Medicare B CONNECTION
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FIRST COAST SERVICE OPTIONS, INC.
A Newsletter for MAC Jurisdiction N Providers
May 2019

In this issue

International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs)

Provider type affected

This MLN Matters Article is for physicians, providers and suppliers billing Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider action needed

CR 11229 constitutes a maintenance update of International Classification of Diseases, 10th Revision (ICD-10) conversions and other coding updates specific to National Coverage Determinations (NCDs). These NCD coding changes are the result of newly available codes, coding revisions to NCDs released separately, or coding feedback received. Make sure your billing staffs are aware of these changes.

Background

Previous NCD coding changes appear in ICD-10 quarterly updates that are available at *https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html*, along with other CRs implementing new NCD policy.

Edits to ICD-10 and other coding updates specific to NCDs will be included in subsequent quarterly releases and individual CRs as appropriate. No policy-related changes are included with the ICD-10 quarterly updates. Any policy related changes to NCDs continue to be implemented via the current, long-standing NCD process. The translations from ICD-9 to ICD-10 are not consistent one-to-one matches, nor are all ICD10 codes appearing in a complete General Equivalence Mappings (GEMs) mapping guide, or other mapping guides appropriate when reviewed against individual NCD policies. In addition, for those policies that expressly allow MAC discretion, there may be changes to those NCDs based on current review of those NCDs against ICD-10 coding. For these reasons, there may be certain ICD-9 codes that were once considered appropriate prior to ICD-10 implementation that are no longer considered acceptable.

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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.

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CR 11229 makes changes to the following ICD-10 codes:

- NCD110.18 - Aprepitant
- NCD220.13 - Percutaneous Image-Guided Breast Biopsy
- NCD20.31 - Intensive Cardiac Rehabilitation (ICR) Programs
- NCD20.31.1 - ICR Pritkin Program
- NCD20.31.2 - ICR Ornish Program
- NCD20.31.3 - ICR Benson-Henry Program
- NCD150.3 - Bone (Mineral) Density Studies

Find the NCD spreadsheets included with this CR at *https://www.cms.gov/Medicare/Coverage/DeterminationProcess/downloads/CR11229.zip*

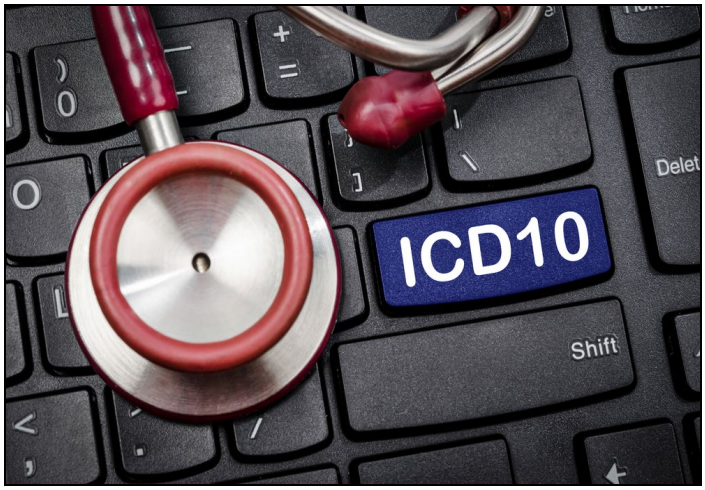
When denying claims associated with the above NCDs, except where otherwise indicated, MACs will use:

- Remittance Advice Remark Codes (RARC) N386 with Claim Adjustment Reason Code (CARC) 50, 96, and/or 119. See latest CAQH CORE update.
- Group Code PR (Patient Responsibility); assigning financial responsibility to the beneficiary (if a claim is received with occurrence code 32, or with occurrence code 32 and a GA modifier, indicating that a signed Advance Beneficiary Notice (ABN) is on file).
- Group Code CO (Contractual Obligation), assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).
- For modifier GZ, use CARC 50.

Note: MACs will adjust any claims processed in error associated with CR 11134 that are brought to their attention.

Additional information

The official instruction, CR11229, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2019Downloads/R2298OTN.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
May 7, 2019	Initial article released.

MLN Matters® Number: MM11229
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Related Change Request (CR) Number: 11229
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Where do I find...

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

Chiropractic Services

Medicare coverage for chiropractic services – medical record documentation requirements for initial and subsequent visits

***Note**. This article was revised on May 7, 2019, to update sources of information regarding chiropractic services with additional references added to the Additional Information section of this article. We deleted resource references that are no longer available. All other information remains the same. This information was previously published in the June 2018 Medicare B Connection, pages 7-10.*

Provider type affected

This MLN Matters® Special Edition article is for doctors of chiropractic and other practitioners who submit claims to Medicare Administrative Contractors (MACs) for chiropractic services provided to Medicare beneficiaries.

This article is part of a series of Special Edition (SE) articles that the Centers for Medicare & Medicaid Services (CMS) prepared for doctors of chiropractic due to the request for educational materials at the September 24, 2015, Special Open Door Forum titled: "Improving Documentation of Chiropractic Services" and includes updated information. Other articles in the series are SE1602, which details the use of the AT modifier on chiropractic claims and SE1603, which identifies other useful resources to help doctors of chiropractic bill Medicare correctly for covered services.

Provider action needed

CMS is providing this SE article to help clarify CMS policy about Medicare coverage of chiropractic services for Medicare beneficiaries and documentation requirements for the beneficiary's initial visit and subsequent visits to the doctor of chiropractic. Know these policies along with any Local Coverage Determinations (LCDs) for these services in your area that might limit circumstances under which Medicare pays for active/corrective chiropractic services.

Background

In 2018, the Comprehensive Error Testing Program (CERT) that measures improper payments in the Medicare Fee-For-Service (FFS) program reported a 41 percent error rate on claims for chiropractic services. Most of those errors were due to insufficient documentation or other documentation errors.

Medicare limits coverage of chiropractic services to treatment by means of manual manipulation (that is, by use of the hands) of the spine to correct a subluxation. The patient must require treatment by means of manual manipulation of the spine to correct a subluxation, and the manipulative services the doctor of chiropractic provides must have a direct therapeutic relationship to the patient's condition and provide reasonable expectation of recovery or improvement of function. The doctor of chiropractic may use manual devices (that is, those that are hand-held with the thrust of the force of the device being controlled manually) in performing manual manipulation of the spine. However, Medicare makes no additional payment for use of the device, nor does Medicare recognize an extra charge for the device itself.

Doctors of chiropractic are limited to billing three Current Procedural Terminology (CPT) codes under Medicare: 98940 (chiropractic manipulative treatment; spinal, one to two regions), 98941 (three to four regions), and 98942 (five regions).When submitting manipulation claims, doctors of chiropractic must use an Acute Treatment (AT) modifier to identify services that are active/corrective treatment of an acute or chronic subluxation. The AT modifier, when used appropriately, should indicate expectation of functional improvement, regardless of the chronic nature or redundancy of the problem.

Documentation requirements

The Social Security Act states that "no payment shall be made to any provider of services or other person under this part unless there has been furnished such information as may be necessary in order to determine the amounts due such provider or other person under this part for the period with respect to which the amounts are being paid or for any prior period." See the Social Security Act (*section 1833(e)*).

In addition, the Medicare Benefit Policy Manual requires that the initial visit and all subsequent visits meet specific documentation requirements. See Chapter 15 (*section 240.1.2*).

Documentation requirements for the initial visit

The following documentation requirements apply for initial visits whether the subluxation is demonstrated by X-ray or by physical examination:

1. **History:** The history the provider records in the patient record should include the following:
   - Chief complaint including the symptoms causing patient to seek treatment
   - Family history if relevant
   - Past medical history (general health, prior illness, injuries, hospitalizations, medications; surgical history)
2. **Present illness:** Description of the present illness including:
   - Mechanism of trauma

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- Quality and character of symptoms/problem
- Onset, duration, intensity, frequency, location, and radiation of symptoms
- Aggravating or relieving factors
- Prior interventions, treatments, medications, secondary complaints
- Symptoms causing patient to seek treatment

Note: Symptoms must be related to the level of the subluxation that the doctor of chiropractic cites. A statement on a claim that there is "pain" is insufficient. Describe the location of the pain and whether the vertebra you listed can produce pain in that area.

3. **Physical exam:** Evaluation of musculoskeletal/nervous system through physical examination. If you demonstrate a subluxation you based on physical examination, two of the following four criteria (one of which must be asymmetry/misalignment or range of motion abnormality) are required and you need to document the criteria:
   - **P - Pain/tenderness:** The perception of pain and tenderness is evaluated in terms of location, quality, and intensity. Most primary neuromusculoskeletal disorders manifest with a painful response. Pain and tenderness findings may be identified through one or more of the following: observation, percussion, palpation, provocation, and so forth. Furthermore, pain intensity may be assessed using one or more of the following; visual analog scales, algometers, pain questionnaires, and so forth.
   - **A - Asymmetry/misalignment:** Asymmetry/misalignment may be identified on a sectional or segmental level through one or more of the following: observation (such as posture and heat analysis), static palpation for misalignment of vertebral segments, and/or diagnostic imaging.
   - **R - Range of motion abnormality:** Changes in active, passive, and accessory joint movements may result in an increase or a decrease of sectional or segmental mobility. Range of motion abnormalities may be identified through one or more of the following: motion palpation, observation, stress diagnostic imaging, range of motion, and/or other measurement(s).
   - **T -Tissue tone, texture, and temperature abnormality:** Changes in the characteristics of contiguous and associated soft tissue including skin, fascia, muscle, and ligament may be identified through one or more of the following procedures: observation, palpation, use of instrumentation, and/or test of length and/or strength.

Note: The P.A.R.T. (Pain/tenderness; Asymmetry/misalignment; Range of motion abnormality; and Tissue tone, texture, and temperature abnormality) evaluation process is recommended as the examination alternative to the previously mandated demonstration of subluxation by x-ray/MRI/CT for services beginning January 1, 2000. The acronym P.A.R.T. identifies diagnostic criteria for spinal dysfunction (subluxation).

4. **Diagnosis**: The primary diagnosis must be subluxation, including the level of subluxation, either so stated or identified by a term descriptive of subluxation. Such terms may refer either to the condition of the spinal joint involved or to the direction of position assumed by the bone named. The precise level of the subluxation must be specified by the doctor of chiropractic to substantiate a claim for manipulation of the spine. This designation is made in relation to the part of the spine in which the subluxation is identified as shown in the following table:

Area of spine	Names of vertebrae	Number of vertebrae	Short form or other name	Subluxation ICD-10 code
Neck	Occiput Cervical Atlas Axis	7	Occ, CO C1-C7 C1 C2	M99.00 M99.01
Back	Dorsal or Thoracic Costovertebral Costotransverse	12	D1-D12 T1-T12 R1-R12 R1-R12	M99.02
Low Back	Lumbar	5	L1-L5	M99.03
Pelvis	Ilii, R and L (I, Si)		I, Si	M99.05
Sacral	Sacrum, Coccyx		S, SC	M99.04

In addition to the vertebrae and pelvic bones listed, the Ilii (R and L) are included with the sacrum as an area where a condition may occur which would be appropriate for chiropractic manipulative treatment.

There are two ways you may specify the level of the subluxation in the patient's record.

- List the exact bones, for example: C5, C6, etc.

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- The area may suffice if it implies only certain bones such as: occipito-atlantal (occiput and Cl (atlas)), lumbo-sacral (L5 and Sacrum) sacro-iliac (sacrum and ilium).

Following are some common examples of acceptable descriptive terms for the nature of the abnormalities:

- Off-centered
- Misalignment
- Malpositioning
- Spacing - abnormal, altered, decreased, increased
- Incomplete dislocation
- Rotation
- Listhesis - antero, postero, retro, lateral, spondylo
- Motion - limited, lost, restricted, flexion, extension, hypermobility, hypomobility, aberrant

You may use other terms. If they are understood clearly to refer to bone or joint space or position (or motion) changes of vertebral elements, they are acceptable.

X-rays

As of January 1, 2000, Medicare does not require an x-ray to demonstrate the subluxation. However, you may use an x-ray for this purpose if you so choose.

The date of the x-ray must be reasonably close to (within 12 months prior or 3 months following) the beginning of treatment. In certain cases of chronic subluxation (for example, scoliosis), an older x-ray may be accepted if the beneficiary's health record indicates the condition has existed longer than 12 months and there is a reasonable basis for concluding that the condition is permanent.

A previous CT scan and/or MRI are acceptable evidence if a subluxation of the spine is demonstrated.

5. **Treatment plan**: The treatment plan should include the following:
   - Recommended level of care (duration and frequency of visits)
   - Specific treatment goals
   - Objective measures to evaluate treatment effectiveness

Date of the initial treatment

The patient's medical record

- Validate all the information on the face of the claim, including the patient's reported diagnosis(s), physician work (CPT code), and modifiers.
- Verify that all Medicare benefit and medical necessity requirements were met.

Documentation requirements for subsequent visits

The following documentation requirements apply whether the subluxation is demonstrated by x-ray or by physical examination:

1. **History**
   a. Review of chief complaint
   b. Changes since last visit
   c. Systems review if relevant
2. **Physical examination**
   a. Examination of area of spine involved in diagnosis
   b. Assessment of change in patient condition since last visit
   c. Evaluation of treatment effectiveness
3. **Documentation of treatment given on day of visit.**

Necessity for treatment of acute and chronic subluxation

The patient must have a significant health problem in the form of a neuromusculoskeletal condition necessitating treatment, and the manipulative services rendered must have a direct therapeutic relationship to the patient's condition and provide reasonable expectation of recovery or improvement of function.

The patient must have a subluxation of the spine as demonstrated by x-ray or physical examination, as described above.

Most spinal joint problems fall into the following categories:

- **Acute subluxation**: A patient's condition is considered acute when the patient is being treated for a new injury, identified by x-ray or physical examination as specified above. The result of chiropractic manipulation is expected to be an improvement in, or arrest of progression, of the patient's condition.
- **Chronic subluxation**: A patient's condition is considered chronic when it is not expected to significantly improve or be resolved with further treatment (as is the case with an acute condition); however, the continued therapy can be expected to result in some functional improvement. Once the clinical status has remained stable for a given condition, without expectation of additional objective clinical improvements, further manipulative treatment is considered maintenance therapy and is not covered.

You must place the HCPCS modifier AT on a claim when providing active/corrective treatment to treat acute or chronic subluxation. However, the presence of the HCPCS modifier AT may not in all instances indicate that the service is reasonable and necessary.

As shown in the Medicare Benefit Policy Manual, Chapter 15, Section 240, the doctor of chiropractic should be afforded the opportunity to effect improvement or arrest or retard deterioration in such condition within a reasonable and generally predictable period of time. Acute subluxation (for example, strains or sprains) problems may require as

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many as three months of treatment but some require very little treatment. In the first several days treatment may be quite frequent but decreasing in frequency with time or as improvement is obtained.

Chronic spinal joint condition implies, of course, the condition has existed for a longer period of time and that, in all probability, the involved joints have already "set" and fibrotic tissue has developed. This condition may require a longer treatment time, but not with higher frequency.

ICD-10 codes that support medical necessity for chiropractic services

The chiropractic LCDs for MACs include ICD-10 Coding Information for ICD-10 Codes that support the medical necessity for chiropractic services. There may be additional documentation information in your LCD. There are links to the chiropractic LCDs in MLN Matters SE article *SE1603*.

The **Group 1 (primary) codes** are the only covered ICD-10-CM codes that support medical necessity for chiropractic services.

- Primary: ICD-10-CM codes (names of vertebrae)
- List the precise level of subluxation as the primary diagnosis.

The Groups 2, 3, and 4 ICD-10-CM codes support the medical necessity for diagnoses and involve short, moderate, and long-term treatment:

- **Group 2 codes**: Category I - ICD-10-CM Diagnosis (diagnoses that generally require **short term treatment**)
- **Group 3 codes**: Category II - ICD-10-CM Diagnosis (diagnoses that generally require **moderate term treatment**)
- **Group 4 codes**: Category III - ICD-10-CM diagnosis (diagnoses that may require **long term treatment**)

ICD-10 Codes that DO NOT Support Medical Necessity are **all** ICD-10-CM codes **not** listed in LCDs under *ICD-10-CM Codes That Support Medical Necessity*.

Additional information

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

A new Medicare Learning Network Educational Tool, Medicare Documentation Job Aid For Doctors of Chiropractic, is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/MLN1232664.html*.

The Medicare Benefit Policy Manual, Chapter 15, Section 240 is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf*.

The CERT 2018 Medicare Fee-For-Service Supplemental Improper Payment Data report is available at: *https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Downloads/2018MedicareFFSSuplementalImproperPaymentData.pdf*.

Article SE1101, Overview of Medicare Policy Regarding Chiropractic Services, is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1101.pdf*.

Article MM3449, Revised Requirements for Chiropractic Billing of Active/Corrective Treatment and Maintenance Therapy, Full Replacement of CR3063 is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm3449.pdf*.

Article SE0749, Addressing Misinformation Regarding Chiropractic Services and Medicare, is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE0749.pdf*.

Other articles in this series on chiropractic services include *SE1602, which is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/se1602.pdf*. SE1602 discusses the use of the AT modifier. Also, *SE1603 at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/se1603.pdf* lists a wide array of other materials to assist doctors of chiropractic in delivering covered services to Medicare beneficiaries and correctly billing for those services.

Document history

- May 7, 2019 – CMS revised this article to update sources of information regarding chiropractic services with additional references added to the Additional Information section of this article. We deleted resource references that are no longer available. All other information remains the same.
- June 18, 2018 – The article was revised to delete the word "always" from the line for item 5 (Treatment plan) under *Documentation requirements for the initial visit*. All other information remains the same.
- March 16, 2016 – Initial article released.

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Implementation Date: N/A

Use of the AT modifier for chiropractic billing (New Information Along with Information in MM3449)

Note. This article was revised on May 7, 2019, to update sources of information regarding chiropractic services with additional references added to the Additional Information section of this article. We deleted resource references that are no longer available. All other information remains the same. This information was previously published in the *March 2016 Medicare B Connection, pages 10-11*.

Provider types affected

This Special Edition (SE) MLN Matters® article is for chiropractors and other practitioners who submit claims to Medicare Administrative Contractors (MACs) for chiropractic services provided to Medicare beneficiaries.

This article is part of a series of Special Edition (SE) articles prepared for chiropractors by the Centers for Medicare & Medicaid Services (CMS) in response to the request for educational materials at the September 24, 2015, Special Open Door Forum titled: Improving Documentation of Chiropractic Services and includes updated information.

Provider action needed

The Active Treatment (AT) modifier was developed to clearly define the difference between active treatment and maintenance treatment. Medicare pays only for active/corrective treatment to correct acute or chronic subluxation. Medicare does not pay for maintenance therapy. Claims should include a primary diagnosis of subluxation and a secondary diagnosis that reflects the patient's neuromusculoskeletal condition. The patient's medical record should support the services you are billing. Related MLN Matters Article *SE1601* discusses those medical record documentation requirements.

Be aware of these policies along with any Local Coverage Determinations (LCDs) for chiropractic services in your area that might limit circumstances under which Medicare pays for active/corrective chiropractic services.

Background

In 2018, the Comprehensive Error Testing Program (CERT) that measures improper payments in the Medicare Fee-for-Service program reported a 41 percent error rate for chiropractic services. Most of those errors were due to insufficient documentation or documentation errors. Year after year these error rates appear. CMS is providing an explanation of the AT modifier to help providers document claims correctly for chiropractic services they provide to Medicare beneficiaries.

The AT modifier defines the difference between active treatment and maintenance treatment. Effective October 1, 2004, Medicare requires the AT Modifier on Medicare claims to receive reimbursement for CPT codes 98940-98942. For Medicare purposes, chiropractors should use the AT modifier only when billing for active/corrective treatment (acute and chronic care). The policy requires the following:

1. Every chiropractic claim for 98940/98941/98942, with a date of service on or after October 1, 2004, should include the AT modifier if active/corrective treatment is being performed
2. Do not use the AT modifier for maintenance therapy. MACs deny chiropractic claims for 98940, 98941, or 98942, with a date of service on or after October 1, 2004, that do not have the AT modifier.

The following categories help determine coverage of treatment. (See the *Necessity for Treatment*, Chapter 15, Section 240.1.3, of the Medicare Benefit Policy Manual (pages 226-227)) at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf*.

1. Acute subluxation: A patient's condition is considered acute when the patient is being treated for a new injury (identified by x-ray or physical examination). (See *SE1601* for details of the x-ray and examination requirements.) The result of chiropractic manipulation is expected to be **an improvement in, or arrest of progression of**, the patient's condition.

2. Chronic subluxation: A patient's condition is considered chronic when it is not expected to significantly improve or be resolved with further treatment (as is the case with an acute condition); however, the continued therapy can be expected to result in some **functional improvement**. Once the clinical status has remained stable for a given condition, without expectation of additional objective clinical improvements, further manipulative treatment is considered maintenance therapy and is not covered.

Medicare covers both these scenarios while there is active treatment which you document correctly and you expect the patient to improve. As stated in the Medicare Benefit Policy Manual, Chapter 15, Section 240, the doctor of chiropractic should be afforded the opportunity to effect improvement or arrest or retard deterioration in such condition within a reasonable and generally predictable period of time. Acute subluxation (for example, strains or sprains) problems may require as many as three months

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from page 10

of treatment but some require very little treatment. In the first several days, treatment may be quite frequent but decreasing in frequency with time or as improvement is obtained.

Chronic spinal joint condition implies, of course, the condition has existed for a longer period of time and that, in all probability, the involved joints have already "set" and fibrotic tissue has developed. This condition may require a longer treatment time, but not with higher frequency.

Maintenance: Maintenance therapy includes services that seek to prevent disease, promote health and prolong and enhance the quality of life, or maintain or prevent deterioration of a chronic condition. When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, Medicare considers the treatment is maintenance therapy. Do not use the AT modifier when you provided maintenance therapy.

Doctors of chiropractic should consider obtaining an Advance Beneficiary Notice (ABN) from beneficiaries in the event of a denial of a claim. Information about the ABN, including downloadable forms is available at *https://www.cms.gov/MEDICARE/medicare-general-information/bni/abn.html*. Also, see the Medicare Claims Processing Manual, *Chapter 23 section 20.9.1.1* pages 49 and 50, for important information about the use of an appropriate modifier on your claims with regard to the ABN.

Be aware that once the provider cannot determine there is any improvement, treatment becomes maintenance and Medicare no longer covers the treatment.

Key points

For Medicare purposes, a doctor of chiropractic must place an AT modifier on a claim when providing active/corrective treatment to treat acute or chronic subluxation. However, the presence of the AT modifier may not in all instances indicate that the service is reasonable and necessary. As always, MACs may deny the claim if a medical review determines that the medical record does not support active/corrective treatment.

Additional information

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

A new Medicare Learning Network Educational Tool, Medicare Documentation Job Aid For Doctors of Chiropractic, is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/MLN1232664.html*.

The Medicare Benefit Policy Manual, Chapter 15, Section 240 is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf*.

The CERT 2018 Medicare Fee-For-Service Supplemental Improper Payment Data report is available at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Downloads/2018MedicareFFSSuplementalImproperPaymentData.pdf*.

Article SE1101, Overview of Medicare Policy Regarding Chiropractic Services, is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1101.pdf*.

Article MM3449, Revised Requirements for Chiropractic Billing of Active/Corrective Treatment and Maintenance Therapy, Full Replacement of CR3063 is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm3449.pdf*.

Article SE0749, Addressing Misinformation Regarding Chiropractic Services and Medicare, is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE0749.pdf*.

Other articles in this series on chiropractic services include SE1601, which is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/se1601.pdf*. SE1601 discusses medical record documentation requirements for chiropractic services. Also, SE1603 at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/se1603.pdf* lists a wide array of other materials to assist doctors of chiropractic in delivering covered services to Medicare beneficiaries and correctly billing for those services

Document history

- May 7, 2019 – CMS revised this article to update sources of information regarding chiropractic services with additional references added to the Additional Information section of this article. We deleted resource references that are no longer available. All other information remains the same.
- March 16, 2016 – Initial article released

MLN Matters® Number: SE1602 *Revised*
Article Release Date: May 7, 2019
Related CR Transmittal Number: N/A
Related Change Request (CR) Number: N/A
Effective Date: NA
Implementation Date: N/A

Educational Resources to Assist Chiropractors with Medicare Billing

Note: *This article was revised on May 7, 2019, to update sources of information regarding chiropractic services with additional references added to the Additional Information section of this article. We deleted several resource references that are no longer available. All other information remains the same. This information was previously published in the April 2017 Medicare B Connection, pages 6-7.*

Provider Types Affected

This Special Edition (SE) MLN Matters® article is for chiropractors submitting claims to Medicare Administrative Contractors (MACs) for chiropractic services provided to Medicare beneficiaries.

This article is part of a series of SE articles prepared for Chiropractors by CMS in response to the request for educational materials at the September 24, 2015 Special Open Door Forum titled: Improving Documentation of Chiropractic Services and includes updated information.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) is providing this article to help chiropractic billers find the correct resources for proper billing. This article is a comprehensive resource for chiropractic documentation and billing.

Be aware of these policies along with any Local Coverage Determinations (LCDs) for these services in your area that might limit circumstances under which Medicare pays for active/corrective chiropractic services.

Background

In 2018, the Comprehensive Error Testing Program (CERT) that measures improper payments in the Medicare Fee-for-Service program reported a 41 percent error rate for Chiropractic services. Most of those errors were due to insufficient documentation or documentation errors. This article provides a detailed list of informational and educational resources that can help chiropractors avoid these errors. Those resources are as follows:

Enrollment information

The Medicare General Information, Eligibility, and Entitlement Manual, Chapter 5, includes *Section 70.6.* This section outlines the definition of a chiropractor, licensure and authorization to practice, and minimum standards.

The Medicare Benefit Policy Manual, Chapter 15, Covered Medical and Other Health Services, includes *Section 40.4*. This section explains that the opt out law does not define physician to include a chiropractor; therefore, a chiropractor may not opt out of Medicare and provide services under a private contract.

The Medicare Program Integrity Manual, Chapter 15 Medicare Enrollment, includes *Section 15.4.4.11*. This section explains that a physician must have legal authority

to practice medicine by the State in which he or she performs such services to enroll in the Medicare Program and to retain Medicare billing privileges. A chiropractor who meets Medicare qualifications may enroll in the Medicare Program.

Coverage, documentation, and billing

The other articles in this series on chiropractic services are *SE1601*, which discusses Medicare's medical record documentation requirements for chiropractic services, and *SE1602*, which discusses the importance of using the AT modifier on claims for chiropractic services.

MLN Matters Article *MM3449* discusses Revised Requirements for Chiropractic Billing of Active/Corrective Treatment and Maintenance Therapy, Full Replacement of CR3063.

The Medicare Benefit Policy Manual, *Chapter 15*, includes the following sections explaining coverage for a chiropractor's services:

- 30.5: Chiropractor's Services
- 240: Chiropractic Services – General; This section establishes that payment for chiropractic services is based on the Medicare Physician Fee Schedule (MPFS) and that Medicare pays the beneficiary or, on assignment, to the chiropractor r.
- 240.1.1: Manual Manipulation
- 240.1.2: Subluxation May Be Demonstrated by X-Ray or Physician's Exam
- 240.1.3: Necessity for Treatment
- 240.1.4: Location of Subluxation
- 240.1.5: Treatment Parameters

The chiropractic LCDs from MACs include ICD-10 Coding Information for ICD-10 Codes that support the medical necessity for chiropractor services. Each contractor has an LCD for chiropractors. There may be additional documentation information in your LCD. There are links to

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the chiropractic LCDs in the additional information section of this article. Some of those LCDs are as follows:

- National Government Services (LCD L33613)
- First Coast Options, Inc (LCD L36617)
- CGS Administrators, LLC (LCD L37254)
- Noridian Healthcare Solutions, LLC (Jurisdiction F) (LCD L34009)
- Noridian Healthcare Solutions, LLC (Jurisdiction E) (LCD L34242)
- Novitas Solutions, Inc (LCD L35424).

The MLN Matters® Article – SE (Special Edition) 1101 Revised *Overview of Medicare Policy Regarding Chiropractic Services* highlights Medicare policy regarding coverage of chiropractic services for Medicare beneficiaries.

The MLN Matters® Article – SE1305 Revised *Full Implementation of Edits on the Ordering/Referring Providers in Medicare Part B, DME, and Part A Home Health Agency (HHA) Claims (Change Requests 6417, 6421, 6696, and 6856)* explains that chiropractors are not eligible to order or refer supplies or services.

The Medicare Claims Processing Manual, *Chapter 1* General Billing Requirements includes the following sections which apply to billing for a chiropractor's services.

- 30.3.12: Carrier Annual Participation Program
- 30.3.12.1: Annual Open Participation Enrollment Process
- 30.3.12.1.2: Annual Medicare Physician Fee Schedule File Information
- 80.3.2.1.3: A/B MAC (B) Specific Requirements for Certain Specialties/Services.

The Medicare Claims Processing Manual, Chapter 12, Physicians/Nonphysician Practitioners, includes *Section 220*, Chiropractic Services. This section explains the documentation requirements when billing for a chiropractor's services. This section explains the claims processing edits related to payment for a chiropractor's services. The Medicare Claims Processing Manual, Chapter 26 Completing and Processing Form CMS-1500 Data Set, includes *Section 10.4* This section includes specific instructions for chiropractic services for items 14, 17, and 19.

Access the **NCCI Policy Manual for Medicare Services** at *https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Downloads/NCCI_Policy_Manual.zip*. Chapter XI, Medicine, Evaluation and Management Services (CPT Codes 90000-99999), includes information on chiropractic manipulative treatment.

The Medicare Claims Processing Manual, Chapter 23 Fee Schedule Administration and Coding Requirements, includes *Section 30*, Services Paid Under the Medicare Physician's Fee Schedule. This section explains that Medicare pays a chiropractor using the MPFS.

Advance beneficiary notice (ABN) information

The Medicare Benefit Policy Manual, Chapter 15 Covered Medical and Other Health Services, includes reference to ABNs in Section *240.1.3*.

The Medicare Claims Processing Manual, Chapter 23 - Fee Schedule Administration and Coding Requirements, includes *Section 20.9.1.1*. This section outlines the modifiers to use when a chiropractor notifies a beneficiary that Medicare may not cover the item or service.

The Medicare Claims Processing Manual, *Chapter 30* includes detailed instructions on completing the ABN and use of the GA modifier.

Information about the ABN, including downloadable forms is available at *https://www.cms.gov/MEDICARE/medicare-general-information/bni/abn.html*.

Additional information

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

A new Medicare Learning Network Educational Tool, Medicare Documentation Job Aid For Doctors of Chiropractic, is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/MLN1232664.html*.

The CERT 2018 Medicare Fee-For-Service Supplemental Improper Payment Data report is available at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Downloads/2018MedicareFFSSuplementalImproperPaymentData.pdf*.

You may also want to review the following:

- Article MM3449, Revised Requirements for Chiropractic Billing of Active/Corrective Treatment and Maintenance Therapy, Full Replacement of CR3063 is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm3449.pdf*.
- MLN Matters article SE0749 (Addressing Misinformation Regarding Chiropractic Services and Medicare) at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/se0749.pdf*
- MLN Matters article SE0416 (Referral of Patients for X-rays by Chiropractors) at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/se0416.pdf*
- MLN Matters article SE1305 (Full Implementation of Edits on the Ordering/Referring Providers in

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Medicare Part B, DME, and Part A Home Health Agency (HHA) Claims (Change Requests 6417, 6421, 6696, and 6856)) at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1305.pdf* that states "Chiropractors are not eligible to order or refer supplies or services for Medicare beneficiaries. All services ordered or referred by a chiropractor will be denied."

- The Chiropractic Services article in the April 2013 issue of the Medicare Quarterly Provider Compliance Newsletter at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedQtrlyComp-Newsletter-ICN908625.pdf*
- The Medicare Benefits Policy Manual, Chapter 13, Section 110.1 at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf* has information on chiropractic services in a rural health clinic or a federally qualified health center.

Document history

Date of change	Description
May 7, 2019	The article was revised to update sources of information regarding chiropractic services with additional references added to the Additional Information section of this article. We deleted several resource references that are no longer available.
April 7, 2017	The article was revised to correct a statement under the "Coverage, documentation and billing." That section included a reference to "220.1.3: Certification and Recertification of Need for Treatment and Therapy Plans of Care." However, chiropractic treatment is not included in that section.
June 21, 2016	The article was revised to add a reference and link to an educational video on Improving the Documentation of Chiropractic Services that gives a thorough presentation on medical necessity and proper documentation.
March 16, 2016	Initial article post

MLN Matters® Number: SE1603 *Revised*
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Medicare Physician Fee Schedule Database

Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - July 2019 Update

Provider type affected

This MLN Matters Article is for physicians, providers and suppliers billing Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider action needed

CR 11293 informs providers that the Centers for Medicare & Medicaid Services (CMS) has issued payment files to the MACs based upon the 2019 Medicare Physician Fee Schedule (MPFS) Final Rule. CR 11293 amends those payment files, to be effective for services furnished between January 1, 2019, and December 31, 2019. Be sure your billing staffs are aware of these updates.

Background

Below is a summary of the changes for the July update to the 2019 MPFSDB. Unless otherwise stated, these changes are effective for dates of service on and after January 1, 2019.

HCPCS Codes and Actions.

Code	Action
27369	Multiple Procedure indicator = 2, Bilateral Surgery = 1, Assistant Surgery = 1
28740	Bilateral Surgery indicator = 1

Revised MP RVU and HCPCS

The malpractice relative value unit (MP RVU) has been revised for numerous HCPCS codes. These MP RVU changes have minimal impact on payment. The complete list of the revised MP RVUs is a part of the CR, which is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2019Downloads/R4292CP.pdf*.

J and Q Code Changes

The MPFSDB file will reflect the changes below effective for dates of service July 1, 2019, and after. Other instructions convey the implementation of these "J" and "Q" code changes are being communicated via other instructions. The descriptors and more information are available at *https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update.html*.

Code	Action
J9031	Procedure Status = I
J9355	Short Descriptor = Inj trastuzumab excl biosimi

Code	Action
J1444	Procedure Status = E; there are no RVUs, payment policy indicators do not apply.
J7208	Procedure Status = E; there are no RVUs, payment policy indicators do not apply.
J7677	Procedure Status = E; there are no RVUs, payment policy indicators do not apply.
J9030	Procedure Status = E; there are no RVUs, payment policy indicators do not apply.
J9036	Procedure Status = E; there are no RVUs, payment policy indicators do not apply.
J9356	Procedure Status = E; there are no RVUs, payment policy indicators do not apply.
Q5112	Procedure Status = E; there are no RVUs, payment policy indicators do not apply.
Q5113	Procedure Status = E; there are no RVUs, payment policy indicators do not apply.
Q5114	Procedure Status = E; there are no RVUs, payment policy indicators do not apply.
Q5115	Procedure Status = E; there are no RVUs, payment policy indicators do not apply.

New CPT Codes

The new CPT codes listed below (0543T through 0562T, and 90619) are effective for dates of service July 1, 2019, and after. On the MPFSDB file, codes 0543T through

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0562T are all Procedure Status C and have no RVUs. The Global Days are YYY for 0543T through 0546T and 0548T through 0553T; XXX for 0547T, 0554T through 0559T, and 0561T; and ZZZ for 0560T and 0562T. Code 90619 is Procedure Status N; there are no RVUs and payment policy indicators do not apply.

Table: CPT Codes Effective for dates of service July 1, 2019, and After

Code	Short descriptor	Long descriptor
0543T	TA MV RPR W/ ARTIF CHORD TEND	Transapical mitral valve repair, including transthoracic echocardiography, when performed, with placement of artificial chordae tendineae
0544T	TCAT MV ANNULUS RCNSTJ	Transcatheter mitral valve annulus reconstruction, with implantation of adjustable annulus reconstruction device, percutaneous approach including transseptal puncture
0545T	TCAT TV ANNULUS RCNSTJ	Transcatheter tricuspid valve annulus reconstruction with implantation of adjustable annulus reconstruction device, percutaneous approach
0546T	RF SPECTRSC NTRAOP MRGN ASMT	Radiofrequency spectroscopy, real time, intraoperative margin assessment, at the time of partial mastectomy, with report
0547T	B1 MATRL QUAL TST MCRIND TIB	Bone-material quality testing by microindentation(s) of the tibia(s), with results reported as a score
0548T	TPRNL BALO CNTNC DEV BI	Transperineal periurethral balloon continence device; bilateral placement, including cystoscopy and fluoroscopy
0549T	TPRNL BALO CNTNC DEV UNI	Transperineal periurethral balloon continence device; unilateral placement, including cystoscopy and fluoroscopy
0550T	TPRNL BALO CNTNC DEV RMVL EA	Transperineal periurethral balloon continence device; removal, each balloon
0551T	TPRNL BALO CNTNC DEV ADJMT	Transperineal periurethral balloon continence device; adjustment of balloon(s) fluid volume
0552T	LOW-LEVEL LASER THERAPY	Low-level laser therapy, dynamic photonic and dynamic thermokinetic energies, provided by a physician or other qualified health care professional
0553T	PERQ TCAT ILIAC ANAST IMPLT	Percutaneous transcatheter placement of iliac arteriovenous anastomosis implant, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention
0554T	B1 STR & FX RSK ANALYSIS	Bone strength and fracture risk using finite element analysis of functional data, and bone-mineral density, utilizing data from a computed tomography scan; retrieval and transmission of the scan data, assessment of bone strength and fracture risk and bone mineral density, interpretation and report
0555T	B1 STR&FX RSK TRANSMIS DATA	Bone strength and fracture risk using finite element analysis of functional data, and bone-mineral density, utilizing data from a computed tomography scan; retrieval and transmission of the scan data

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Code	Short descriptor	Long descriptor
0556T	B1 STR & FX RSK ASSESSMENT	Bone strength and fracture risk using finite element analysis of functional data, and bone-mineral density, utilizing data from a computed tomography scan; assessment of bone strength and fracture risk and bone mineral density
0557T	B1 STR & FX RSK I&R	Bone strength and fracture risk using finite element analysis of functional data, and bone-mineral density, utilizing data from a computed tomography scan; interpretation and report
0558T	CT SCAN F/ BIOMCHN CT ALYS	Computed tomography scan taken for the purpose of biomechanical computed tomography analysis
0559T	ANTMC MDL 3D PRINT 1ST CMPNT	Anatomic model 3D-printed from image data set(s); first individually prepared and processed component of an anatomic structure
0560T	ANTMC MDL 3D PRINT EA ADDL	Anatomic model 3D-printed from image data set(s); each additional individually prepared and processed component of an anatomic structure (List separately in addition to code for primary procedure)
0561T	ANTMC GUIDE 3D PRINT 1ST GD	Anatomic guide 3D-printed and designed from image data set(s); first anatomic guide
0562T	ANTMC GUIDE 3D PRINT EA ADDL	Anatomic guide 3D-printed and designed from image data set(s); each additional anatomic guide (List separately in addition to code for primary procedure)
90619	MENACWY-TT VACCINE IM	Meningococcal conjugate vaccine, serogroups A, C, W, Y, quadrivalent, tetanus toxoid carrier (MenACWY-TT), for intramuscular use

Additional information

The official instruction, CR 11293, issued to your MAC regarding this change, is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2019Downloads/R4292CP.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
May 3, 2019	Initial article released.

MLN Matters® Number: MM11293
Related CR Release Date: May 3, 2019
Related CR Transmittal Number: R4292CP
Related Change Request (CR) Number: 11293
Effective Date: January 1, 2019
Implementation Date: July 1, 2019

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.

Your Feedback Matters

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

Revised LCD

E&M home and domiciliary visits – revision to the Part B LCD

LCD ID number: L33817 (Florida/Puerto Rico/ U.S. Virgin Islands)

Based on change request (CR) 10901, the local coverage determination (LCD) for E&M home and domiciliary visits was revised to remove all billing and coding and all language not related to reasonable and necessary provisions ("Bill Type Codes," "Revenue Codes," "CPT®/ HCPCS Codes," "Documentation Requirements," and "Utilization Guidelines" sections of the LCD) and place them into a newly created billing and coding article. Also, the LCD was revised to update internet-only manual (IOM) references in the "Centers for Medicare & Medicaid (CMS) National Coverage Policy" section of the LCD. Additionally, based on the Federal Register, November 23, 2018, (83 FR 59630) final rule, the " Coverage Indications, Limitations, and/or Medical Necessity" section of the LCD was revised to remove the requirement of furnishing a visit in the home rather than in the office.

Effective date

The revision related to the Federal Register is effective for claims processed **on or after April 16, 2019**, for services rendered **on or after January 1, 2019**.

The revision related to CR 10901 is effective for claims processed **on or after January 8, 2019**, for services rendered **on or after October 3, 2018.**

LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

A billing and 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*.

Retired LCD

Noncovered service – dopamine transporter single-photon emission computed tomography (DAT-SPECT) with iodine I-123 ioflupane – retired Part A and Part B LCD

LCD ID number: DL37804 (Florida/Puerto Rico/U.S. Virgin Islands)

The proposed local coverage determination (LCD) for noncovered service – dopamine transporter single-photon emission computed tomography (DAT-SPECT) with iodine I-123 ioflupane is being retired after review of extensive clinical literature provided during the comment period between May 17, 2018, and July 5, 2018. The contractor would like to thank those who submitted comments, and the contractor considers there is sufficient clinical literature in support of DAT-SPECT for its Food and Drug Administration (FDA) approved indication.

Effective date

The retirement of this proposed LCD is effective for services rendered **on or after May 2, 2019.**

LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Upcoming provider outreach and educational events

Medicare quarterly updates (Part B)

Date: Wednesday, June 12
Time: 11:00 a.m.-12:30 p.m.
Type of Event: Webcast

https://medicare.fcso.com/Events/0430194.asp

Medicare Speaks 2019 Tallahassee

Date: June 25-26
Time: 8:00 a.m.-4:30 p.m.
Type of Event: Face-to-face

https://medicare.fcso.com/Events/0434630.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 *First Coast University*, 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**.**

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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 April 23, 2019

CMS Proposes 5 Rules Affecting FY20 Payment & Quality Programs

- Proposed FY 2020 IPPS and LTCH PPS Address Rural Health & Medical Innovation
- IRF: FY 2020 Proposed Payment and Policy Changes
- IPF: FY 2020 Proposed Payment and Quality Reporting Updates
- SNF: FY 2020 Proposed Payment and Policy Changes
- Hospice: FY 2020 Proposed Payment Rate Update

Proposed FY 2020 IPPS and LTCH PPS Address Rural Health & Medical Innovation

On April 23, the Trump Administration proposed changes that build on the progress made over the last two years and further the agency's priority to transform the health care delivery system through competition and innovation while providing patients with better value and results. The proposed rule would update Medicare payment policies for hospitals under the Inpatient Prospective Payment System (IPPS) and the Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) for FY 2020 and advances two key CMS priorities, "Rethinking Rural Health" and "Unleashing Innovation," by proposing historic changes to the way Medicare pays hospitals.

"One in five Americans are living in rural areas and the hospitals that serve them are the backbone of our nation's health care system," said CMS Administrator Seema Verma. "Rural Americans face many obstacles as the result of our fragmented health care system, including living in communities with disproportionally higher poverty rates, more chronic conditions, and more uninsured or underinsured individuals. The Trump administration is committed to addressing inequities in health care, which is why we are proposing historic Medicare payment changes that will help bring stability to rural hospitals and improve patients' access to quality health care."

In last year's proposed rule, CMS invited comments on changes to the Medicare inpatient hospital wage index. Many responses reflected a common concern that the current wage index system makes the disparities between high and low wage index hospitals worse. To address these disparities, we are proposing to increase the wage index of low wage index hospitals. This change would ensure that people living in rural areas have access to high quality, affordable health care. We are considering several ways to implement this change, and the agency looks forward to comments on the different approaches.

We are also announcing proposals that would ensure Medicare beneficiaries have access to a world-class health care system by unleashing innovation in medical technology and removing potential barriers to innovation and competition in order to expedite access to novel medical technology.

"Transformative technologies are coming to the private market, but Medicare's antiquated payment systems have not contemplated these technologies," said CMS Administrator Seema Verma. "I am particularly concerned about cases that have been reported to the agency in which Medicare's inadequate payment has led hospitals to curtail access to needed therapies. We must continually update our policies in response to the rapid pace of advancement in medical science."

To ensure that Medicare payment supports broad access to transformative technologies, we are proposing several payment policy changes. These include proposing to increase the new technology add-on payment, which provides hospitals with additional payments for cases with high costs involving new technologies, including potentially new antimicrobial therapies. The increase would apply to all technologies receiving add-on payments starting on October 1, so that when a physician determines that a patient needs a qualifying new therapy, the hospital at which the therapy is administered would be able to more completely cover its costs. This change would promote patient access and reduce the uncertainty that innovators face regarding payment for new medical technologies for Medicare beneficiaries.

We are also proposing to modernize payment policies for medical devices that meet the Food and Drug Administration's (FDA's) Breakthrough Devices designation. For devices granted this expedited FDA approval, real-world data regarding outcomes for the devices in different patient populations is often limited. At the time of approval, it can be challenging for innovators to meet the requirement for evidence demonstrating "substantial clinical improvement" in order to qualify for new technology add-on payments.

Therefore, we are proposing to waive for two years the requirement for evidence that these devices represent

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a "substantial clinical improvement." Waiving this requirement would provide additional Medicare payment for the technologies for a period of time while real-world evidence is emerging, so Medicare beneficiaries do not have to wait for access to the latest innovations. In the proposed rule, we highlight the unique challenges associated with paying for CAR-T technology in particular, the first-ever gene therapy to treat certain forms of cancer for which no other treatment options exist.

For More Information:

- *Proposed Rule*
- *Fact Sheet*, includes proposed changes to payment rates and quality programs

See the full text of this excerpted *CMS Press Release* (issued April 23).

IRF: FY 2020 Proposed Payment and Policy Changes

On April 17, CMS proposed a rule that would update Medicare payment policies for facilities under the Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) and the Inpatient Rehabilitation Quality Reporting Program for FY 2020.We are proposing to update IRF PPS payment rates using the most recent data to reflect an estimated 2.5 percent increase factor (reflecting an IRF-specific market basket estimate of 3.0 percent increase factor, reduced by a 0.5 percentage point multifactor productivity adjustment). We are proposing that if more recent data becomes available, we would use the more recent estimates to determine the FY 2020 market basket update and multi-factor productivity adjustment in the final rule. Accounting for an additional update to the outlier threshold so that estimated outlier payments remain at 3.0 percent of total payments, we project that IRF payments will increase by 2.3 percent (or $195 million) for FY 2020, relative to payments in FY 2019.

The proposed rule also includes:

- Proposed case-mix group revisions (using FY 2017 and FY 2018 data)
- Proposal to rebase and revise the IRF market basket
- Ensuring quality and safety/interoperability

CMS will accept comments on the *proposed rule* until June 17. See the full text of this excerpted *CMS Fact Sheet* (issued April 18).

IPF: FY 2020 Proposed Payment and Quality Reporting Updates

On April 18, CMS proposed a rule that would update Medicare payment policies and rates for the Inpatient Psychiatric Facility (IPF) Prospective Payment System and the IPF Quality Reporting Program for FY 2020. We estimate total IPF payments to increase by 1.7 percent or $75 million in FY 2020. The IPF market basket update, which is used to update IPF payment rates, is 3.1 percent. After adjusting that 3.1 percent by two reductions required by law (the productivity adjustment of 0.5 percentage point and a 0.75 percentage point reduction), the net market basket update to IPF payment rates is 1.85 percent. Additionally, estimated payments to IPFs are reduced by 0.15 percentage point due to updating the threshold amount used in calculating outlier payments. For FY 2020, we are proposing to rebase and revise the IPF market basket to reflect a 2016 base year from a 2012 base year.

CMS will accept comments on the *proposed rule* until June 17. See the full text of this excerpted *CMS Fact Sheet* (issued April 18).

SNF: FY 2020 Proposed Payment and Policy Changes

On April 19, CMS issued a proposed rule for FY 2020 that updates the Medicare payment rates and the quality programs for Skilled Nursing Facilities (SNFs). Effective October 1, we will begin using a new case-mix model, the Patient Driven Payment Model (PDPM). The PDPM focuses on the patient's condition and resulting care needs, rather than on the amount of care provided, in order to determine Medicare payment.

We project that aggregate payments to SNFs will increase by $887 million, or 2.5 percent, for FY 2020 compared to FY 2019. We attribute this estimated increase to a 3.0 percent market basket increase factor with a 0.5 percentage point reduction for multifactor productivity adjustment.

The proposed rule also includes:

- Sub-regulatory process for ICD-10 code revisions for PDPM
- Aligning SNF PPS group therapy definitions with other post-acute care settings

CMS will accept comments on the *proposed rule* until June 18. See the full text of this excerpted *CMS Fact Sheet* (issued April 19).

Hospice: FY 2020 Proposed Payment Rate Update

On April 19, CMS issued a proposed rule that would update the hospice payment rates, wage index, and cap amount for FY 2020. This rule also:

- Proposes to rebase the continuous home care, general inpatient care, and inpatient respite care per diem payment rates in a budget-neutral manner
- Proposes to modify the election statement requirements to require the hospice to include additional information aimed at increasing coverage transparency for patients that elect hospice
- Solicits comments on the interaction of the hospice benefit and various alternative care delivery models

As proposed, hospice payment rates are updated by 2.7 percent ($540 million increase in their payments) for FY 2020. This is based on the proposed FY 2020 hospital market basket increase of 3.2 percent reduced by the multifactor productivity adjustment of 0.5 percentage point,

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MLN Connects® for Thursday, April 25, 2019

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News

- HHS To Deliver Value-Based Transformation in Primary Care
- New Part D Opioid Overutilization Policies: Myths and Facts
- Medicare Shared Savings Program: Do You Plan to Apply to be an ACO?
- Open Payments: Review and Dispute Data by May 15
- Proposed Rules on Interoperability: Comment Period Extended to June 3
- Quality Payment Program: MIPS 2019 Call for Measures/Activities Ends July 1
- SNF PPS Patient Driven Payment Model: Get Ready for Implementation on October 1
- Ensuring Safety and Quality in America's Nursing Homes

Compliance

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

Claims, Prices & Codes

- DMEPOS 2019 Fee Schedule File Revision

Events

- Vitamin D Testing: Comparative Billing Report Webinar — May 7
- Air Ambulance Transports: Comparative Billing Report Webinar — May 9
- Promising Practices for Duals with Substance Use Disorders Webinar— May 16

MLN Matters® Articles

- Appeals of Claims Decisions – Revisions
- New Waived Tests
- NCD: Next Generation Sequencing — Revised
- Implementation to eMDR for Registered Providers via the esMD System — Reissued

Publications

- 2019 MIPS Group Participation
- Provider Compliance Tips for Ordering Lower Limb Orthoses — Revised
- Provider Compliance Tips for Ordering Lower Limb Prostheses — Revised
- Provider Compliance Tips for Ostomy Supplies — Revised

MLN Connects® for Thursday, May 2, 2019

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- New Medicare Card: Transition Period Ends in 8 Months
- Addressing Social Determinants of Health Will Help Achieve Health Equity
- Clinical Diagnostic Laboratories: Resources about the Private Payor Rate-Based CLFS
- IRF, LTCH, and SNF Quality Reporting Programs: Submission Deadline May 15
- Medicare Promoting Interoperability Program: Submit a Measure Proposal by June 28
- Nursing Home Compare Refresh
- Save Lives: Clean Your Hands

Compliance

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

Events

- DMEPOS Competitive Bidding Webcast Series: Get Ready for Round 2021
- CMS Primary Cares Initiative: Direct Contracting Model Webcast — May 7
- Quality Payment Program: Advanced APMs Webinar — May 9
- CMS Primary Cares Initiative: Primary Care First Model Webcast — May 16

MLN Matters® Articles

- ESRD PPS: Quarterly Update

Publications

- Medicare Billing: CMS Form CMS-1450 and the 837 Institutional — Reminder
- Medicare Billing: CMS Form CMS-1500 and the 837 Professional — Reminder

Multimedia

- Opioid Video

MLN Connects® for Thursday, May 9, 2019

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News

- DMEPOS Competitive Bidding: Registration and Bid Window for Round 2021
- Comprehensive Strategy to Foster Innovation for Transformative Medical Technologies
- Recovery Audits: Improvements to Protect Taxpayer Dollars and Put Patients over Paperwork
- New Part D Opioid Overutilization Policies: Myths and Facts
- Open Payments: Review and Dispute Data by May 15
- SNF Provider Preview Reports: Review Your Data by May 30
- Medicare Shared Savings Program: Submit Notice of Intent to Apply Beginning June 11
- Promoting Interoperability Programs: Submit Comments on Proposed Changes by June 24
- Part D Prescriber PUF and Opioid Prescribing Mapping Tools Updated with 2017 Data
- Quality Payment Program Look Up Tool: Secure Access for APM Entities
- National Women's Health Week Kicks Off on Mother's Day

Compliance

- Laboratory Blood Counts: Provider Compliance Tips

Events

- DMEPOS Competitive Bidding: Round 2021 Webcast Series
- Medicare Documentation Requirement Lookup Service Special Open Door Forum — May 14

MLN Matters® Articles

- AMCC Lab Panel Claims Payment System Logic
- E/M Services of Teaching Physicians: Documentation
- FISS: Updates for Pricing Drugs Depending on Provider Type
- HH Patient-Driven Groupings Model Additional Manual Instructions
- IPPS-Excluded Hospitals: System Changes
- Medicare Physician Fee Schedule Database File Record Layout
- Clinical Laboratory Fee Schedule: Quarterly Update
- Medicare Physician Fee Schedule Database: Quarterly Update
- Typhoon Yutu and Medicare Disaster Related Commonwealth of the Northern Mariana Islands Claims — Revised
- Implementation of the SNF Patient Driven Payment Model — Revised

Publications

- AMCC Lab Panel Claims Payment System Logic
- E/M Services of Teaching Physicians: Documentation
- FISS: Updates for Pricing Drugs Depending on Provider Type
- HH Patient-Driven Groupings Model Additional Manual Instructions
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- Medicare Physician Fee Schedule Database: Quarterly Update
- Typhoon Yutu and Medicare Disaster Related Commonwealth of the Northern Mariana Islands Claims — Revised
- Implementation of the SNF Patient Driven Payment Model — Revised

Multimedia

- Medicare Billing: Form CMS-1500 and the 837 Professional Web-Based Training Course — Revised

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resulting in a proposed 2.7 percent increase in hospice payment rates for FY 2020. Hospices that fail to meet quality reporting requirements receive a 2 percentage point reduction to the annual market basket update for the year.

The hospice payment system includes a statutory aggregate cap. The aggregate cap limits the overall payments per patient made to a hospice annually. The proposed hospice cap amount for the FY 2020 cap year will be $29,993.99, which is equal to the FY 2019 cap amount ($29,205.44) updated by the proposed FY 2020 hospice payment update percentage of 2.7 percent.

CMS will accept comments on the *proposed rule* until June 18. See the full text of this excerpted *CMS Fact Sheet* (issued April 19)

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MLN Connects® for Thursday, May 16, 2019

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- New Medicare Card: Need an MBI for a Patient?
- Putting our Rural Health Strategy into Action
- Hospital Quality Reporting: 2020 QRDA I Implementation Guide, Schematron, and Sample File
- eCQM: Specifications and Materials for 2020 Reporting
- Promoting Interoperability Program: Hardship Exception Application
- Emergency Department Services: Comparative Billing Report in May
- Help Prevent Older Adult Falls: New Clinical Tools from the CDC
- Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier
- Talk to Your Patients about Mental Health

Compliance

- Improper Payment for Intensity-Modulated Radiation Therapy Planning Services

Events

- DMEPOS Competitive Bidding Webcast Series: Get Ready for Round 2021
- MIPS Improvement Activities Performance Category in 2019 Webinar — May 23
- Post-Acute Care QRPs: Reporting Requirements and Resources Call — June 5

MLN Matters® Articles

- International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs)
- Medicare Summary Notice (MSN) Changes to Assist Beneficiaries Enrolled in the Qualified Medicare Beneficiary (QMB) Program
- Educational Resources to Assist Chiropractors with Medicare Billing — Revised
- Medicare Coverage for Chiropractic Services – Medical Record Documentation Requirements for Initial and Subsequent Visits — Revised
- Use of the AT modifier for Chiropractic Billing (New Information Along with Information in MM3449) — Revised

Publications

- Medicare Part B Immunization Billing: Seasonal Influenza Virus, Pneumococcal, and Hepatitis B — Reminder

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