Medicare B CONNECTION

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FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction N Providers

July 2018

In this issue

MLN Connects® – Special Edition for July 12, 2018

CMS Proposes Historic Changes to Modernize Medicare and Restore the Doctor-Patient Relationship

Proposed changes to the Medicare Physician Fee Schedule and Quality Payment Program would streamline clinician billing and expand access to high-quality care

On July 12, CMS proposed historic changes that would increase the amount of time that doctors and other clinicians can spend with their patients by reducing the burden of paperwork that clinicians face when billing Medicare. The proposed rules would fundamentally improve the nation's health care system and help restore the doctor-patient relationship by empowering clinicians to use their Electronic Health Records (EHRs) to document clinically meaningful information, instead of information that is only for billing purposes.

"Today's reforms proposed by CMS bring us one step closer to a modern health care system that delivers better care for Americans at a lower cost," said HHS Secretary Alex Azar. "Such a system requires empowering American patients by giving them price and quality transparency and control over their own interoperable health records, goals supported by CMS's proposals. These proposals will also advance the successful Medicare Advantage program and accomplish a historic regulatory rollback to help physicians put patients over paperwork. Further, today's proposed reforms to how CMS pays for medicine demonstrate the commitment of HHS to implementing President Trump's blueprint for lowering drug prices. The ambitious reforms proposed by CMS under Administrator Verma will help deliver on two HHS priorities: creating a value-based health care system for the 21st century and making prescription drugs more affordable."

"Today's proposals deliver on the pledge to put patients over paperwork by enabling doctors to spend more time with their patients," said CMS Administrator Seema Verma. "Physicians tell us they continue to struggle with excessive regulatory requirements and unnecessary paperwork that steal time from patient care. This Administration has listened and is taking action. The proposed changes to the Physician Fee Schedule and Quality Payment Program address those problems head-on, by streamlining documentation requirements to focus on patient care and

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Contents

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

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

About the Medicare B Connection

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

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

Quarterly update to the NCCI procedure-to-procedure edits, version 24.3

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) 10827 updates the National Correct Coding Initiative (NCCI) procedure-to-procedure (PTP) edits, which relate to Chapter 23, Section 20.9 of the *Medicare Claims Processing Manual* (Pub. 100-04). Please make sure your billing staffs are aware of these updates.

Background

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

Version 24.2 will include all previous versions and updates from January 1, 1996, to the present. In the past, NCCI was organized in two tables: Column 1/column 2 correct coding edits and mutually exclusive code (MEC) edits. In order to simplify the use of NCCI edit files (two tables), April 1, 2012, CMS consolidated these two edit files into the column 1/column 2 correct coding edit file. Separate consolidations have occurred for the two practitioner NCCI edit files and the two NCCI edit files used for the Outpatient Code Editor (OCE).

It will only be necessary to search the column 1/column 2 correct coding edit file for active or previously deleted edits. CMS no longer publishes a mutually exclusive edit file on its website for either practitioner or outpatient hospital services, since all active and deleted edits will appear in the single column 1/column 2 correct coding edit file on each website. The edits previously contained in the mutually exclusive edit file are NOT being deleted but are being moved to the column 1/column 2 correct coding edit file.

Refer to the CMS NCCI website for additional information at *https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html*.

The coding policies developed are based on coding conventions defined in the American Medical Association's *Current Procedural Terminology* (CPT®) manual, national

and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practice, and review of current coding practice.

Additional information

The official instruction, CR 10827, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and- Guidance/Guidance/Transmittals/2018Downloads/R4080CP.pdf*.

If you have questions, your MACs may have more information. Find its website at *https://go.cms.gov/MAC-website-list*.

Document history

Date of change	Description
June 29, 2018	Initial article released.

MLN Matters® Number: MM10827
Related CR Release Date: June 29, 2018
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Related Change Request (CR) Number: 10827
Effective Date: October 1, 2018
Implementation October 1, 2018

Ambulatory Surgical Center

July 2018 update of the ASC payment system

***Note**: This article was revised June 28, 2018, to reflect an updated change request (CR). To reflect those changes this article modified Section 2.b and the related Table 1. It also added Section 2e and 2f with corresponding Table 3. The CR release date, transmittal number and link to the transmittal also changed. All other information remains the same. This information was previously published in the June 2018 Medicare B Connection, pages 5-7.*

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.

Provider action needed

CR 10788 informs MACs about updates to the ASC payment system for July 2018. Be sure your billing staffs are aware of these changes.

Background

CR 10788 describes changes to and billing instructions for various payment policies implemented in the July 2018 ASC payment system update. As appropriate, this notification also includes updates to the Healthcare Common Procedure Coding System (HCPCS). Included in CR 10788 are 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. The CR also includes a July 2018 ASC payment rates for covered surgical and ancillary services (ASCFS) update file. CR 10788 is not issuing a "No ASC Code Pair"file. The key changes are as follows:

1. Bilateral indicator for HCPCS code C9749

In the April 2018 outpatient prospective payment system (OPPS) update (Transmittal 4005, CR 10515, dated March 20, 2018), the Centers for Medicare & Medicaid Services (CMS) announced the establishment of HCPCS code C9749 (Repair of nasal vestibular lateral wall stenosis with implant(s)), effective April 1, 2018. CMS is clarifying that this code describes an inherently bilateral procedure, and that for unilateral procedures; ASCs need to report either modifier 73 or 74. Modifiers 73 and 74 are only used to indicate discontinued procedures for which anesthesia is planned or provided.

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 + six percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological, or therapeutic radiopharmaceutical. In addition, in 2018, a single payment of ASP + six percent continues to be made for pass-through drugs, biologicals, and therapeutic 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 July 1, 2018, and drug price restatements are available in the July 2018 update of ASC Addendum BB, which is at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html*.

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

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

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

HCPCS code	Long descriptor	Short descriptor	ASC PI
C9030	Injection, copanlisib, 1 mg	Inj copanlisib	K2
C9032	Injection, voretigene neparvovec-rzyl, 1 billion vector genome	Voretigene neparvovec-rzyl	K2
Q5105	Injection, epoetin alfa, biosimilar, (Retacrit) (for esrd on dialysis), 100 units	Inj Retacrit esrd on dialysi	K2
Q5106	Injection, epoetin alfa, biosimilar, (Retacrit) (for non-esrd use), 1000 units	Inj Retacrit non-esrd use	K2
Q9991	Injection, buprenorphine extended-release (Sublocade), less than or equal to 100 mg	Buprenorph xr 100 mg or less	K2

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HCPCS code	Long descriptor	Short descriptor	ASC PI
Q9992	Injection, buprenorphine extended-release (Sublocade), greater than 100 mg	Buprenorphine xr over 100 mg	K2
Q9995	Injection, emicizumab-kxwh, 0.5 mg	inj. emicizumab-kxwh, 0.5 mg	K2

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 payment rates will be accessible on the first date of the quarter at *https://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/index.html*.

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

d. Other changes to 2018 HCPCS codes for certain drugs, biologicals, and radiopharmaceuticals effective July 1, 2018

Effective July 1, 2018, HCPCS code Q9993 (Injection, triamcinolone acetonide, preservative-free, extended-release, microsphere formulation, 1 mg) will replace HCPCS code C9469 (Injection, triamcinolone acetonide, preservative-free, extended-release, microsphere formulation, 1 mg). The ASC Payment Indicator will remain K2, "Drugs and biologicals paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate." These codes are listed in Table 2 (page 8).

e. New biosimilar biological products effective July 1, 2018

Two new HCPCS codes will be created for reporting Retacrit, (epoetin alfa-epbx) as a biosimilar to Epogen/Procrit (epoetin alfa) for the treatment of anemia caused by chronic kidney disease, chemotherapy, or use of zidovudine in patients with HIV infection. Retacrit is also approved for use before and after surgery to reduce the chance that red blood cell transfusions will be needed because of blood loss during surgery. The codes, descriptors, and ASC payment indicators are separately listed in Table 3, and are effective for services furnished on or after July 1, 2018. Payment for each of these codes can be found in Addendum BB of the July 2018 ASC addenda that are posted on the CMS website.

Table 3 - New biosimilar biological products effective July 1, 2018

HCPCS code	Long descriptor	Short descriptor	ASC PI
Q5105	Injection, epoetin alfa, biosimilar, (Retacrit) (for esrd on dialysis), 100 units	Inj Retacrit esrd on dialysi	K2
Q5106	Injection, epoetin alfa, biosimilar, (Retacrit) (for non-esrd use), 1000 units	Inj Retacrit non-esrd use	K2

f. Drugs and biologicals with a change in status indicator

Two drugs, specifically, HCPCS codes J9216 and Q2049, have a change in status indicator from "K2" to not separately payable, effective July 1, 2018, since we do not have pricing information for either drug code.

3. **Category III CPT® code effective July 1, 2018**

The AMA releases Category III CPT® codes twice per year:

- In January, for implementation beginning the following July
- In July, for implementation beginning the following January

For the July 2018 update, CMS is implementing one Category III CPT® code that the AMA released in January 2018 for implementation on January 1, 2018. The ASC payment indicator for this code is shown in Table 4. The payment rate for this service is in Addendum BB of the July 2018 ASC addenda at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html*.

Table 4 — Category III CPT® codes effective July 1, 2018

CPT® code	Long descriptor	Short	ASC PI
0508T	Pulse-echo ultrasound bone density measurement resulting in indicator of axial bone mineral density, tibia	Pls echo us b1 dns meas tib	Z2

4. Reassignment of skin substitute product from the low-cost group to the high-cost group

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

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are divided into two groups: 1) High-cost skin substitute products and 2) Low-cost skin substitute products for packaging purposes.

The skin substitute product listed in Table 5 has been reassigned from the low-cost skin substitute group to the high-cost skin substitute group based on updated pricing information.

Note: This skin substitute product is packaged and should not be separately billed by ASCs

Table 5 – Reassignment of skin substitute product from the low-cost group to the high-cost group effective July 1, 2018

2018 HCPCS code	2018 short descriptor	2018 ASC PI	Low/high cost skin substitute
Q4178	Floweramniopatch, per sq cm	N1	High

ASCs should not separately bill for packaged skin substitutes (ASC PI=N1). High-cost skin substitute products should only be used in combination with the performance of one of the skin application procedures described by CPT® codes 15271-15278. Low-cost skin substitute products should only be used in combination with the performance of one of the skin application procedures described by HCPCS codes C5271-C5278. All OPPS pass-through skin substitute products (ASC PI=K2) should be billed in combination with one of the skin application procedures described by CPT® codes 15271-15278.

5. Coverage determinations

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

Additional information

The official instruction, CR 10788, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4076CP.pdf*.

If you have questions, your MACs may have more information. Find their website at *https://go.cms.gov/MAC-website-list*.

Document history

Date of change	Description
June 28, 2018	This article was revised to reflect an updated change request (CR). To show those changes this article modified Section 2.b and the related Table 1. It also added Section 2e and 2f with corresponding Table 3. The CR release date, transmittal number and link to the transmittal also changed.
June 1, 2018	Initial article released.

MLN Matters® Number: MM10788 *Revised*
Related CR Release Date: June 26, 2018
Related CR Transmittal Number: R4076CP
Related Change Request (CR) Number: 10788
Effective Date: July 1, 2018
Implementation July 2, 2018

Table 2 – Other changes to 2018 HCPCS codes for certain drugs, biologicals, and radiopharmaceuticals effective July 1, 2018

HCPCS code	Long descriptor	Short descriptor	ASC PI	Effective date	Termination date
C9469	Injection, triamcinolone acetonide, preservative-free, extended-release, microsphere formulation, 1 mg	Inj triamcinolone acetonide	K2	4/1/18	6/30/18
Q9993	Injection, triamcinolone acetonide, preservative-free, extended-release, microsphere formulation, 1 mg	Inj., triamcinolone ext rel	K2	7/1/18	

Drugs & Biologicals

July 2018 update of drug and biological code changes

***Note**: This article was revised June 26, 2018, to reflect a revised change request (CR) issued June 26. In the article, the new codes of Q5105 and Q5106 are added. The type of service code for CPT® code 90739 is updated to 1, V. Also, the CR release date, transmittal number, and the web address of the CR are revised. All other information is the same. This information was previously published in the June 2018 Medicare B Connection, page 5.*

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

CR 10624 informs MACs of updated drug/biological HCPCS codes. The HCPCS code set is updated on a quarterly basis. The July 2018 HCPCS file includes six new HCPCS codes: Q9991, Q9992, Q9993, Q9995, Q5105, and Q5106. Please make sure your billing staffs are aware of these updates.

Background

The July 2018 HCPCS file includes six new HCPCS codes, which are payable by Medicare, effective for claims with dates of service on or after July 1, 2018. Part B payment for HCPCS code Q9995 will include the clotting factor furnishing fee. These codes are:

- **Q9991**
  - Short description: Buprenorph xr 100 mg or less
  - Long description: Injection, buprenorphine extended-release (sublocade), less than or equal to 100 mg
  - Type of service (TOS) code: 1
  - Medicare Physician fee schedule data base (MPFSDB) status indicator: E
- **Q9992**
  - Short description: Buprenorphine xr over 100 mg
  - Long description: Injection, buprenorphine extended-release (sublocade), greater than 100 mg
  - TOS code: 1
  - MPFSDB status indicator: E
- **Q9993**
  - Short description: Inj., triamcinolone ext rel
  - Long description: Injection, triamcinolone acetonide, preservative-free, extended-release, microsphere formulation, 1 mg
  - TOS code: 1,P
  - MPFSDB status indicator: E
- **Q9995**
  - Short description: Inj. emicizumab-kxwh, 0.5 mg
  - Long description: Injection, emicizumab-kxwh, 0.5 mg
  - TOS code: 1
  - MPFSDB status indicator: E
- **Q5105**
  - Short description: Inj Retacrit esrd on dialysi
  - Long description: Injection, epoetin alfa, biosimilar, (Retacrit) (for esrd on dialysis), 100 units
  - TOS code: 1, L
  - MPFSDB status indicator: E
- **Q5106**
  - Short description: Inj Retacrit non-esrd use
  - Long description: Injection, epoetin alfa, biosimilar, (Retacrit) (for non-esrd use), 1000 units
  - TOS code: 9
  - MPFSDB status indicator: E

In addition to the new codes, the TOS code for CPT® code 90739 is updated to 1, V.

Additional information

The official instruction, CR 10624, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4078CP.pdf*.

If you have questions, your MACs may have more information. Find their website at *http://go.cms.gov/MAC-website-list*.

Document history

Date of change	Description
June 26, 2018	The article was revised to reflect a revised CR issued June 26. In the article, the new codes of Q5105 and Q5106 are added. The type of service code for CPT® code 90739 is updated to 1, V. Also, the CR release date, transmittal number, and the web address of the CR are revised. All other information is the same.
May 14, 2018	This article was revised to reflect a revised CR issued May 11. In the article, a sentence is added to show that Part B payment for Q9995 includes the clotting factor furnishing fee. Also, the CR release date, transmittal number, and the web address of the CR are revised. All other information is the same.
April 20, 2018	Initial article released.

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Evaluation and Management

Medical review of evaluation & management documentation

Provider type affected

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

Provider action needed

Change request (CR) 10627 establishes a new Section (6.8) in Chapter 6 of the *Medicare Program Integrity Manual* (Pub. 100-08), titled, *Medical Review of Evaluation and Management (E/M) Documentation*. Please make sure your billing staffs are aware of this new content.

Background

CR 10627 establishes Section 6.8 (Medical Review of Evaluation and Management (E/M) Documentation) with subsection 6.8.1 (Medical Review of E/M Documentation Provided by Student). These sections provide direction to Medicare's medical review contractors on how to review claims where a medical student documented the E/M service. This is a follow-up instruction to CR 10412 (published in February 2018), which allowed teaching physicians to verify a student's E/M visit notes rather than re-documenting them.

Note: The *MLN Matters*® article based on CR 10412 (MM10412) is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10412.pdf*.

The new section of the *Medicare Program Integrity Manual* states the following:

"The *Medicare Claims Processing Manual*, Chapter 12, Section 100.1.1 (B) states the teaching physician must personally perform (or re-perform) the physical exam and medical decision making activities of the E/M service being billed, but may verify any student documentation of them in the medical record rather than re-documenting this work. If the teaching physician chooses to rely on the medical student documentation and chooses not to re-document the E/M services, contractors shall consider this requirement met if the teaching physician signs and dates the medical student's entry in the medical record."

Additional information

The official instruction, CR 10627, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R808PI.pdf*.

If you have questions, your MACs may have more information. Find their website at *https://go.cms.gov/MAC-website-list*.

Document history

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MLN Matters® Number: MM10624 *Revised*
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Implementation July 2, 2018

General Coverage

Comprehensive ESRD care (CEC) model telehealth – implementation

***Note**: This article was revised June 28, 2018, to reflect a revised change request (CR) 10314 issued June 27. In the article, the CR release date, transmittal number, and the web address of the CR are revised. All other information remains the same. This information was previously published in the May 2018 Medicare B Connection, page 12-14.*

Provider type affected

This *MLN Matters*® article is intended for physicians, providers, and suppliers billing Medicare administrative contractors (MACs) and participating in the comprehensive ESRD care (CEC) Model for telehealth services provided to Medicare end-stage renal disease (ESRD) beneficiaries associated with the CEC model.

Provider action needed

CR 10314 details the CEC model telehealth program and how it will be implemented. Make sure your billing staffs are aware of this initiative.

Background

Section 1115A) of the Social Security Act (the Act) (added by Section 3021 of the Affordable Care Act (ACA) (42 USC 1315a) authorizes the Center for Medicare and Medicaid Innovation (CMMI) to test innovate health care payment and service-delivery models that have the potential to lower Medicare, Medicaid, and the Child Health Insurance Program (CHIP) spending while maintaining or improving the quality of beneficiaries' care.

The CEC model is designed to identify, test, and evaluate new ways to improve care for Medicare beneficiaries with ESRD. Through the CEC model, the Centers for Medicare & Medicaid Services (CMS) will partner with health care providers and suppliers to test the effectiveness of a new payment and service delivery model in providing beneficiaries with person-centered, high-quality care. The model builds on Accountable Care Organization (ACO) experience from the Pioneer ACO Model, Next Generation ACO Model, and the Medicare Shared Savings Program to test ACOs for ESRD beneficiaries.

More than 600,000 Americans have ESRD and require life-sustaining dialysis treatments several times per week. Many beneficiaries with ESRD suffer from poorer health outcomes, often the result of underlying disease complications and multiple co-morbidities. These can lead to high rates of hospital admission and readmissions, as well as a mortality rate that is higher than that of the general Medicare population.

According to United States Renal Data System, in 2014, ESRD beneficiaries comprised less than one percent of the Medicare population, but accounted for an estimated 7.2 percent of total Medicare fee-for-service (FFS) spending, totaling more than $32.8 billion.

Because of their complex health needs, beneficiaries often require visits to multiple providers and follow multiple care plans, all of which can be challenging for beneficiaries if care is not coordinated. The CEC model seeks to create incentives to enhance care coordination and to create a person-centered, coordinated care experience, and to ultimately improve health outcomes for this population.

In the CEC model, dialysis clinics, nephrologists and other providers collaborate to create an ESRD Seamless Care Organization (ESCO) to coordinate care for matched beneficiaries. ESCOs are accountable for clinical quality outcomes and financial outcomes measured by Medicare Part A and B spending, including all spending on dialysis services for their aligned ESRD beneficiaries. This model encourages dialysis providers to think beyond their traditional roles in care delivery and supports them as they provide patient-centered care that will address beneficiaries' health needs, both in and outside of the dialysis clinic.

The CEC model includes separate financial arrangements for larger and smaller dialysis organizations. Large dialysis organizations (LDOs), defined as having 200 or more dialysis facilities, will be eligible to receive shared savings payments. These LDOs will also be liable for shared losses and will have higher overall levels of risk compared with their smaller counterparts.

Non-large dialysis organizations (Non-LDOs) include chains with fewer than 200 dialysis facilities, independent dialysis facilities, and hospital-based dialysis facilities. Non-LDOs will have the option of participating in a one-sided track where they will be able to receive shared savings payments, but will not be liable for payment of shared losses, or participating in a track with higher risk and the potential for shared losses. The one-sided track is offered in recognition of the Non-LDOs more limited resources.

The CEC model began October 1, 2015, and will run until December 31, 2020. The CEC model conducted a solicitation in 2016 to add more ESCOs for performance year two of the model, beginning January 1, 2017. The CEC model has no current plans for another round of solicitations.

The CEC model LDO payment track and Non-LDO two-sided payment track are considered advance payment models (APMs) regarding the Quality Payment Program.

The CEC model will implement design elements with implications for the FFS system for its third performance year that includes benefit enhancements to give ACOs the tools to direct care and engage beneficiaries in their own care. The model also offers increased monitoring to account for different financial incentives and the provision of enhanced benefits. The model's quality requirements

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are similar to Shared Savings Program (SSP) and pioneer, modified as needed to take into account unique aspects of dialysis care, in keeping with the agencies initiatives to unify and streamline quality measurement and requirements.

Telehealth waiver

In order to emphasize high-value services and support the ability of ESCOs to manage the care of beneficiaries, CMS plans to design policies and use the authority under Section 1115A of the Social Security Act (Section 3021 of the Affordable Care Act) to conditionally waive certain Medicare payment requirements as part of the CEC model.

CMS will make available to qualified ESCOs a waiver of the originating site requirement for services provided via telehealth. This benefit enhancement will allow beneficiaries to receive qualified telehealth services in non-rural locations and locations that are not specified by statute, such as homes and dialysis facilities. The waiver will apply only to eligible aligned beneficiaries receiving services from ESCO providers.

An aligned beneficiary will be eligible to receive telehealth services through this waiver if the services are otherwise qualified with respect to:

1) The service provided, as designated by *Current Procedural Terminology* (CPT®) or Healthcare Common Procedure Coding System (HCPCS) codes, and
2) The remote site.

MACs will apply claim processing edit logic, audit, medical review, Medicare secondary payor, and fraud and abuse activities, appeals and overpayment processes for CEC claims in the same manner as normal FFS claims.

Notwithstanding these waivers, all telehealth services must be furnished in accordance with all other Medicare coverage and payment criteria, and no additional reimbursement will be made to cover set-up costs, technology purchases, training and education, or other related costs. In particular, the services allowed through telehealth are limited to those described under Section 1834(m)(4)(F) of the Act, and subsequent additional services specified through regulation with the exception that claims **will not** be allowed for the following telehealth services rendered to aligned beneficiaries located at their residence:

- Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or skilled nursing facilities (SNFs) - HCPCS codes G0406-G0408.
- Subsequent hospital care services, with the limitation of one telehealth visit every three days - CPT® codes 99231-99233.
- Subsequent nursing facility care services, with the limitation of one telehealth visit every 30 days - CPT® codes 99307-99310.
- Telehealth consultations, emergency department or initial inpatient - HCPCS codes G0425-G0427.
- Telehealth consultation, critical care, initial - HCPCS code G0508.
- Telehealth consultation, critical care, subsequent - HCPCS code G0509.
- Prolonged service in the inpatient or observation setting requiring unit/floor time beyond the usual service - CPT® codes 99356-99357.

MACs will be ready to process Part B CEC claims for dates of service on or after October 1, 2018. MACs will process CEC telehealth claims (place of service (POS) 02) when providers are ESCO providers and beneficiaries are aligned to the same ESCO for the date of service (DOS) on the claims and contains the demo code 85 and one of the following CPT® or HCPCS codes:

90785, 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90846, 90847, 90951, 90952, 90954, 90955, 90957, 90958, 90960, 90961, 90963, 90964, 90965, 90966, 90967, 90968, 90969, 90970, 96116, 96150, 96151, 96152, 96153, 96154, 96160, 96161, 97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99354, 99355, 99406, 99407, 99495, 99496, 99497, 99498, G0108, G0109, G0270, G0396, G0397, G0420, G0421, G0438, G0439, G0442, G0443, G0444, G0445, G0446, G0447, G0459, G0506, G9481, G9482, G9483, G9484, G9485, G9486, G9487, G9488, G9489

For Part A CEC claims when providers are ESCO providers and beneficiaries are aligned to the same ESCO for the date of service (DOS) on the claims submitted on type of bill (TOB) 12x, 13x, 22x, 23x, 71x, 72x, 76x, 77x, or 85x and contains the demo code 85 and one of the following CPT® or HCPCS codes:

90785, 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90846, 90847, 90951, 90952, 90954, 90955, 90957, 90958, 90960, 90961, 90963, 90964, 90965, 90966, 90967, 90968, 90969, 90970, 96116, 96150, 96151, 96152, 96153, 96154, 96160, 96161, 97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99354, 99355, 99406, 99407, 99495, 99496, 99497, 99498, G0108, G0109, G0270, G0396, G0397, G0420, G0421, G0438, G0439, G0442, G0443, G0444, G0445, G0446, G0447, G0459, G0506, G9481, G9482, G9483, G9484, G9485, G9486, G9487, G9488, G9489

MACs will not process as CEC telehealth claims that contain the following codes. Claims that contain these codes can be processed following existing claims processing logic:

- HCPCS codes G0406 – G0408.
- CPT® codes 99231 – 99233.
- CPT® codes 99307 – 99310.
- HCPCS codes G0425-G0427
- HCPCS code G0508

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- HCPCS code G0509
- CPT® codes 99356-99357

MACs will treat CEC payments the same as Medicare patients for cost reporting purposes.

Providers submitting electronic 837 claims should enter DEMO 85 in the REF segment 2300 loop demonstration project identifiers and providers will include qualifier P4. Providers submitting a paper claim should enter demo 85 in the treatment authorization field.

Providers should be aware that MACs will return claims if you append demo code 85, and:

- You are not on the CEC participant provider list with a telehealth record type; or
- DOS "from date" is prior to your telehealth effective date, or
- DOS "from date" is after your telehealth termination date, or
- The DOS "from date" is prior to the beneficiary's effective date; or
- The DOS "from date" is after the beneficiary's termination date, or
- The DOS "from date" is more than 90 days after the beneficiary's termination date; or
- The beneficiary was not aligned to the same ESCO with which you are participating, as identified by ESCO ID; or the claim is for Part A and the TOB is other than 12x, 13x, 22x, 23x, 71x, 72x, 76x, 77x, and 85x,
- Other, non-telehealth services are billed on the same claim. In these cases, none of the services on the claim are processed.

In returning Part B claims, your MAC will use the following messaging:

- Claims adjustment reason code (CARC) 16: (Claim/service lacks information or has submission/billing error(s) which is needed for adjudication) and
- Remittance advice remark code (RARC) N763 (The demonstration code is not appropriate for this claim; resubmit without a demonstration code.)
- Group code: CO (contractual obligation)

For Part A claims, your MAC will just return the claim to the provider (RTP).

Additional information

The official instruction, CR 10314, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R198DEMO.pdf*.

If you have questions, your MACs may have more information. Find their website at *https://go.cms.gov/MAC-website-list*.

Document history

Date of change	Description
June 28, 2018	The article was revised to reflect a revised CR 10314 issued June 27. In the article, the CR release date, transmittal number, and the web address of the CR are revised. All other information remains the same.
April 27, 2018	Initial article released.

MLN Matters® Number: MM10314 *Revised*
Related CR Release Date: June 27, 2018
Related CR Transmittal Number: R198DEMO
Related Change Request (CR) Number: 10314
Effective Date: October 1, 2018
Implementation October 1, 2018

Prompt payment interest rate revision

Medicare must pay interest on clean claims if payment is not made within the applicable number of calendar days after the date of receipt. The applicable number of days is also known as the payment ceiling.

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

The new rate of 3.500 percent is in effect through December 18, 2018.

Interest is not paid on:

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

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

New physician specialty code for undersea and hyperbaric medicine

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) 10666 informs you that the Centers for Medicare & Medicaid Services (CMS) has established a new physician specialty code for undersea and hyperbaric medicine. This new code is D4. Make sure your billing staffs are aware of these changes.

Background

Physicians self-designate their Medicare physician specialty on the Medicare enrollment application (CMS-855I or CMS-855O) or via the Internet-based Provider Enrollment, Chain and Ownership System (PECOS) when they enroll in the Medicare program. Medicare physician specialty codes describe the specific/unique types of medicine that physicians (and certain other suppliers) practice. Specialty codes are used by CMS for programmatic and claim processing purposes.

The CMS-855I and CMS-855O paper applications will be updated to reflect the new physician specialty in the future. In the interim, providers shall select the 'Undefined physician type' option on the enrollment application and specify Undersea and Hyperbaric Medicine in the space provided.

Existing enrolled providers who want to update their specialty to reflect the new specialty must submit a change of information application to their Medicare administrative contractor (MAC). Providers may submit an enrollment application to initially enroll or update their specialty within 60 days of the implementation date of the new specialty.

MACs will recognize undersea and hyperbaric medicine (D4) as a valid specialty type for the following edits:

- Ordering/referring
- Critical access hospital (CAH) method II attending and rendering
- Attending, operating, or other physician or non-physician practitioner listed on a CAH claim

Additional information

The official instructions, CR 10666, issued to your MAC are available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R306FM.pdf* and *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4087CP.pdf*.

If you have questions, your MACs may have more information. Find their website at *https://go.cms.gov/MAC-website-list*.

Document history

Date of change	Description
July 13, 2018	Initial article released.

MLN Matters® Number: MM10666
Related CR Release Date: July 13, 2018
Related CR Transmittal Number: R4087CP, R306FM
Related Change Request (CR) Number: 10666
Effective Date: January 1, 2019
Implementation January 7, 2019

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.

New Medicare beneficiary identifier (MBI) get it, use it

***Note**: This article was revised June 25 and July 11, 2018, to provide additional information regarding the ways your staff can get MBIs ("Provider action needed" section) and regarding the format of the MBI not using letters S, L, O, I, B, and Z ("Background" section). All other information remains the same. This information was previously published in the June 2018 Medicare A Connection, pages 3-5.*

Provider type affected

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

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) is mailing the new Medicare cards with the MBI in phases by *geographic location*. Here are three ways you and your office staff can get MBIs:

1. Ask your Medicare patients

Ask your Medicare patients for their new Medicare card when they come for care. If they haven't received a new card at the completion of their geographic mailing wave, give them the "Still Waiting for Your New Card?" handout (in *English* or *Spanish*) or refer them to 1-800-Medicare (1-800-633-4227).

2. Use the MAC's secure MBI look-up tool

Once we mail the new Medicare card with the MBI to your patient, you can look up MBIs for your Medicare patients when they don't or can't give them. If the tool indicates the card hasn't been mailed for your Medicare patient who lives in a geographic location where the card mailing is finished, tell your patient to call 1-800-Medicare (1-800-633-4227). *Sign up* for the portal to use the tool. You can use this tool even after the end of the transition period – it doesn't end December 31, 2019.

3. Check the remittance advice

Starting in October 2018 through the end of the transition period, we'll also return the MBI on every remittance advice when you submit claims with valid and active health insurance claim numbers (HICNs).

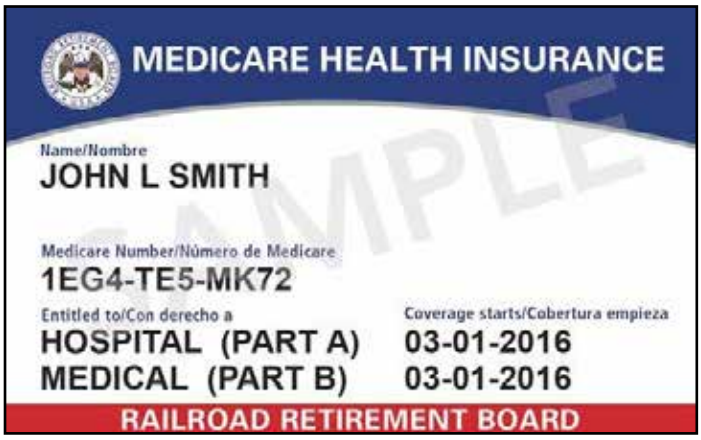
You can start using the MBIs even if the other health care providers and hospitals who also treat your patients haven't. When the transition period ends on December 31, 2019, you must use the MBI for most transactions.

Background

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS to remove Social Security Numbers from all Medicare cards by April 2019. A new, randomly generated Medicare beneficiary identifier, or MBI, is replacing the SSN-based HICN. The new MBI is noticeably different than the HICN. **Just like with the HICN, the MBI hyphens on the card are for illustration purposes: don't include the hyphens or spaces on transactions.** The MBI uses numbers 0-9 and all uppercase letters except for S, L, O, I, B, and Z. We exclude these letters to avoid confusion when differentiating some letters and numbers **(e.g., between "0" and "O").**

The Railroad Retirement Board (RRB) is also mailing new Medicare cards with the MBI. The RRB logo will be in the upper left corner and "Railroad Retirement Board" at the bottom, but you can't tell from looking at the MBI if your patients are eligible for Medicare because they're railroad retirees. You'll be able to identify them by the RRB logo on their card, and we'll return a Railroad retirement Medicare beneficiary message on the fee-for-service (FFS) MBI eligibility transaction response.

RRB issued Medicare card



Use the MBI the same way you use the HICN today. Put the MBI in the same field where you've always put the HICN. This also applies to reporting informational only and no-pay claims. **Don't use hyphens or spaces with the MBI to avoid rejection of your claim.** The MBI will replace the HICN on Medicare transactions including Billing, Eligibility Status, and Claim Status. The effective date of the MBI, like the old HICN, is the date each beneficiary was or is eligible for Medicare. Until December 31, 2019, you can use either the HICN or the MBI in the same field where you've always put the HICN. After that the remittance advice will tell you if we rejected claims because the MBI wasn't used. It will include claim adjustment reason code (CARC) 16, "Claim/service lacks information or has submission/billing error(s)." along with remittance advice remark code (RARC) N382 "Missing/ incomplete/invalid patient identifier".

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The beneficiary or their authorized representative can request an MBI change. CMS can also initiate a change to an MBI. An example is if the MBI is compromised. There are different scenarios for using the old or new MBIs:

FFS claims submissions with:

- Dates of service before the MBI change date – use the old or new MBI.
- Span-date claims with a "From Date" before the MBI change date – use the old or new MBI.
- Dates of service that are entirely on or after the effective date of the MBI change – use the new MBI.

FFS eligibility transactions when the:

- Inquiry uses new MBI – we'll return all eligibility data.
- Inquiry uses the old MBI and request date or date range overlap the active period for the old MBI – we'll return all eligibility data. We'll also return the old MBI termination date.
- Inquiry uses the old MBI and request date or date range are entirely on or after the effective date of the new MBI – we'll return an error code (AAA 72) of "invalid member ID."

When the MBI changes, we ask the beneficiary to share the new MBI with you. You can also get the MBI from your MACs secure MBI lookup tool.

Protect the MBI as personally identifiable information (PII); it is confidential like the HICN.

Submit all HICN-based claims by the end of the transition period, December 31, 2019. On January 1, 2020, even for dates of services before this date, you must use MBIs for all transactions; there are a few exceptions when you can use either the HICN or MBI:

- **Appeals** – You can use either the HICN or MBI for claim appeals and related forms.
- **Claim status query** – You can use HICNs or MBIs to check the status of a claim (276transactions) if the earliest date of service on the claim is before January 1, 2020. If you are checking the status of a claim with a date of service on or after January 1, 2020, you must use the MBI.
- **Span-date claims** – You can use the HICN or the MBI for 11x-inpatient hospital, 32x-home health (home health claims and request for anticipated payments [RAPs]) and 41x-religious non-medical health care institution claims if the "From Date" is before the end of the transition period (December 31, 2019). If a patient starts getting services in an inpatient hospital, home health, or religious non-medical health care institution before December 31, 2019, but stops getting those services after December 31, 2019, you may submit a claim using either the HICN or the MBI, even if you submit it after December 31, 2019. Since you submit home health claims for a 60-day payment episode, you can send in the episode's RAP with either the HICN or the MBI, but after the transition period ends on December 31, 2019, you have to use the MBI when you send in the final claim that goes with it.

The MBI does not change Medicare benefits. Medicare beneficiaries may start using their new Medicare cards and MBIs as soon as they get them. Use MBIs as soon as your patients share them. The new cards are effective the date beneficiaries are eligible for Medicare.

Medicare advantage and prescription drug plans continue to assign and use their own identifiers on their health insurance cards. For patients in these plans, continue to ask for and use the plans' health insurance cards.

Additional information

If you have questions, your MACs may have more information. Find their website at *https://go.cms.gov/MAC-website-list*.

The MBI format specifications, which provide more details on the construct of the MBI, are available at *https://www.cms.gov/Medicare/New-Medicare-Card/Understanding-the-MBI.pdf*.

A fact sheet discussing the transition to the MBI and the new cards is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TransitiontoNewMedicareNumbersandCards-909365.pdf*.

Document history

Date of change	Description
June 25, 2018	This article was revised to provide additional information regarding the ways your staff can get MBIs (*Provider action needed* section).
June 21, 2018	The article was revised to emphasize the need to submit the MBI without hyphens or spaces to avoid rejection of your claim. All other information remains the same.
May 25, 2018	Initial article released.

MLN Matters® Number: SE18006 *Revised*
Related CR Release Date: June 25, 2018
Related CR Transmittal Number: N/A
Related Change Request (CR) Number: N/A
Effective Date: N/A
Implementation N/A

Prohibition on billing dually eligible individuals enrolled in the QMB program

***Note**: This article was revised June 26, 2018, to clarify the description of the qualified Medicare beneficiary (QMB) program. It also adds that starting July 2018 the Medicare summary notice (MSN) is another way for providers to verify the QMB status of beneficiaries for Medicare fee-for-service (FFS) claims. All other information remains the same. This information was previously published in the March 2018 Medicare A Connection, pages 6-8.*

Provider type 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 the Medicare 270/271 HIPAA eligibility transaction system (HETS) (effective November 2017), CMS' eligibility-verification system, and the provider remittance advice (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 RA for FFS claims to verify QMB after claim processing. Work with your office staff and vendors to make sure your insurance verification and billing systems are ready to incorporate these QMB updates. 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 provides Medicaid coverage of Medicare Part A and Part B premiums and cost sharing to low income Medicare beneficiaries. QMB is an eligibility category under the Medicare savings programs. 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:

- Establish processes to routinely identify the QMB status of Medicare beneficiaries prior to billing for items and services. Use the Medicare 270/271 HETS data provided to Medicare providers, suppliers, and their authorized billing agents (including clearinghouses and third party vendors) (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, visit the *HETS* website.
    - In July 2018, CMS will reintroduce QMB information in the Medicare RA that original Medicare providers and suppliers can use

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  - 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.
  - Providers and suppliers may also verify beneficiaries' QMB status through automated Medicaid eligibility-verification systems in the state in which the person is a resident or by asking beneficiaries for other proof, such as their Medicaid identification card, MSN (starting July 2018) or other 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.
- 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, but may have 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 11, 2018, for Part B claims and by September 12, 2018, for Part A/durable medical equipment C 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/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*.

If you have questions, your MACs may have more information. Find their website at *https://go.cms.gov/MAC-website-list*.

Document history

Date of change	Description
June 26, 2018	This article was revised to clarify the description of the QMB program. It also adds that starting July 2018 the Medicare summary notice (MSN) is another way for providers to verify the QMB status of beneficiaries for Medicare fee-for-service (FFS) claims. All other information remains the same.

See **QMB**, page 19

QMB

from page 18

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 two 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 CR Release Date: June 26, 2018
Related CR Transmittal Number: N/A
Related Change Request (CR) Number: N/A
Effective Date: N/A
Implementation N/A

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.

Retired LCD

Non-emergency ground ambulance services – retired Part A and Part B LCD

LCD ID number: L33383 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for non-emergency ground ambulance services is being retired based on the development of the new LCD for emergency and non-emergency ground ambulance services (L37697).

Effective date

This LCD retirement is effective for services rendered **on or after June 28, 2018.** First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Revisions to LCDs

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

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

Based on a reconsideration request, the local coverage determination (LCD) for bisphosphonates (intravenous [IV]) and monoclonal antibodies in the treatment of osteoporosis and their other indications was updated to add the Food and Drug Administration (FDA) approved indication for the "treatment of glucocorticoid-induced osteoporosis in men and women at high risk of fracture who are either initiating or continuing systemic glucocorticoids in a daily dosage equivalent to 7.5 mg or greater of prednisone and expected to remain on glucocorticoids for at least six months" to the "FDA indications for Prolia®" section of the LCD. In addition, ICD-10-CM diagnosis code range T38.0X5A - T38.0X5S was added to the "ICD-10 Codes that Support Medical Necessity" section of the LCD under "Group 1 Codes:" for Healthcare Common Procedure Coding System (HCPCS) code J0897 (Prolia®). Also, the "Sources of Information" section of the LCD was updated.

Effective date

This LCD revision is effective for claims processed **on or after July 19, 2018**, for services rendered **on or after May 21, 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*.

Emergency and non-emergency ground ambulance services – revision to the Part A and Part B LCD

LCD ID number: L37697 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on change request (CR) 10550 (Ambulance Transportation for a Skilled Nursing Facility (SNF) Resident in a Stay Not Covered by Part A), the local coverage determination (LCD) for emergency and non-emergency ground ambulance services was revised to add the bulleted statement *"From a SNF to the nearest supplier of medically necessary services not available at the SNF where the beneficiary is a resident and not in a covered Part A stay, including the return trip;"* in "The Destination" section of the LCD.

Effective date

This LCD revision is effective for services rendered **on or after July 16, 2018.** LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

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

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

Based on an annual review of the local coverage determination (LCD) for hepatitis B surface antibody and surface antigen, it was determined that some of the italicized language in the "Coverage Indications, Limitations, and/or Medical Necessity" section of the LCD does not represent direct quotations from the Centers for Medicare & Medicaid Services (CMS) sources listed in the LCD; therefore, this LCD is being revised to assure consistency with the CMS sources.

Effective date

This LCD revision is effective for services rendered **on or after June 26, 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*.

High sensitivity c-reactive protein (hsCRP) – revision to the Part B LCD

LCD ID number: L33908 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on a local coverage determination (LCD) reconsideration request for high sensitivity c-reactive protein, the LCD was revised to add ICD-10-CM diagnosis codes Z74.09, Z78.9 and I25.10 and the asterisked explanation language, "*Use ICD-10-CM code Z74.09 and Z78.9 for patients at intermediate risk for CAD who do not have elevated lipids (i.e., do not meet criteria to use ICD-10-CM codes E78.00-E78.4)" to the "ICD-10 Codes that Support Medical Necessity" section of the LCD for *Current Procedural Terminology* (CPT®) code 86141. 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 July 10, 2018**. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Noncovered services – revision to the 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 the Centers for Medicare & Medicaid Services (CMS) approval of the investigational device exemption (IDE) study titled, "Hemodynamic-Guided Management of Heart Failure." The symbol "++" was added to *Current Procedural Terminology* (CPT®) code 93799 [unlisted cardiovascular service or procedure (CardioMEMS™) to indicate that this service is covered if the beneficiary is enrolled in an approved category B IDE study.

Effective date

This LCD revision is effective for claims processed **on or after July 3, 2018**, for services rendered **on or after February 23, 2018.** LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

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

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

Based on reconsideration requests of the transcranial magnetic stimulation for major depressive disorder local coverage determination (LCD), the "Sources of Information" section of the LCD was updated to add multiple published sources. The content of the LCD has not been changed in response to the reconsideration requests.

Effective date

This revision to the LCD is effective for services rendered **on or after June 26, 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*.

Treatment of varicose veins of the lower extremity – revision to the Part A and Part B LCD

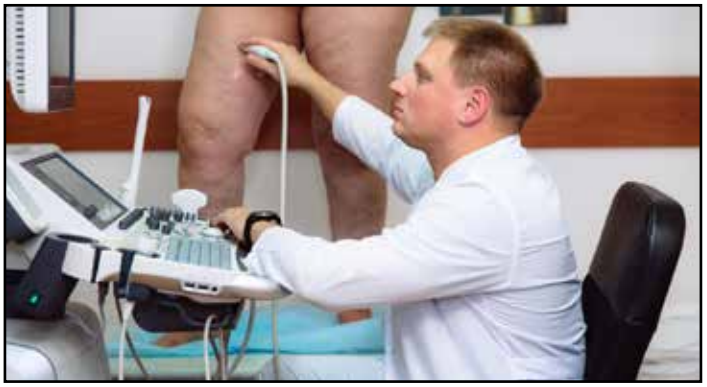
LCD ID number: L33762 (Florida, Puerto Rico/ U.S. Virgin Islands)

Due to a change in the scope of practice for nonphysician practitioners (NPPs), the treatment of varicose veins of the lower extremity local coverage determination (LCD) has been revised to remove the following language "Use of ultrasound for chronic venous disease (CVD) diagnosis or therapy guidance is not covered" from the "Training and qualifications" section of the LCD.

Effective date

This revision to the LCD is effective for claims processed **on or after July 10, 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*.

Additional Information

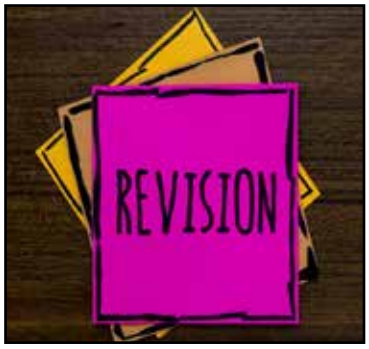
Gene expression profiling panel for use in the management of breast cancer treatment – revision to the Part A and Part B "coding guidelines" article

LCD ID number: L33586 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on an annual review of the gene expression profiling panel for use in the management of breast cancer treatment local coverage determination (LCD), it was determined that the italicized language in the "coding guidelines" article does not represent direct quotation from the Centers for Medicare & Medicaid Services (CMS) sources. Therefore, the "coding guidelines" article is being revised to assure consistency with the CMS manual language.

Effective date

This "coding guidelines" article revision is effective for services rendered **on or after June 26, 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*.

Laser trabeculoplasty – retired Part B "coding guidelines" article

LCD ID number: L33917 (Florida, Puerto Rico/ U.S. Virgin Islands)

The laser trabeculoplasty local coverage determination (LCD) "coding guidelines" article is being retired due to changes in the descriptor for *Current Procedural Terminology* (CPT®) code 65855, which removed the phrase "one or more sessions."

Effective date

The effective date of this "coding guidelines" article retirement is for claims processed **on or after June 26, 2018**, for services rendered **on or after January 1, 2016.** 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*.

Upcoming provider outreach and educational events

Topic: Home health referrals and clinical documentation requirements – A Part B and Home Health & Hospice MAC collaborative webinar

Date: Wednesday, August 15
Time: 2:00 -3:00 p.m.
Type of Event: Webcast

https://medicare.fcso.com/Events/0412160.asp

Topic: Medicare Part B changes and regulations

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

https://medicare.fcso.com/Events/0409582.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, *https://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® – Special Edition for June 25, 2018

New Medicare Card Mailing Update – Wave 3 Begins, Wave 1 Ends

We started mailing new Medicare cards to people with Medicare who live in Wave 3 states: Arkansas, Illinois, Indiana, Iowa, Kansas, Minnesota, Nebraska, North Dakota, Oklahoma, South Dakota and Wisconsin. We continue to mail new cards to people who live in Wave 2 states and territories (Alaska, American Samoa, California, Guam, Hawaii, Northern Mariana Islands, Oregon), as well as nationwide to people who are new to Medicare.

We finished mailing most cards to people with Medicare who live in Wave 1 states: Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, and West Virginia. If someone with Medicare says they did not get a card:

Print and give them the "Still Waiting for Your New Card?" handout (in *English* or *Spanish*).

- Or tell them to call 1-800-Medicare (1-800-633-4227). There might be something that needs to be corrected, such as updating their mailing address.

All Medicare Administrative Contractor (MAC) secure portal Medicare Beneficiary Identifier (MBI) look-up tools are ready for use. If you do not already have access, *sign up* for your MAC's portal to use the tool. Once we mail the new Medicare card with the MBI to your patient, you can look up MBIs for your Medicare patients when they do not or cannot give them. If the tool indicates the card has not been mailed for your Medicare patient who lives in a geographic location where the card mailing is finished, tell your patient to call 1-800-Medicare (1-800-633-4227).

To ensure people with Medicare continue to get health care services, continue to use the Health Insurance Claim Number (HICN) through December 31, 2019 or until your patient brings in their new card with the new number.

Check this *website* as the mailings progress. Continue to direct people with Medicare to *Medicare.gov/NewCard* for information about the mailings and to sign up to get email about the status of card mailings in their state.

We're committed to mailing new cards to all people with Medicare by April 2019.

Information on the transition to the new Medicare Beneficiary identifier:

- *New MBI Get It, Use It* MLN Matters® Article (Updated 6/25/18)
- *Transition to New Medicare Numbers and Cards* MLN Fact Sheet
- *New Medicare Card information* website

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.

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by modernizing payment policies so seniors and others covered by Medicare can take advantage of the latest technologies to get the quality care they need."

The proposals, part of the Physician Fee Schedule (PFS) and the Quality Payment Program (QPP), would also modernize Medicare payment policies to promote access to virtual care, saving Medicare beneficiaries time and money while improving their access to high-quality services no matter where they live. Such changes would establish Medicare payment for when beneficiaries connect with their doctor virtually using telecommunications technology (e.g., audio or video applications) to determine whether they need an in-person visit. Additionally, the QPP proposal would make changes to quality reporting requirements to focus on measures that most significantly impact health outcomes. The proposed changes would also encourage information sharing among health care providers electronically, so patients can see various medical professionals according to their needs while knowing that their updated medical records will follow them through the health care system. The QPP proposal would make important changes to the Merit-based Incentive Payment System (MIPS) "Promoting Interoperability" performance category to support greater EHR interoperability and patient access to their health information, as well as to align this clinician program with the proposed new "Promoting Interoperability" program for hospitals.

If these proposals were finalized, clinicians would see a significant increase in productivity – leading to substantially more and better care provided to their patients. Removing unnecessary paperwork requirements through the PFS proposal would save individual clinicians an estimated 51 hours per year if 40 percent of their patients are in Medicare. Changes in the QPP proposal would collectively save clinicians an estimated 29,305 hours and approximately $2.6 million in reduced administrative costs in CY 2019.

Proposed CY 2019 PFS Key Changes:

The PFS establishes payment for physicians and medical professionals treating Medicare patients. It is updated annually to make changes to payment policies, payment rates and quality-related provisions. Extensive public feedback the agency has received has highlighted a need to streamline documentation requirements for physician services known as Evaluation and Management (E&M) visits, as well as a need to support greater access to care using telecommunications technology. The proposed changes to the PFS would reinforce CMS' *Patients Over Paperwork* initiative focused on reducing administrative burden while improving care coordination, health outcomes, and patients' ability to make decisions about their own care.

Streamlining E&M Payment and Reducing Clinician Burden:

CMS and the Office of the National Coordinator for Health Information Technology have heard from stakeholders that CMS's extensive documentation requirements for E&M codes have resulted in unintended consequences. To meet these documentation requirements, providers have to create medical records that are a collection of predefined templates and boilerplate text for billing purposes, in many cases reflecting very little about the patients' actual medical care or story.

Responding to stakeholder concerns, several provisions in the proposed CY 2019 PFS would help to free EHRs to be powerful tools that would actually support efficient care while giving physicians more time to spend with their patients, especially those with complex needs, rather than on paperwork. Specifically, this proposal would:

Simplify, streamline and offer flexibility in documentation requirements for E&M office visits — which make up about 20 percent of allowed charges under the PFS and consume much of clinicians' time

Reduce unnecessary physician supervision of radiologist assistants for diagnostic tests

Remove burdensome and overly complex functional status reporting requirements for outpatient therapy

Advancing Virtual Care:

"CMS is committed to modernizing the Medicare program by leveraging technologies, such as audio/video applications or patient-facing health portals, that will help beneficiaries access high-quality services in a convenient manner," said Administrator Verma.

Getting to the doctor can be a challenge for some beneficiaries, whether they live in rural or urban areas. Innovative technology that enables remote services can expand access to care and create more opportunities for patients to access personalized care management as well as connect with their physicians quickly. Provisions in the proposed CY 2019 PFS would support access to care using telecommunications technology by:

Paying clinicians for virtual check-ins – brief, non-face-to-face appointments via communications technology

Paying clinicians for evaluation of patient-submitted photos

Expanding Medicare-covered telehealth services to include prolonged preventive services

Lowering Drug Costs:

President Trump is putting American patients first and lowering prescription drug costs, and CMS is committed to advancing this effort. CMS is proposing changes as part of the continued rollout of the Administration's blueprint to lower drug prices and reduce out-of-pocket costs. The changes would affect payment under Medicare Part B. Part B covers medicines that patients receive in a doctor's office, such as infusions. CMS is proposing a change in the payment amount for new drugs under Part B, so that the payment amount would more closely match the actual cost of the drug. This change would be effective January 1, 2019, and would reduce the amount that seniors would have to pay out-of-pocket, especially for drugs with high launch prices. This is one of many steps that CMS is

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taking to ensure that seniors have access to the drugs they need.

Proposed CY 2019 Quality Payment program Key Changes:

To implement the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), CMS established the QPP, which consists of two participation pathways for doctors and other clinicians – MIPS, which measures performance in four categories to determine an adjustment to Medicare payment, and Advanced Alternative Payment Models (Advanced APMs), in which clinicians may earn an incentive payment through sufficient participation in risk-based payment models. The proposed changes to QPP aim to reduce clinician burden, focus on outcomes, and promote interoperability of EHRs, including by:

Removing MIPS process-based quality measures that clinicians have said are low-value or low-priority, in order to focus on meaningful measures that have a greater impact on health outcomes

Overhauling the MIPS "Promoting Interoperability" performance category to support greater EHR interoperability and patient access to their health information, as well as to align this performance category for clinicians with the proposed new *Promoting Interoperability Program* for hospitals

Under the requirements of the Bipartisan Budget Act of 2018, CMS is continuing the gradual implementation of certain MIPS requirements to ease administrative burden on clinicians. The proposed changes to the QPP reflect feedback and input from clinicians and stakeholders, and we will continue to offer free and customized support from CMS's technical assistance networks.

Medicare Advantage Qualifying Payment Arrangement Incentive Demonstration:

Aligning with the agency's goals of improving quality of care and responding to the feedback we have received from clinicians, CMS also proposes waivers of MIPS requirements as part of testing a demonstration called the Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) demonstration. The MAQI demonstration would test waiving MIPS reporting requirements and payment adjustments for clinicians who participate sufficiently in Medicare Advantage (MA) arrangements that are similar to Advanced APMs.

Some MA plans are developing innovative arrangements that resemble Advanced APMs. However, without this demonstration, physicians are still subject to MIPS even if they participate extensively in Advanced APM-like arrangements under Medicare Advantage. The demonstration will look at whether waiving MIPS requirements would increase levels of participation in such MA payment arrangements and whether it would change how clinicians deliver care.

Price transparency: Request for information:

Finally, as part of its commitment to price transparency, CMS is seeking comment through a Request for Information asking whether providers and suppliers can and should be required to inform patients about charge and payment information for health care services and out-of-pocket costs, what data elements would be most useful to promote price shopping, and what other changes are needed to empower health care consumers.

Public comments on the proposed rules are due by September 10.

For More Information:

- *Proposed Rule*
- *Proposed Policy, Payment, and Quality Provisions Changes to the Medicare PFS for CY 2019 Fact Sheet*
- *Proposed Rule for the QPP Year 3 Fact Sheet*
- *MA Qualifying Payment Arrangement Incentive Demonstration Fact Sheet*

MLN Connects® for June 28, 2018

MLN Connects® for June 28, 2018

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News & Announcements

- New Medicare Card: Use MBI Like HICN
- CMS Data Element Library Supports Interoperability
- Physician Self-referral Law RFI: Submit Comments by August 24
- Qualified Medicare Beneficiary Information on RAs and MSNs
- Laboratory Date of Service Exception — Reminder
- Administrative Simplification Compliance Resources
- 2016 CMS Program Statistics
- Pride in Putting Patients First
- Health Care System Response to Mass Shootings

Provider Compliance

- Comprehensive Error Rate Testing: Arthroscopic Rotator Cuff Repair

Claims, Pricers & Codes

- New Part B Edit for Duplication of Diagnosis Codes on Hard Copy Claims

Upcoming Events

- Provider Compliance Focus Group — July 13

Medicare Learning Network Publications & Multimedia

- Medicare Billing for Cardiac Device Credits Fact Sheet — New
- MBI: Get It, Use It MLN Matters Article — Revised
- Medicare Coverage for Chiropractic Services MLN Matters Article — Revised
- ESRD PPS: Quarterly Update MLN Matters Article — Revised
- I/OCE Specification Version 19.2: July 2018 MLN Matters® Article — Revised
- Hospital OPPS: July 2018 Update MLN Matters® Article — Revised
- Telehealth Billing Requirements for Distant Site Services MLN Matters® Article — Revised
- MLN Learning Management System FAQs Booklet — Revised

MLN Connects® – Special Edition for July 2, 2018

CMS Takes Action to Modernize Medicare Home Health

On July 2, CMS proposed significant changes to the Home Health Prospective Payment System (PPS) to strengthen and modernize Medicare, drive value, and focus on individual patient needs rather than volume of care. Specifically, CMS is proposing changes to improve access to solutions via remote patient monitoring technology, and to update the payment model for home health care.

"Today's proposals would give doctors more time to spend with their patients, allow home health agencies to leverage innovation and drive better results for patients," said CMS Administrator Seema Verma. "The redesign of the home health payment system encourages value over volume and removes incentives to provide unnecessary care."

CMS's proposed changes promote innovation to modernize home health by allowing the cost of remote patient monitoring to be reported by home health agencies as allowable costs on the Medicare cost report form. This is expected to help foster the adoption of emerging technologies by home health agencies and result in more effective care planning, as data is shared among patients, their caregivers, and their providers. Supporting patients in sharing this data will advance the Administration's MyHealthEData initiative.

As required by the Bipartisan Budget Act of 2018, this proposed rule would also implement a new Patient-Driven Groupings Model (PDGM) for home health payments. The proposed rule also includes information on the implementation of home infusion therapy temporary transitional payments as required by the Bipartisan Budget Act of 2018. In addition, the proposed rule solicits comments on elements of the new home infusion therapy benefit category and proposes standards for home infusion therapy suppliers and accrediting organizations of these suppliers as required by the 21st Century Cures Act.

Physicians who order home health services for their patients would also see administrative burden reduced under this rule. CMS is proposing to eliminate the requirement that the certifying physician estimate how much longer skilled services would be needed when recertifying the need for continuing home health care, as this information is already gathered on a patient's plan of care.

The proposed rule helps advance the Trump Administration's Meaningful Measures Initiative. CMS is proposing changes to the Home Health Quality Reporting Program (HH QRP). The cost impact related to updated data collection processes as a result of the proposed implementation of the PDGM and proposed changes to the HH QRP are estimated to result in a net $60 million in annualized cost savings to Home Health Agencies (HHAs), or $5,150 in annualized cost savings per HHA, beginning in CY 2020.

See **CONNECTS**, page 30

MLN Connects® for July 5, 2018

MLN Connects® for July 5, 2018
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News & Announcements

- MIPS Payment Adjustment Targeted Review: Request by September 30
- Open Payments Program 2017 Financial Data
- Laboratory Date of Service Exception
- Qualified Medicare Beneficiary Information on RAs and MSNs

Provider Compliance

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

Claims, Pricers & Codes

- Rejected Claims for Medicare Diabetes Prevention Program Services
- ESRD Claims Error: Transitional Drug Adjustment Add-On Payment Adjustment

Upcoming Events

- CMS Data Element Library Webinar — July 11
- Public Reporting on Physician Compare Webinar — July 24 or 26

Medicare Learning Network Publications & Multimedia

- NCCI PTP Edits, Version 24.3: Quarterly Update MLN Matters Article — New
- Medicare Diabetes Prevention Program Call: Audio Recording and Transcript — New

- IMPACT Act Call: Audio Recording and Transcript — New
- Prohibition Billing Dually Eligible Individuals Enrolled in the QMB Program MLN Matters Article — Revised
- Global Surgical Days for CAH Method II MLN Matters Article — Revised
- HCPCS Drug/Biological Code Changes: July 2018 Quarterly Update MLN Matters Article — Revised
- Comprehensive ESRD Care Model Telehealth: Implementation MLN Matters Article — Revised
- ASC Payment System: July 2018 Update MLN Matters Article — Revised

CONNECTS

from page 29

In the proposed rule CMS is releasing a Request for Information to welcome continued feedback on the Medicare program and interoperability. CMS is gathering stakeholder feedback on revising the CMS patient health and safety standards that are required for providers and suppliers participating in the Medicare and Medicaid programs to further advance electronic exchange of information that supports safe, effective transitions of care between hospitals and community providers.

For More Information:

- *Proposed Rule*
- *Fact Sheet*
- *Home Health PPS website*
- *HHA Center website*
- *Home Health Value-Based Purchasing Model webpage*
- *Home Health Quality Reporting Requirements webpage*

See the full text of this excerpted *CMS Press Release* (issued July 2).

MLN Connects® – Special Edition for July 11, 2018

New CMS Proposals to Modernize and Drive Innovation in DME and ESRD Programs

Combined actions would increase access to durable medical equipment, reduce administrative burden, and encourage development of innovative therapies for beneficiaries on dialysis

On July 11, CMS proposed innovative changes to the payment rules for Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) and the End-Stage Renal Disease (ESRD) program. The DME proposals in the proposed rule aim to increase access to items for patients and simplify Medicare's DMEPOS Competitive Bidding Program (CBP) to drive competition and increase affordability. The rule also includes ESRD proposals, including a proposal to address new renal dialysis drug and biological costs and foster innovations in treatment by incentivizing new therapies for patients on dialysis and a proposal to reduce facility-related documentation burden.

"At CMS, we celebrate innovation in the health care system and encourage new therapies that will help save lives and lower costs for patients," said CMS Administrator Seema Verma. "Today's proposals will help secure sustainable access to durable medical equipment and reward dialysis facilities that adopt innovative new therapies."

The proposed rule takes key steps towards changing Medicare's DME fee schedule payments and the DMEPOS CBP. CMS sought ways to improve competitive bidding going forward and worked with market experts to leverage opportunities to increase the program's effectiveness. This rule proposes market-oriented reforms to the DMEPOS CBP. The process for recompeting contracts with suppliers currently in effect under the DMEPOS CBP has not yet been initiated. As a result, we note that the current contracts for the DMEPOS CBP will expire on December 31, 2018. Beginning January 1, 2019, and until new contracts are awarded under the DMEPOS CBP, beneficiaries may receive DMEPOS items from any Medicare enrolled DMEPOS supplier.

As required by the 21st Century Cures Act, this rule also includes proposals that address Medicare fee schedule payments for DME furnished on or after January 1, 2019, in areas of the country where competitive bidding is not in effect. The proposed rule also solicits stakeholder feedback on CMS' approach to establishing the fee

schedule amounts for new DME technologies. These improvements will modernize the Medicare DME program.

CMS is also taking steps to promote innovation in Medicare's ESRD prospective payment system by expanding the ESRD Transitional Drug Add-on Payment Adjustment to encourage the use of new drug therapies and the development and use of new treatments and therapies. We are proposing to make changes to Medicare's payment structure that will support access to new renal dialysis drugs and foster innovation in this critical area of heath care.

This proposed rule also takes significant steps forward by strengthening quality incentives and reducing administrative burden. Based on stakeholder feedback, CMS intends to reduce ESRD facility-related documentation burdens for certain payment adjustments so that requirements are more consistent with other payment systems. These changes will allow doctors to spend less time on paperwork and more time with their patients, which is in line with the CMS *Patients Over Paperwork* initiative. Also, CMS is proposing to update the measure set for the ESRD Quality Incentive Program so that it is more closely aligned with the quality priorities the agency has adopted as part of the Meaningful Measures Initiative.

For More Information:

- *Proposed Rule*
- *Fact Sheet*

See the full text of this excerpted *CMS Press Release* (issued July 11).

MLN Connects® for July 12, 2018

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News & Announcements

- New Medicare Card Reminder: Wave 1 Mailing Complete
- Qualified Medicare Beneficiary: Learn about State Medicaid Agency Requirements
- MIPS 2019 Payment Adjustment Fact Sheet
- Quality Payment Program: Obtaining Your EIDM Credentials
- IRF QRP Non-Compliance Letters: Request for Reconsideration by August 7
- LTCH QRP Non-Compliance Letters: Request for Reconsideration by August 7
- SNF QRP Non-Compliance Letters: Request for Reconsideration by August 7
- HQRP Non-Compliance Letters: Request for Reconsideration by August 7

Provider Compliance

- Proper Use of the KX Modifier for Part B Immunosuppressive Drug Claims — Reminder

Medicare Learning Network Publications & Multimedia

- HHA Star Ratings Call: Audio Recording and Transcript — New
- Ambulance Services Listening Session: Audio Recording and Transcript — New
- HCPCS Drug/Biological Code Changes: July 2018 Quarterly Update MLN Matters® Article — Revised
- Dual Eligible Beneficiaries under Medicare and Medicaid Booklet — Revised
- Medicare Vision Services Fact Sheet — Revised
- SNF Consolidated Billing Web-Based Training Course — Revised
- Looking for Educational Materials?

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MLN Connects® for July 19, 2018

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News & Announcements

- MIPS 2017 Performance Feedback User Guide
- MIPS Payment Adjustment Targeted Review: Request by October 1
- PEPPERs for Home Health Agencies, Partial Hospitalization Programs
- July Quarterly Provider Update

Provider Compliance

- Cardiac Device Credits: Medicare Billing

Upcoming Events

- CY 2018 eCQM Self-Directed Tools and Resources Webinar — July 24
- IMPACT Act and SPADE Special Open Door Forum — July 25
- Meeting the Behavioral Health Needs of the Dually Eligible Webinar — August 2
- ESRD Quality Incentive Program: CY 2019 ESRD PPS Proposed Rule Call — August 14
- CBR on Independent Diagnostic Testing Facilities Referring Providers Webinar — August 22

Medicare Learning Network Publications & Multimedia

- New MBI: Get It, Use It MLN Matters® Article — Revised
- Medical Review of E/M Documentation MLN Matters® Article — New
- New Physician Specialty Code for Undersea and Hyperbaric Medicine MLN Matters® Article — New
- Medicare Part A SNF PPS Pricer Update MLN Matters® Article — New
- Automating First Claim Review in Serial Claims for DMEPOS MLN Matters® Article — Revised
- Medicare Preventive Services Educational Tool — Revised
- Behavioral Health Integration Services Fact Sheet — Reminder
- Chronic Care Management Services: Changes for 2017 Fact Sheet — Reminder
- Chronic Care Management Services Fact Sheet — Reminder
- Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians Web-based Training — Reminder

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Medicare Part B Redetermination
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Jacksonville, FL 32232-5056

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ATTN: Administration Manager
PO Box 45300
Jacksonville, FL 32232-5300

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