019 skilled nursing facility (SNF) update due to Section 53111 of the BBA of 2018. To help answer these questions, we are providing information about the estimated market-basket update for FY 2019 based on currently available data. This estimate may be updated in the notice of proposed rulemaking for the FY 2019 SNF prospective payment system (PPS).

Read the *full summary*.

MLN Connects® for March 1, 2018

MLN Connects® for March 1, 2018

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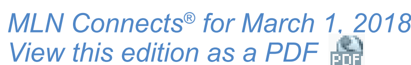

News & Announcements

- New Medicare Card: Video for Your Waiting Room
- Patients over Paperwork Newsletter
- CMS Launches Public Reporting of CAHPS® Hospice Survey Results
- Hospice Compare Quarterly Refresh
- Medicare Diabetes Prevention Program: Supplier Enrollment
- Medicare EHR Incentive Program Hospital Attestation: Deadline Extended to March 16
- Draft 2019 QRDA Category I Implementation Guide: Submit Comments by March 21
- MIPS: Apply to Participate in Quality Measures Study by March 23
- MIPS Reporting Deadlines
- MIPS 2018 QCDR Measure Specifications
- MIPS Claims Based Quality Measures Projections and Results Video
- eCQM Annual Update Pre-Publication Document
- What's New with Physician Compare Webinar Materials
- Are You Prepared for a Health Care Emergency?
- March is National Colorectal Cancer Awareness Month

Provider Compliance

- Provider Compliance Tips for Laboratory Blood Counts Fact Sheet – New

Upcoming Events

- Low Volume Appeals Settlement Option Update Call – March 13
- Open Payments: The Program and Your Role Call – March 14
- Dementia Care: Person-Centered Care Planning and Practice Recommendations Call – March 20
- E/M Services: Documentation Guidelines and Burden Reduction Listening Session – March 21

Medicare Learning Network Publications & Multimedia

- Provider Compliance Tips for PAP Devices and Accessories Including CPAP Fact Sheet – New
- Provider Compliance Tips for Oral Anticancer Drugs and Antiemetic Drugs Used in Conjunction Fact Sheet – New
- Provider Compliance Tips for Bariatric Surgery Fact Sheet – New
- Provider Compliance Tips for Diabetic Shoes Fact Sheet – New

See **Connects®**, page 43

MLN Connects® for March 8, 2018

MLN Connects® for March 8, 2018

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News & Announcements

- MyHealthEData Initiative Puts Patients at the Center of the US Health Care System
- New Medicare Card Transition Begins In Less Than a Month
- MACRA Funding Opportunity: Measure Development for the Quality Payment Program
- IRF and LTCH Compare Refresh
- Quality Payment Program: Submit 2017 Participation Data through March 31
- EHR Incentive Program: Hospitals Submit Proposals for New Measures until June 29
- PEPPER for Short-term Acute Care Hospitals
- DME Supplier Feedback on Telephone Discussion and Reopening Process Demonstration
- EHR Incentive Programs FAQs
- Antipsychotic Drug Use in Nursing Homes: Trend Update
- Help Your Patients Go Further With Food

Provider Compliance

- Bill Correctly for Device Replacement Procedures – Reminder

Claims, Pricers & Codes

- April 2018 Average Sales Price Files

Upcoming Events

- Low Volume Appeals Settlement Option Update Call – March 13
- National Patient Safety Week Panel Discussion – March 13
- Open Payments: The Program and Your Role Call – March 14
- QRDA Category I Implementation Guide for CY 2018 Hospital Quality Reporting Webinar – March 19
- Dementia Care: Person-Centered Care Planning and Practice Recommendations Call – March 20
- E/M Services: Documentation Guidelines and Burden Reduction Listening Session – March 21

Medicare Learning Network Publications & Multimedia

- Provider Compliance Tips for Glucose Monitors Fact Sheet – New
- Provider Compliance Tips for Manual Wheelchairs Fact Sheet – New
- Provider Compliance Tips for Ordering Lower Limb Prostheses Fact Sheet – New
- Provider Compliance Tips for Laboratory Tests – Bacterial Cultures Fact Sheet – New
- Provider Compliance Tips for Wheelchair Options/ Accessories Fact Sheet – New
- Provider Compliance Tips for Ostomy Supplies Fact Sheet – New
- Provider Compliance Tips for Ordering Oxygen Supplies and Equipment Fact Sheet – New
- Provider Compliance Tips for Negative Pressure Wound Therapy Fact Sheet – New
- Provider Compliance Tips for Surgical Dressings Fact Sheet – New
- Provider Compliance Tips for Urological Supplies Fact Sheet – New
- Low Volume Appeals Settlement Call: Video Presentation – New
- ESRD QIP Call: Audio Recording and Transcript – New
- Rural Health Clinic Fact Sheet — Revised

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CONNECTS®

from page 38

- Provider Compliance Tips for Lower Limb Orthoses Fact Sheet – New
- Provider Compliance Tips for Enteral Nutrition Fact Sheet – New
- Provider Compliance Tips for Immunosuppressive Drugs Fact Sheet – New
- Provider Compliance Tips for Ambulance Services Fact Sheet – Revised
- Provider Compliance Tips for Clinic ESRD Services (Part A Non-DRG) Fact Sheet – Revised
- Provider Compliance Tips for CT Scans Fact Sheet – Revised
- Medicare Part D Vaccines and Vaccine Administration Fact Sheet – Revised
- Medicare Part B Immunization Billing Educational Tool – Revised
- Screening Pap Tests and Pelvic Examinations Booklet – Revised
- Medicare Enrollment for Physicians, NPPs, and Other Part B Suppliers Booklet – Revised
- Hospital Outpatient Prospective Payment System Booklet – Revised

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MLN Connects® for March 15, 2018

MLN Connects® for March 15, 2018
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News & Announcements

- MIPS Reporting Deadlines Approaching
- EHR Incentive Program: Hospital Attestation Deadline Changed to March 16
- Hospice Provider Preview Reports: Review Your Data by March 30
- IRF and LTCH Provider Preview Reports: Review Your Data by April 5
- Medicare Pharmaceutical and Technology Ombudsman
- Updated QRDA III Implementation Guide with Advancing Care Information Identifier
- Hospice QRP Timeliness Compliance Threshold Report: Footnote Update
- Influenza Activity Continues: Are Your Patients Protected?

Provider Compliance

- Provider Compliance Tips for Hospital Beds and Accessories

Claims, Pricers & Codes

- Integrated OCE Files for April 2018

Upcoming Events

- New Medicare Card Project Special Open Door Forum — March 20
- Dementia Care: Person-Centered Care Planning and Practice Recommendations Call — March 20
- E/M Services: Documentation Guidelines and Burden Reduction Listening Session — March 21
- Interdisciplinary Team Building, Management, and Communication Webinar — March 21
- Hospice Quality Reporting Program Webinar — March 27
- IMPACT Act and Improving Care Coordination Special Open Door Forum — March 28
- Managing Transitions with Adults with Disabilities Webinar — March 28
- Building Partnerships: Health Plans and Community-based Organizations Webinar — April 4

Medicare Learning Network Publications & Multimedia

- Appropriate Use Criteria for Advanced Diagnostic Imaging: HCPCS Modifier QQ MLN Matters® Article — New
- April 2018 I/OCE Specifications Version 19.1 MLN Matters® Article — New
- April 2018 Update of the Hospital OPPS MLN Matters® Article — New
- Provider Compliance Tips for Enteral Nutrition Fact Sheet — New
- Provider Compliance Tips for Walkers Fact Sheet — New
- Provider Compliance Tips for Home Health Services Fact Sheet — New
- Provider Compliance Tips for Respiratory Assistive Devices Fact Sheet— New
- ICD-10 and Other Coding Revisions to NCDs MLN Matters Article — Revised
- Diagnosis Code Update for Add-on Payments for Blood Clotting Factor Administered to Hemophilia Inpatients MLN Matters® Article — Revised
- Supervised Exercise Therapy for Symptomatic PAD MLN Matters® Article — Revised
- Quarterly HCPCS Drug/Biological Code Changes MLN Matters® Article — Revised
- Provider Compliance Tips for Laboratory Tests: Other Fact Sheet – Revised
- Provider Compliance Tips for Ordering Hospital Outpatient Services Fact Sheet — Revised
- Provider Compliance Tips for Skilled Nursing Facility Services Fact Sheet — Revised
- Provider Compliance Tips for Enteral Nutrition Therapy Pumps Fact Sheet — Revised
- Provider Compliance Tips for IRF Fact Sheet — Revised
- Ambulatory Surgical Center Payment System Fact Sheet — Revised
- Beneficiaries in Custody under a Penal Authority Fact Sheet—Revised
- Medicare Ambulance Transports Booklet — Revised
- Medicare Provider-Supplier Enrollment National Educational Products Listing — Revised
- Global Surgery Booklet — Reminder

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MLN Connects® for March 22, 2018

MLN Connects® for March 22, 2018

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News & Announcements

- Coverage of Next Generation Sequencing Tests Ensures Enhanced Access for Cancer Patients
- IMPACT Act Transfer of Health Measures: Public Comment Period Ends May 3
- Hospice Quality Reporting Program: HART v1.4.0
- Hospital VBP Program FY 2020 Baseline Measures Report

Provider Compliance

- Billing for Stem Cell Transplants — Reminder

Upcoming Events

- IMPACT Act and Improving Care Coordination Special Open Door Forum — March 28
- Spinal Orthoses Referring Providers Comparative Billing Report Webinar — April 11
- CMS National Provider Enrollment Conference — April 24 and 25

Medicare Learning Network Publications & Multimedia

- April 2018 Update: ASC Payment System MLN Matters® Article — New
- Internet Only Manual Update to Correct Errors and Omissions: SNF 2018 MLN Matters® Article — New
- SSI/Medicare Beneficiary Data for FY 2016: IPPS Hospitals, IRFs, LTCHs MLN Matters® Article — New
- Billing Requirements for OPPS Providers with Multiple Service Locations MLN Matters® Article — New
- Reinstating the QMB Indicator in the Medicare FFS Claims Processing System MLN Matters® Article — Revised
- Quarterly Update for CLFS and Laboratory Services Subject to Reasonable Charge Payment MLN Matters® Article — Revised
- Home Health Prospective Payment System Booklet — Revised
- Federally Qualified Health Center Booklet — Revised
- Medicare Parts A and B Appeals Process Booklet — Reminder
- The Medicare Secondary Payer Provisions Web-Based Training Course — Reminder
- CLIA Program and Medicare Laboratory Services — Reminder

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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.*

Phone numbers

Customer service

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

Education event registration hotline

904-791-8103 (NOT toll-free)

Electronic data interchange (EDI)

888-670-0940

Electronic funds transfers (EFT) (CMS-588)

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

Fax number (for general inquiries)

904-361-0696

Interactive voice response (IVR) system

877-847-4992

Provider enrollment

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

The SPOT help desk

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

Addresses

Claims

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

Redeterminations

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

Redetermination of overpayments

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

Reconsiderations

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

General inquiries

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

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

Provider enrollment

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

Medical policy

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

Medicare secondary payer

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

Electronic data interchange (EDI)

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

Overpayments

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

Medicare Education and Outreach

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

Fraud and abuse

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

Freedom of Information Act requests

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

Overnight mail and/or special courier service

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

Websites

Provider

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

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

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

E-learning Center
https://gm1.geolearning.com/geonext/fcso/opensite.geo

Beneficiaries

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

Phone numbers

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

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

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

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

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

Addresses

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Websites

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Centers for Medicare & Medicaid Services

https://www.cms.gov

E-learning Center
https://gm1.geolearning.com/geonext/fcso/opensite.geo

Beneficiaries
Centers for Medicare & Medicaid Services

https://www.medicare.gov

Phone numbers

Customer service

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

Education event registration hotline

904-791-8103 (NOT toll-free)
904-361-0407 (FAX)

Electronic data interchange (EDI)

888-875-9779

Electronic funds transfers (EFT) (CMS-588)

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

General inquiries

877-715-1921
888-216-8261 (TTY)

Interactive voice response (IVR) system

877-847-4992

Provider enrollment

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

The SPOT help desk

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

Addresses

Claims

Medicare Part B Claims
P.O. Box 45036
Jacksonville, FL 32232-5036

Redeterminations

Medicare Part B Redetermination
P.O. Box 45056
Jacksonville, FL 32232-5056

Redetermination of overpayments

First Coast Service Options Inc.
P.O Box 45015
Jacksonville, FL 32232-5015

Reconsiderations

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

General inquiries

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

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

Provider enrollment

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

Medical policy

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

Medicare secondary payer

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

Electronic data interchange (EDI)

Medicare EDI, 4C
P.O. Box 44071
Jacksonville, FL 32231-4071

Overpayments

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

Medicare Education and Outreach

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

Fraud and abuse

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

Freedom of Information Act requests

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

Special courier service

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532 Riverside Avenue
Jacksonville, FL 32202-4914

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