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Noridian Part B Customer Service Contact and Hours of Operation

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<th>Contact Method</th>
<th>Phone Number</th>
<th>Hours of Operation</th>
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<tr>
<td>Interactive Voice Response (IVR)</td>
<td>855-609-9960</td>
<td>General IVR inquiries available 24/7</td>
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<tr>
<td>Provider Contact Center (PCC)</td>
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<tr>
<td>Telephone Reopenings</td>
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<tr>
<td>Provider Enrollment</td>
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<tr>
<td>Electronic Data Interchange Support Services (EDISS)</td>
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<tr>
<td>User Security (including Endeavor)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Text Teletype Calls (TTY)</td>
<td>855-549-9874</td>
<td>Monday – Friday 8 a.m. – 5 p.m. PT</td>
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MLN Matters Disclaimer Statement

Below is the CMS Medicare Learning Network (MLN) Matters Disclaimer statement that applies to all MLN Matters articles in this bulletin.

“This article was prepared as a service to the public and is not intended to grant rights or impose obligations. MLN Matters articles may contain references or links to statutes, regulations or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.”

Sources for “Medicare B News” Articles

The purpose of “Medicare B News” is to educate the Noridian Medicare Part B provider community. The educational articles can be advice written by Noridian staff or directives from CMS. Whenever we publish material from CMS, we will do our best to retain the wording given to us; however, due to limited space in our bulletins, we will occasionally edit this material. Noridian includes “Source” following CMS derived articles to allow for those interested in the original material to research it at the CMS website, [http://www.cms.gov/manuals](http://www.cms.gov/manuals). The CMS Change Request (CR) and the date issued will be referenced within the “Source” portion of applicable articles.

CMS publishes a series of educational articles within their Medicare Learning Network (MLN), titled “MLN Matters.” These “MLN Matters” articles are also included in Noridian bulletins. The Medicare Learning Network is a brand name for official CMS national provider education products designed to promote national consistency of Medicare provider information developed for CMS initiatives.
Quarterly Provider Update from CMS

The Quarterly Provider Update is a comprehensive resource published by CMS on the first business day of each quarter. It is a listing of all non-regulatory changes to Medicare including Change Requests (CRs), manual changes and any other instructions that could affect providers. Regulations and instructions published in the previous quarter are also included in the Update.

The purpose of the Quarterly Provider Update is to:

- Inform providers about new developments in the Medicare program;
- Assist providers in understanding CMS programs and complying with Medicare regulations and instructions;
- Ensure that providers have time to react and prepare for new requirements;
- Announce new or changing Medicare requirements on a predictable schedule; and
- Communicate the specific days that CMS business will be published in the Federal Register.

Sign up for the Quarterly Provider Update listserv to receive notification when regulations and program instructions are added throughout the quarter, (electronic mailing list) at [http://www.cms.gov/About-CMS/Agency-Information/Aboutwebsite/EmailUpdates.html](http://www.cms.gov/About-CMS/Agency-Information/Aboutwebsite/EmailUpdates.html) Indicate that you wish to receive the CMS-QPU Listserv on the list of available publications.


Source: PM AB-03-075, CR 2686 dated May 23, 2003

Unsolicited or Voluntary Refunds Reminder

All Medicare providers need to be aware that the acceptance of a voluntary refund as repayment for the claims specified in no way affects or limits the rights of the Federal Government, or any of its agencies or agents, to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims.

Background

Medicare carriers and intermediaries and AB MACs receive unsolicited or voluntary refunds from providers. These voluntary refunds are not related to any open accounts receivable. Providers billing intermediaries typically make these refunds by submitting adjustment bills, but they occasionally submit refunds via check. Providers billing carriers usually send these voluntary refunds by check.

Related Change Request (CR) 3274 is intended mainly to provide a detailed set of instructions for Medicare carriers and intermediaries regarding the handling and reporting of such refunds. The implementation and effective dates of that CR apply to the carriers and intermediaries. But, the important message for providers is that the submission of such a refund related to Medicare claims in no way limits the rights of the Federal Government, or any of its agencies or agents, to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims.

Additional Information


Effective Date: January 1, 2005

Implementation Date: January 4, 2005

2018 JE Part B Quarterly Ask-the-Contractor Teleconferences

Below is the listing of the 2018 Part B Quarterly Ask-the-Contractor Teleconferences (ACTs).

- March 21, 2018 – Appeals/Adjudication
- July 18, 2018
- November 14, 2018

ACTs are designed to open communication between providers and Noridian, which allows for timely identification of problems, and sharing information in an informal and interactive question and answer (Q&A) format. No Personal Health Information (PHI) is allowed.

Noridian representatives from various Part B departments are available to address your Medicare questions and concerns. All questions are entertained and the Q&As are posted on our website for provider convenience.

To view ACT dates, times, toll-free number, and Q&As, go to https://med.noridianmedicare.com/web/jeb/education/act.

No registration is required for these calls. Please call in 10 minutes prior, all calls start promptly at the time designated in the schedule listing.

By completing and submitting the Noridian “Ask the Contractor Teleconference Question Submission Form,” providers may ask question(s), up to five (5) days prior, to be answered during the next ACT. Questions submitted with this form will be answered first. Lines will then be opened for additional questions, as time permits. Do not include any Personal Health Information (PHI) or claim specific inquiries on this form. If you have claim specific questions, contact the Provider Contact Center.

Providers will need to have Version 7 or higher of Adobe Reader to use this form.

We look forward to your participation in these important calls.

Medicare Part B ACTs do not address Medicare Part A or Durable Medical Equipment (DME) inquiries. If you are interested in attending a Part A or a DME ACT, select the appropriate link below for more information.

<table>
<thead>
<tr>
<th>ACT Type</th>
<th>Link</th>
</tr>
</thead>
<tbody>
<tr>
<td>JE Part A</td>
<td><a href="https://med.noridianmedicare.com/web/jea/education/act">https://med.noridianmedicare.com/web/jea/education/act</a></td>
</tr>
<tr>
<td>JD DME</td>
<td><a href="https://med.noridianmedicare.com/web/jddme/education/act">https://med.noridianmedicare.com/web/jddme/education/act</a></td>
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<tr>
<td>JA DME</td>
<td><a href="https://med.noridianmedicare.com/web/jadme/education/act">https://med.noridianmedicare.com/web/jadme/education/act</a></td>
</tr>
</tbody>
</table>

2018 Medicare Parts A & B Premiums and Deductibles Announced


Medicare Part B Premiums/Deductibles

Medicare Part B covers physician services, outpatient hospital services, certain home health services, durable medical equipment, and other items.

The standard monthly premium for Medicare Part B enrollees will be $134 for 2018, the same amount as in 2017. Some beneficiaries who were held harmless against Part B premium increases in prior years will have a Part B premium increase in 2018, but the premium increase will be offset by the increase in their Social Security benefits next year.

“Medicare’s top priority is to ensure that beneficiaries have choices for affordable, high-quality care that fit their needs,” said CMS Administrator Seema Verma. “Next year, no beneficiary protected by the hold-harmless provision will see a Part B premium increase that is greater than the increase in their Social Security benefits. We encourage Medicare beneficiaries to explore their options to make an informed choice between Original Medicare and Medicare Advantage before Open Enrollment ends on December 7.”
CMS recently released the benefit, premium, and Star Ratings information for Medicare health and drug plans which shows that there will be more health coverage choices, improved access to high-quality health choices, and decreased premiums in 2018. CMS estimates that the Medicare Advantage average monthly premium will decrease by $1.91 (about 6 percent) in 2018, from an average of $31.91 in 2017 to $30. More than three-fourths (77 percent) of Medicare Advantage enrollees remaining in their current plan will have the same or lower premium for 2018. The average basic premium for a Medicare prescription drug plan in 2018 is projected to decline to an estimated $33.50 per month. This represents a decrease of approximately $1.20 below the average basic premium of $34.70 in 2017. The Medicare prescription drug plan average basic premium is projected to decline for the first time since 2012.

CMS also announced that the annual deductible for all Medicare Part B beneficiaries will be $183 in 2018, the same annual deductible in 2017. Premiums and deductibles for Medicare Advantage and Medicare Prescription Drug plans are already finalized and are unaffected by this announcement.

Medicare Part A Premiums/Deductibles

Medicare Part A covers inpatient hospital, skilled nursing facility, and some home health care services. About 99 percent of Medicare beneficiaries do not have a Part A premium since they have at least 40 quarters of Medicare-covered employment.

The Medicare Part A annual inpatient hospital deductible that beneficiaries pay when admitted to the hospital will be $1,340 per benefit period in 2018, an increase of $24 from $1,316 in 2017.


Resource: CMS News: November 17, 2017

2018 Medicare Physician Fee Schedule Now Available

The 2018 Medicare Physician Fee Schedule (MPFS) has been published to the MPFS page under the Fees & News tab on the Noridian website and is posted in convenient Adobe PDF and Microsoft Excel formats.

Modifier 59/NCCI Education on Demand Tutorial Available

Noridian has posted a new Education on Demand Tutorial regarding Modifier 59 and the National Correct Coding Initiative (NCCI). This tutorial reviews how to locate and use the Procedure-to-Procedure (PTP) edits, modifier indicators, examples of the Correspondence Language Manual, and valid uses and examples of modifier 59.

To view this tutorial and others, see the Education on Demand Tutorials webpage.

MSP Payment Calculator Now Offers Enhanced Details

Do you want a better understanding of Medicare Secondary Payer (MSP) payments and what the payment amounts mean? Use the updated MSP Payment calculator to assist in determining the line by line claim payment for covered services when Medicare is the secondary payer.

The Medicare remittance advice and the primary payer Explanation of Benefits (EOB) will provide the numbers needed for the MSP calculator. The MSP calculator allows the user to enter claim line details and view the estimated MSP payment and patient responsibility. Using the “Calculate with Details” option provides the Medicare primary payment, the primary allowed amount and the primary allowed minus primary paid amount for the information entered.

View the Medicare Secondary Payer (MSP) page to use the MSP Payment Calculator and learn more about MSP payments.
MSP Top Denial and Call Driver - Education on Demand Tutorials Available

Medicare Secondary Payer (MSP) is routinely one of the top drivers of telephone inquiries as well as one of the top ten reasons claims are denied. Providers are encouraged to learn more about what is needed for successful claim processing and working with the beneficiary for reporting updates to the Benefit Coordination and Recovery Center (BCRC) contractor.

This includes compliance and provisions that result in a different company processing a claim prior to Medicare. There is also training on how Medicare arrives at the payment based on calculations including the primary insurance, Medicare fee schedule and related factors.

- Benefit Coordination and Recovery Center (BCRC) 7:59 minutes
- Compliance and Provisions 13:45 minutes
- MSP Calculations 12:59 minutes

Provides are encouraged to complete the tutorials and share this information with their team members. These and additional training topics are available in the Education & Outreach / Education on Demand Tutorials section of our website.

Observation and Inpatient E/M Common Denial Resolution Options

Receiving a denial for observation and inpatient evaluation and management (E/M) claim after another observation or inpatient E/M claim has been processed? A webpage has been created to offer providers options for such denied claims.

See the Observation and Inpatient (E/M) Common Denials and Resolutions webpage for a processing overview of related claims billed. To view options, locate the denied CPT code in bold, and review the options based on the previously processed code.

Qualified Medicare Beneficiary (QMB) Program Details Available

On October 2, 2017, Change Request (CR) 9911 modified the Medicare claims processing systems to help providers more readily identify the Qualified Medicare Beneficiary (QMB) status of each patient and to support providers’ ability to follow QMB billing requirements. The QMB Program was designed for low income dual eligible beneficiaries and a webpage has been created to assist providers with details and resources regarding the program.

View the Noridian Qualified Medicare Beneficiary (QMB) Program webpage for program details, what can be expected on a Remittance Advice (RA), and access resources.

Common Working File MSP Type for Liability Medicare Set-Aside Arrangements and No-Fault Medicare Set-Aside Arrangements - Rescinded

MLN Matters® Number: MM9893 Rescinded
Related Change Request (CR) #: CR 9893
Effective Date: October 1, 2017
Implementation Date: October 2, 2017
This article was rescinded.
Updated Editing of Always Therapy Services - MCS

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

This article was revised on December 21, 2017, to reflect an updated CR10176. The CR was revised to delete HCPCS code 97532 from the list of therapy codes in the attachment to the CR. That code is also removed from the list of those codes in this article. Also, in the article, the CR release date, transmittal, number and link to the transmittal changed. All other information is unchanged.

PROVIDER TYPE AFFECTED

This MLN Matters Article is intended for therapists, physicians, and certain other practitioners billing Medicare Administrative Contractors (MACs) for therapy services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

CR 10176 implements revised editing of Part B “Always Therapy” services to require the appropriate therapy modifier in order for the service to be accurately applied to the therapy cap. CR10176 contains no new policy. Instead, the guidelines presented in the CR improve the enforcement of longstanding, existing instructions. Make sure your billing staffs are aware of these revisions.

BACKGROUND

Services furnished under the Outpatient Therapy (OPT) services benefit – including Speech-Language Pathology (SLP), Occupational Therapy (OT), and Physical Therapy (PT) – are subject to the financial limitations, known as therapy caps, originally required under Section 4541 of the Balanced Budget Act (1997).

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

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

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

- Must always be furnished under an SLP, OT, or PT plan of care, regardless of who furnishes them; and, as such,

- Must always be accompanied by one of the GN, GO, or GP therapy modifiers.

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

<table>
<thead>
<tr>
<th>Code</th>
<th>CPT Short Descriptor</th>
<th>Therapy Modifier Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>92521</td>
<td>Evaluation of speech fluency</td>
<td>GN</td>
</tr>
<tr>
<td>92522</td>
<td>Evaluate speech production</td>
<td>GN</td>
</tr>
<tr>
<td>92523</td>
<td>Speech sound lang comprehend</td>
<td>GN</td>
</tr>
<tr>
<td>92524</td>
<td>Behavral quality analys voice</td>
<td>GN</td>
</tr>
<tr>
<td>92597</td>
<td>Oral speech device eval</td>
<td>GN</td>
</tr>
<tr>
<td>92607</td>
<td>Ex for speech device rx 1hr</td>
<td>GN</td>
</tr>
</tbody>
</table>
Table 2: Codes Requiring the “GO” Therapy Modifier

<table>
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<tr>
<th>Code</th>
<th>CPT Short Descriptor</th>
<th>Therapy Modifier Required</th>
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</thead>
<tbody>
<tr>
<td>97165</td>
<td>Ot eval low complex 30 min</td>
<td>GO</td>
</tr>
<tr>
<td>97166</td>
<td>Ot eval mod complex 45 min</td>
<td>GO</td>
</tr>
<tr>
<td>97167</td>
<td>Ot eval high complex 60 min</td>
<td>GO</td>
</tr>
<tr>
<td>97168</td>
<td>Ot re-eval est plan care</td>
<td>GO</td>
</tr>
</tbody>
</table>

Table 3: Codes Requiring the “GP” Therapy Modifier

<table>
<thead>
<tr>
<th>Code</th>
<th>CPT Short Descriptor</th>
<th>Therapy Modifier Required</th>
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<tr>
<td>97161</td>
<td>Pt eval low complex 20 min</td>
<td>GP</td>
</tr>
<tr>
<td>97162</td>
<td>Pt eval mod complex 30 min</td>
<td>GP</td>
</tr>
<tr>
<td>97163</td>
<td>Pt eval high complex 45 min</td>
<td>GP</td>
</tr>
<tr>
<td>97164</td>
<td>Pt re-eval est plan care</td>
<td>GP</td>
</tr>
</tbody>
</table>

The following “Always Therapy” HCPCS codes require a GN, GO, or GP modifier, as appropriate. Descriptors for these codes are included as an attachment to CR 10176.

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

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

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

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

These claims represent non-compliant billing by TPPs, physicians, and NPPs, and hamper CMS’ ability to properly track the therapy caps and analyze claims data for purposes of Medicare program improvements. The requirements in CR10176 will create new edits for Medicare professional claims processing systems to return claims when “always therapy” codes and the associated therapy modifiers are improperly reported.

Providers should expect the following:

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

ADDITIONAL INFORMATION

If you have any questions, please contact your MAC at their toll-free number. That number is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/.

**DOCUMENT HISTORY**

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<td>December 21, 2017</td>
<td>The article was revised to reflect an updated CR. The CR was revised to remove HCPCS code 97532 from the list of always therapy codes in the attachment to the CR. That code is also removed from the list of those codes in this article. Also, in the article, the CR release date, transmittal, number and link to the transmittal changed. All other information is unchanged.</td>
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<td>September 15, 2017</td>
<td>The article was revised to reflect an updated CR. In the article, the CR release date, transmittal, number and link to the transmittal changed. All other information is unchanged.</td>
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<td>July 31, 2017</td>
<td>Initial article released.</td>
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**Payment Reduction for X-Rays Taken Using Computed Radiography**

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

**PROVIDER TYPE AFFECTED**

This MLN Matters® Article is intended for physicians and other providers submitting claims to Medicare Administrative Contractors (MACs) for computed radiography services provided to Medicare beneficiaries.

**PROVIDER ACTION NEEDED**

This article is based on Change Request (CR) 10188 which announces that beginning January 1, 2018, and including Calendar Years (CY) 2018-CY 2022, a payment reduction of 7 percent applies to the technical component (and the technical component of the global fee) for computed radiography services that would otherwise be made under the Physician Fee Schedule (PFS) (without application of subparagraph (B)(i) and before application of any other adjustment), or under the hospital Outpatient Prospective Payment System (OPPS).

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

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

**BACKGROUND**

New paragraph 1848 (b)(9) of the Social Security Act (SSA) provides that payments for imaging services that are X-rays taken using computed radiography (including the technical component portion of a global service) furnished during Calendar Year (CY) 2018, 2019, 2020, 2021, or 2022, that would otherwise be made under the Medicare Physician Fee Schedule (MPFS) (without application of subparagraph (B)(i) and before application of any other adjustment), be reduced by 7 percent, and similarly, if such X-ray services are furnished during CY 2023 or a subsequent year, by 10 percent. Computed radiography technology is defined for purposes of this paragraph as cassette-based imaging which utilizes an imaging plate to create the image involved.
The statutory provision requires that information be provided and attested to by a supplier and a hospital outpatient department that indicates whether an applicable CR service was furnished, and that such information may be included on a claim and may be a modifier.

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

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

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

- Remittance Advice Remark Code (RARC) N794 - Payment adjusted based on type of technology used
- Claim Adjustment Reason Code (CARC) CARC 237 - Legislated/Regulatory Penalty
- Group Code - CO

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

ADDITIONAL INFORMATION


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<td>November 28, 2017</td>
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**Influenza Vaccine Payment Allowances - Annual Update for 2017-2018 Season – Revised**

MLN Matters Number: MM10224 Revised  
Related Change Request (CR) Number: CR 10224  
Related CR Release Date: November 3, 2017  
Effective Date: August 1, 2017  
Related CR Transmittal Number: R3908CP  
Implementation Date: No later than October 2, 2017

This article was revised on November 3, 2017 to reflect an updated Change Request (CR). That CR changed the instruction to the MACs for searching files- see note on page 3 below. The CR release date, transmittal number and link to the transmittal also changed. All other information is unchanged.

**PROVIDER TYPE AFFECTED**

This MLN Matters Article is intended for physicians and other providers submitting claims to Medicare Administrative Contractors (MACs) for influenza vaccines provided to Medicare beneficiaries.

**PROVIDER ACTION NEEDED**

CR 10224 informs MACs about the payment allowances for seasonal influenza virus vaccines, which are updated on August 1 of each year. The Centers for Medicare & Medicaid Services (CMS) will post the payment allowances for influenza vaccines that are approved after the release of CR10224 at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/MctPartBDrugAvgSalesPrice/VaccinesPricing.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/MctPartBDrugAvgSalesPrice/VaccinesPricing.html). Make sure your billing staffs are aware that the payment allowances are being updated.
BACKGROUND

The Medicare Part B payment allowance limits for influenza and pneumococcal vaccines are 95 percent of the Average Wholesale Price (AWP) as reflected in the published compendia except where the vaccine is furnished in a hospital outpatient department, Rural Health Clinic (RHC), or Federally Qualified Health Center (FQHC). Where the vaccine is furnished in the hospital outpatient department, RHC, or FQHC, payment for the vaccine is based on reasonable cost.

The Medicare Part B payment allowances for the following Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes below apply for the effective dates of August 1, 2017 - July 31, 2018:

- CPT 90653 Payment allowance is $50.217.
- CPT 90655 Payment allowance is pending.
- CPT 90656 Payment allowance is $19.247.
- CPT 90657 Payment allowance is pending.
- CPT 90661 Payment allowance is pending.
- CPT 90685 Payment allowance is $21.198.
- CPT 90686 Payment allowance is $19.032.
- CPT 90687 Payment allowance is $9.403.
- CPT 90688 Payment allowance is $17.835.
- HCPCS Q2035 Payment allowance is $17.685.
- HCPCS Q2036 Payment allowance is pending.
- HCPCS Q2037 Payment allowance is $17.685.
- HCPCS Q2038 Payment allowance is pending.

Payment for the following CPT or HCPCS codes may be made if your MAC determines its use is reasonable and necessary for the beneficiary, for the effective dates of August 1, 2017 - July 31, 2018:

- CPT 90630 Payment allowance is $20.343.
- CPT 90654 Payment allowance is pending.
- CPT 90662 Payment allowance is $49.025.
- CPT 90672 Payment allowance is pending.
- CPT 90673 Payment allowance is $40.613.
- CPT 90674 Payment allowance is $24.047.
- CPT 90682 Payment allowance is $46.313. (New code)
- CPT 90756 Payment allowance is $22.793. Effective dates: 1/1/2018-7/31/2018 (Note: Providers and Medicare Administrative Contractors shall use HCPCS Q2039 for dates of service from 8/1/2017 – 12/31/2017. See special note under HCPCS Q2039 for payment amounts for this product prior to 1/1/2018.)
- HCPCS Q2039 Flu Vaccine Adult - Not Otherwise Classified. Payment allowance is to be determined by your MAC with effective dates of 8/1/2017 - 7/31/2018.
- Special note: Until CPT code 90756 is implemented on 1/1/2018, Q2039 shall be used for products described by the following language: influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, antibiotic free, 0.5mL dosage, for intramuscular use. The payment allowance for these products, effective for dates of service 8/1/2017 - 12/31/2017 is $22.793.

CMS will post payment limits for influenza vaccines that are approved after the release date of CR10224 on the CMS Seasonal Influenza Vaccines Pricing webpage at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html as information becomes
available. Effective dates for these vaccines shall be the date of Food and Drug Administration (FDA) approval.

The payment allowances for pneumococcal vaccines are based on 95 percent of the AWP and are updated on a quarterly basis via the Quarterly Average Sales Price (ASP) Drug Pricing Files.

Providers should note that:

- All physicians, non-physician practitioners, and suppliers who administer the influenza virus vaccination and the pneumococcal vaccination must take assignment on the claim for the vaccine.
- The annual Part B deductible and coinsurance amounts do not apply.

Note: MACs will reprocess any previously processed and paid claims for the current flu season, that were paid using influenza vaccine payment allowances other than the allowances published in the influenza vaccine pricing website for the 2017/2018 season that began on August 1, 2017. MACs will initiate the mass adjustment process to reprocess claims by November 1, 2017. A MAC that requires more time to meet this deadline may contact their Contracting Officer’s Representative (COR) for additional direction.

ADDITIONAL INFORMATION


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<td>November 3, 2017</td>
<td>The article was revised to reflect an updated Change Request (CR). That CR changed the instruction to the MACs for searching files- see note on page 3 above. The CR release date, transmittal number and link to the transmittal also changed.</td>
</tr>
<tr>
<td>November 2, 2017</td>
<td>This article was revised to add a reference to MLN Matters Article SE17026 which reminds health care professionals that Medicare Part B reimburses health care providers for flu vaccines and their administration. (Medicare provides coverage of the flu vaccine without any out-of-pocket costs to the Medicare patient. No deductible or copayment/coinsurance applies.)</td>
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<tr>
<td>August 18, 2017</td>
<td>Initial article released.</td>
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ICD-10 and Other Coding Revisions to NCDs

MLN Matters Number: MM10318
Related Change Request (CR) Number: 10318
Related CR Release Date: November 9, 2017
Effective Date: April 1, 2018 - Unless otherwise noted in CR10318
Related CR Transmittal Number: R19750TN
Implementation Date: December 29, 2017 for local MAC edits; April 2, 2018 - for shared system edits (except FISS for NCDs (see below) 1, 8, 12, 19, 21); July 2, 2018 - FISS only for NCDs 1, 8, 12, 19, 21

PROVIDER TYPES AFFECTED

This MLN Matters® Article is intended for physicians and other providers submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

Change Request (CR) 10318 constitutes a maintenance update of the International Code of Diseases, Tenth Revision (ICD-10) conversions and other coding updates specific to National Coverage Determinations (NCDs). These NCD coding changes are the result of newly available codes, coding revisions to NCDs.
released separately, or coding feedback received. Please follow the link below for the NCD spreadsheets included with this CR: https://www.cms.gov/Medicare/Coverage/DeterminationProcess/downloads/CR10318.zip.

BACKGROUND

Previous NCD coding changes appear in ICD-10 quarterly updates available at https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html, along with other CRs implementing new policy NCDs. Edits to ICD-10 and other coding updates specific to NCDs will be included in subsequent quarterly releases and individual CRs as appropriate. No policy-related changes are included with the ICD-10 quarterly updates. Any policy-related changes to NCDs continue to be implemented via the current, long-standing NCD process.

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

NOTE: The translations from ICD-9 to ICD-10 are not consistent one-to-one matches, nor are all ICD-10 codes appearing in a complete General Equivalence Mappings (GEMs) mapping guide or other mapping guides appropriate when reviewed against individual NCD policies. In addition, for those policies that expressly allow MAC discretion, there may be changes to those NCDs based on current review of those NCDs against ICD-10 coding. For these reasons, there may be certain ICD-9 codes that were once considered appropriate prior to ICD-10 implementation that are no longer considered acceptable.

CR10318 makes coding and clarifying adjustments to the following NCDs:

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

When denying claims associated with the above NCDs, except where otherwise indicated, MACs will use.
• Remittance Advice Remark Codes (RARC) N386 with Claim Adjustment Reason Code (CARC) 50, 96, and/or 119.

• Group Code PR (Patient Responsibility) assigning financial responsibility to the beneficiary (if a claim is received with occurrence code 32, or with occurrence code 32 and a GA modifier, indicating a signed Advance Beneficiary Notice (ABN) is on file).

• Group Code CO (Contractual Obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

• For modifier GZ, use CARC 50

ADDITIONAL INFORMATION

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<td>November 16, 2017</td>
<td>Initial article released.</td>
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ASP Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files – January 2018

MLN Matters Number: MM10320
Related Change Request (CR) Number: 10320
Related CR Release Date: October 6, 2017
Effective Date: January 1, 2018
Related CR Transmittal Number: R3878CP
Implementation Date: January 2, 2018

PROVIDER TYPE AFFECTED
This MLN Matters Article is intended for physicians, providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs) for Medicare Part B drugs provided to Medicare beneficiaries.

WHAT YOU NEED TO KNOW
Change Request (CR) 10320 instructs MACs to download and implement the January 2018 and, if released, the revised October 2017, July 2017, April 2017, and January 2017, Average Sales Price (ASP) drug pricing files for Medicare Part B drugs via the Centers for Medicare & Medicaid Services (CMS) Data Center (CDC). Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after January 2, 2018, with dates of service January 1, 2018, through March 31, 2018. Make sure your billing staffs are aware of these changes.

BACKGROUND
The Average Sales Price (ASP) methodology is based on quarterly data that manufacturers submit to the CMS. CMS supplies the MACs with the ASP and Not Otherwise Classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the Outpatient Prospective Payment System (OPPS) are incorporated into the Outpatient Code Editor (OCE) through separate instructions that are in Chapter 4, Section 50 of the “Internet Only Manual” (IOM) which is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf.

• File: January 2018 ASP and ASP NOC --Effective for Dates of Service: January 1, 2018, through March 31, 2018

• File: October 2017 ASP and ASP NOC --Effective for Dates of Service: October 1, 2017, through December 31, 2017
For any drug or biological not listed in the ASP or NOC drug-pricing files, MACs will determine the payment allowance limits in accordance with the policy described in the “Medicare Claims Processing Manual,” Chapter 17, Section 20.1.3, which is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c17.pdf.

For any drug or biological not listed in the ASP or NOC drug-pricing files that is billed with the KD modifier, MACs will determine the payment allowance limits in accordance with instructions for pricing and payment changes for infusion drugs furnished through an item of Durable Medical Equipment (DME) on or after January 1, 2017, associated with the passage of the 21st Century Cures Act.

ADDITIONAL INFORMATION


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Summary of Policies in the Calendar Year (CY) 2018 Medicare Physician Fee Schedule (MPFS) Final Rule, Telehealth Originating Site Facility Fee Payment Amount and Telehealth Services List, and CT Modifier Reduction List

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

PROVIDER TYPES AFFECTED

This MLN Matters® Article is intended for physicians and other providers who submit claims to Medicare Administrative Contractors (MACs) for services paid under the Medicare Physician Fee Schedule (MPFS) and provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

Change Request (CR) 10393 provides a summary of policies in the Calendar Year (CY) 2018 MPFS Final Rule and announces the Telehealth Originating Site Facility Fee payment amount and makes other policy changes related to Medicare Part B payment. These changes are applicable to services furnished in CY 2018. Make sure your billing staffs are aware of these updates.

BACKGROUND

Section 1848(b)(1) of the Social Security Act (the Act) requires the Secretary of Health and Human Services to establish by regulation a fee schedule of payment amounts for physicians’ services for the subsequent year. The Centers for Medicare & Medicaid Services (CMS) issued a final rule on November 2, 2017, that updates payment policies and Medicare payment rates for services furnished by physicians and Non-Physician Practitioners (NPPs) that are paid under the MPFS in CY 2018. The final rule, CMS-1676-F, also addresses public comments on Medicare payment policies proposed earlier this year. The final rule,
“Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2018,” was published in the Federal Register on November 2, 2017. The key changes are as follows:

**Overall Payment Update and Misvalued Code Target**

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

After applying these adjustments and the budget neutrality adjustment to account for changes in Relative Resource Units (RVUs), all required by law, the final 2018 Physician Fee Schedule (PFS) conversion factor is $35.99, an increase to the 2017 PFS conversion factor of $35.89.

**Payment Rates for Non-excepted Off-Campus Provider-Based Hospital Departments Paid Under the MPFS**

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

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

**Telehealth originating site facility fee payment amount update**

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

**Medicare Telehealth Services**

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

- HCPCS code G0296 (visit to determine Low Dose Computed Tomography (LDCT) eligibility)
- CPT code 90785 (Interactive Complexity)
- CPT codes 96160 and 96161 (Health Risk Assessment)
- HCPCS code G0506 (Care Planning for Chronic Care Management)
- CPT codes 90839 and 90840 (Psychotherapy for Crisis)

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

In addition, CMS stated the following in the CY 2018 MPFS Final Rule (82 FR 53014):

- CMS is adopting CPT prefatory guidance that this code should be billed no more than once every 30 days.
- CMS is allowing CPT code 99091 to be billed once per patient during the same service period as chronic care management (CCM) (CPT codes 99487, 99489, and 99490), Transitional Care Management (TCM)
(CPT codes 99495 and 99496), and behavioral health integration (BHI) services (CPT codes 99492, 99493, 99494, and 99484).

- CMS is requiring that the practitioner obtain advance beneficiary consent for the service and document this in the patient’s medical record.
- For new patients or patients not seen by the billing practitioner within one year prior to billing CPT code 99091, CMS requires initiation of the service during a face-to-face visit with the billing practitioner, such as an Annual Wellness Visit or Initial Preventive Physical Exam, or other face-to-face visit with the billing practitioner.

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

**Care Management Services**

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

**Improvement of Payment Rates for Office-based Behavioral Health Services**

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

**Evaluation and Management Comment Solicitation**

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

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

**Prolonged Preventive Services**

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

**Payments for Imaging Services that are X-rays Taken Using Computed Radiography**

CMS is finalizing policy required by Section 1848(b)(9) of the Act, which requires payments for imaging services that are X-rays taken using computed radiography (including the technical component portion of a global service) furnished during CYs 2018-2022, that would otherwise be made under the MPFS (without application of subparagraph (B)(i) and before application of any other adjustment), be reduced by 7 percent.

**Solicitations on Burden Reduction**

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

CMS will retain the coding and valuation of cognitive therapy services through the creation of HCPCS code G0515 that will mirror CPT code 97532 deleted for CY 2018 instead of valuing CPT code 97127. CMS will assign status indicator “I” to CPT code 97127 to indicate that it is “Invalid” for Medicare purposes. HCPCS code G0515 has been added to the therapy code list, see CR 10303 for more information. MLN Matters article MM10303 discusses CR10303 and it is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm10303.pdf.

ADDITIONAL INFORMATION


DOCUMENT HISTORY

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<td>December 26, 2017</td>
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**Medicare Deductible, Coinsurance and Premium Rates – 2018 Update**

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

**PROVIDER TYPE AFFECTED**

This MLN Matters® Article is intended for physicians, providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs), including Home Health and Hospice MACs and Durable Medical Equipment MACs for services to Medicare beneficiaries.

**PROVIDER ACTION NEEDED**

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

**BACKGROUND**

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

Most individuals age 65 and older, and many disabled individuals under age 65, are insured for Health Insurance (HI) benefits without a premium payment. The Social Security Act provides that certain aged and disabled persons who are not insured may voluntarily enroll, but are subject to the payment of a monthly premium. Since 1994, voluntary enrollees may qualify for a reduced premium if they have 30 - 39 quarters of covered employment. When voluntary enrollment takes place more than 12 months after a person’s initial enrollment period, a 10 percent penalty is assessed for 2 years for every year they could have enrolled and failed to enroll in Part A.
Under Part B of the Supplementary Medical Insurance (SMI) program, all enrollees are subject to a monthly premium. Most SMI services are subject to an annual deductible and coinsurance (percent of costs that the enrollee must pay), which are set by statute. When Part B enrollment takes place more than 12 months after a person’s initial enrollment period, there is a permanent 10 percent increase in the premium for each year the beneficiary could have enrolled and failed to enroll.

### 2018 PART A HOSPITAL INSURANCE (HI)
- Deductible: $1,340.00
- Coinsurance
  - $335.00 a day for 61st - 90th day
  - $670.00 a day for 91st - 150th day (lifetime reserve days)
  - $167.50 a day for 21st - 100th day (Skilled Nursing Facility coinsurance)
- Base Premium (BP): $422.00 a month BP with 10 percent surcharge: $464.20 a month
- BP with 45 percent reduction: $232.00 a month (for those who have 30-39 quarters of coverage)
- BP with 45 percent reduction and 10 percent surcharge: $255.20 a month

### 2018 PART B - SUPPLEMENTARY MEDICAL INSURANCE (SMI)
- Standard Premium: $134.00 a month
- Deductible: $183.00 a year
- Pro Rata Data Amount:
  - $126.88 1st month
  - $56.12 2nd month
- Coinsurance: 20 percent

### ADDITIONAL INFORMATION

### DOCUMENT HISTORY

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### Prohibition on Billing Dually Eligible Individuals Enrolled in the QMB Program - Seventh Revision

**MLN Matter® Number: SE1128 Revised**
**Related Date of Revised Article: December 4, 2017**

Note: This article was revised to indicate that on December 8, 2017, CMS will suspend modifications to the Provider Remittance Advice and the Medicare Summary Notice for QMB claims made on 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.

**Provider Types Affected**
This article pertains to all Medicare physicians, providers and suppliers, including those serving beneficiaries enrolled in Original Medicare or a Medicare Advantage (MA) plan.
Provider Action Needed

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

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

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

Background

All Original Medicare and MA providers and suppliers—not only those that accept Medicaid—must refrain from charging individuals enrolled in the QMB program for Medicare cost-sharing. Providers who inappropriately bill individuals enrolled in QMB are subject to sanctions. Providers and suppliers may bill State Medicaid agencies for Medicare cost-sharing, but States can limit Medicare cost-sharing payments under certain circumstances.

Billing of QMBs Is Prohibited by Federal Law

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

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

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

Refer to the Important Reminders Concerning QMB Billing Requirements Section below for key policy clarifications.

Inappropriate Billing of QMB Individuals Persists

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

**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.
  - Beginning in November 2017, providers and suppliers can use Medicare eligibility data provided to Medicare providers, suppliers, and their authorized billing agents (including clearinghouses and third party vendors) by CMS’ HETS to verify a beneficiary’s QMB status and exemption from cost-sharing charges. For more information on HETS, visit https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/index.html.
  - In 2018, CMS will reintroduce QMB information in the Medicare RA that Original Medicare providers and suppliers can use to identify the QMB status of beneficiaries.
  - MA providers and suppliers should also contact the MA plan to learn the best way to identify the QMB status of plan members.
  - Providers and suppliers may also verify beneficiaries’ QMB status through State online Medicaid eligibility systems in the State in which the person is a resident or by asking beneficiaries for other proof, such as their Medicaid identification card or documentation of their QMB status. Ensure that billing procedures and third-party vendors exempt individuals enrolled in the QMB program from Medicare charges and that you remedy billing problems should they occur. If you have erroneously billed individuals enrolled in the QMB program, recall the charges (including referrals to collection agencies) and refund the invalid charges they paid.
  - 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:

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

<table>
<thead>
<tr>
<th>Program</th>
<th>Income Criteria*</th>
<th>Resources Criteria*</th>
<th>Medicare Part A and Part B Enrollment</th>
<th>Other Criteria</th>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>QMB Only</td>
<td>≤100% of Federal Poverty Line (FPL)</td>
<td>≤3 times SSI resource limit, adjusted annually in accordance with increases in Consumer Price Index</td>
<td>Part A***</td>
<td>Not Applicable</td>
<td>Medicaid pays for Part A (if any) and Part B premiums, and may pay for deductibles, coinsurance, and copayments for Medicare services furnished by Medicare providers to the extent consistent with the Medicaid State Plan (even if payment is not available under the State plan for these charges, QMBs are not liable for them)</td>
</tr>
<tr>
<td>QMB Plus</td>
<td>≤100% of FPL</td>
<td>Determined by State</td>
<td>Part A***</td>
<td>Meets financial and other criteria for full Medicaid benefits</td>
<td>Full Medicaid coverage Medicaid pays for Part A (if any) and Part B premiums, and may pay for deductibles, coinsurance, and copayments to the extent consistent with the Medicaid State Plan (even if payment is not available under the State plan for these charges, QMBs are not liable for them)</td>
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</table>

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

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

**Additional Information**

Accepting Payment from Patients with a Medicare Set-Aside Arrangement – Reissued

MLN Matters Number: SE17019 Reissued
Article Release Date: November 8, 2017

This article was reissued on November 8, 2017, to clarify information. The title of the article was also changed to better reflect the information.

PROVIDER TYPE AFFECTED

This MLN Matters® Article is intended for providers, physicians, and other suppliers who are told by patients that they must pay the bill themselves because they have a Medicare Set-Aside Arrangement (MSA).

WHAT YOU NEED TO KNOW

This article is based on information received from Medicare beneficiaries, their legal counsel, and other entities that assist these individuals, indicating that physicians, providers, and other suppliers are often
reluctant to accept payment directly from Medicare beneficiaries who state they have a MSA and must pay for their services themselves. This article explains what a MSA is and explains why it is appropriate to accept payment from a patient that has a funded MSA. Please review your billing practices to be sure they are in line with the information provided.

BACKGROUND

Medicare is always a secondary payer to liability insurance (including self-insurance), no-fault insurance, and workers’ compensation benefits. The law precludes Medicare payment for services to the extent that payment has been made, or can reasonably be expected to be made promptly. When future medical care is claimed, or a settlement, judgment, award, or other payment releases (or has the effect of releasing) claims for future medical care, it can reasonably be expected that the monies from the settlement, judgment, award, or other payment are available to pay for future medical items and services which are otherwise covered and reimbursable by Medicare.

Medicare should not be billed for future medical services until those funds are exhausted by payments to providers for services that would otherwise be covered and reimbursable by Medicare.

A MSA is a financial arrangement that allocates a portion of a settlement, judgment, award, or other payment to pay for future medical services. The law mandates protection of the Medicare trust funds but does not mandate a MSA as the vehicle used for that purpose. MSAs are the most frequently used formal method of preserving those funds for the Medicare beneficiary to pay for future items or services which are otherwise covered and reimbursable by Medicare and which are related to what was claimed or the settlement, judgment, award, or other payment had the effect of releasing. These funds must be exhausted before Medicare will pay for treatment related to the claimed injury, illness, or disease.

Medicare beneficiaries are advised that before receiving treatment for services to be paid by their MSA, they should advise their health care provider about the existence of the MSA. They are also notified that their health care providers should bill them directly, and that they should pay those charges out of the MSA if:

- The treatment or prescription is related to what was claimed or the settlement, judgment, award, or other payment had the effect of releasing AND
- The treatment or prescription is something Medicare would cover.

The obligation to protect the Medicare trust funds exists regardless of whether or not there is a formal CMS approved MSA amount. A Medicare beneficiary may or may not have documentation they can provide the physician, provider, or supplier from Medicare approving a Medicare Set-Aside amount.

PROVIDER ACTION NEEDED

Where a patient who is a Medicare beneficiary states that he/she is required to use funds from the settlement, judgment, award, or other payment to pay for the items or services related to what was claimed or which the settlement, judgment, award, or other payment, it is appropriate for you to document your records with that information and accept payment directly from the patient for such services.

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<td>November 8, 2017</td>
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<tr>
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<td>September 19, 2017</td>
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Radiopharmaceutical Fee Schedule 2017 Updates for A9604 and A9552

An incorrect price of $43,012.56 was published in the July 2017 updates for A9604, Samarium sm-153 Lexidronam (Quadramet). The correct pricing for 2017 is $14,337.50.

Upon reviewing the invoices submitted, pricing for A9552, Fluorodexy Glucose (FDG); F-18 NAF Fluorine-18, will remain at a reimbursement of $250.00 with the exception of Alaska and Hawaii. Pricing will be updated to reflect $400.00 in Alaska, and $551.50 in Hawaii as of October 1, 2017.

Radiopharmaceutical Fee Schedule 2018 Updates

Effective January 15, 2018, the codes below will be changed per the Radiopharmaceutical Fee Schedule.

Inactive National Drug Codes (NDCs):
- A9539
- A9572

Procedure Codes invoice pricing from established pricing:
- A9512
- A9516
- A9555

Procedure Codes Pricing Increase:
- A9507 - $835.24
- A9543 - $53,815.93
- A9558 - $39.52
- Q9982 - $3,960.00
- Q9983 - $3,360.00
Ambulance Inflation Factor and Productivity Adjustment for CY 2018

MLN Matters Number: MM10323
Related Change Request (CR) Number: CR 10323
Related CR Release Date: October 27, 2017
Effective Date: January 1, 2018
Related CR Transmittal Number: R3893CP
Implementation Date: January 2, 2018

PROVIDER TYPES AFFECTED
This MLN Matters® Article is intended for ambulance providers and suppliers submitting claims to Medicare Administrative Contractors (MACs) for Medicare Part B ambulance services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED
Change Request (CR) 10323 furnishes the Calendar Year (CY) 2018 Ambulance Inflation Factor (AIF) for determining the payment limit for ambulance services. The AIF for CY 2018 is 1.1 percent. Make sure that your billing staffs are aware of this change.

BACKGROUND
CR10323 furnishes the Calendar Year (CY) 2018 Ambulance Inflation Factor (AIF) for determining the payment limit for ambulance services required by Section 1834(l)(3)(B)) of the Social Security Act (the Act) which is available at https://www.ssa.gov/OP_Home/ssact/title18/1834.htm.

Section 1834(l)(3)(B) of the Act provides the basis for an update to the payment limits for ambulance services that is equal to the percentage increase in the Consumer Price Index for all Urban Consumers (CPI-U) for the 12-month period ending with June of the previous year. Section 3401 of the Affordable Care Act amended Section 1834(l)(3)(B) of the Act to apply a productivity adjustment to this update equal to the 10-year moving average of changes in economy-wide private nonfarm business Multi-Factor Productivity (MFP) beginning January 1, 2011. The resulting update percentage is referred to as the AIF.

The MFP for Calendar Year (CY) 2018 is 0.5 percent and the CPI-U for 2018 is 1.6 percent. According to the Affordable Care Act, the CPI-U is reduced by the MFP, even if this reduction results in a negative AIF update. Therefore, the AIF for CY 2018 is 1.1 percent. Part B coinsurance and deductible requirements apply to payments under the ambulance fee schedule.

ADDITIONAL INFORMATION

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QMB Indicator in the Medicare Fee-For-Service Claims Processing System – Third Revision

MLN Matters® Number: MM9911 Revised
Related Change Request (CR) #: CR 9911
Related CR Release Date: November 15, 2017
Effective Date: for claims processed on or after October 2, 2017
Related CR Transmittal #: R3920CP
Implementation Date: October 2, 2017

The article was revised on November 16, 2017, to reflect a revised CR9911 issued on November 15, 2017. In the article, the CR release date, transmittal number, and the Web address of CR9911 are revised. All other information remains the same.

Provider Types Affected
This MLN Matters® Article is intended for physicians, providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs), including Home Health & Hospice MACs and Durable Medical Equipment MACs, for services provided to Medicare beneficiaries.

Provider Action Needed
Change Request (CR) 9911 modifies the Medicare claims processing systems to help providers more readily identify the Qualified Medicare Beneficiary (QMB) status of each patient and to support providers’ ability to follow QMB billing requirements. Beneficiaries enrolled in the QMB program are not liable to pay Medicare cost-sharing for all Medicare A/B claims. CR 9911 adds an indicator of QMB status to Medicare’s claims processing systems. This system enhancement will trigger notifications to providers (through the Provider Remittance Advice) and to beneficiaries (through the Medicare Summary Notice) to reflect that the beneficiary is enrolled in the QMB program and has no Medicare cost-sharing liability. Make sure that your billing staffs are aware of these changes.

Background
QMB is a Medicaid program that assists low-income beneficiaries with Medicare premiums and cost-sharing. In 2015, 7.2 million persons (more than one out of every ten Medicare beneficiaries) were enrolled in the QMB program.

Federal law bars Medicare providers from billing a QMB individual for Medicare Part A and B deductibles, coinsurance, or copayments, under any circumstances. Sections 1902(n)(3)(B); 1902(n)(3)(C); 1905(p)(3); 1866(a)(1)(A); 1848(g)(3)(A) of the Social Security Act. State Medicaid programs may pay providers for Medicare deductibles, coinsurance, and copayments. However, as permitted by Federal law, states can limit provider payment for Medicare cost-sharing, under certain circumstances. Regardless, QMB individuals have no legal liability to pay Medicare providers for Medicare Part A or Part B cost-sharing. Providers may seek reimbursement for unpaid Medicare deductible and coinsurance amounts as a Medicare bad debt related to dual eligible beneficiaries under CMS Pub. 15-1, Chapter 3 of the “Provider Reimbursement Manual (PRM)“.

CR 9911 aims to support Medicare providers’ ability to meet these requirements by modifying the Medicare claims processing system to clearly identify the QMB status of all Medicare patients. Currently, neither the Medicare eligibility systems (the HIPAA Eligibility Transaction System (HETS)), nor the claims processing systems (the FFS Shared Systems), notify providers about their patient’s QMB status and lack of Medicare cost-sharing liability. Similarly, Medicare Summary Notices (MSNs) do not inform those enrolled in the QMB program that they do not owe Medicare cost-sharing for covered medical items and services.

CR 9911 includes modifications to the FFS claims processing systems and the “Medicare Claims Processing Manual” to generate notifications to Medicare providers and beneficiaries regarding beneficiary QMB status and lack of liability for cost-sharing.

With the implementation of CR 9911, Medicare’s Common Working File (CWF) will obtain QMB indicators so the claims processing systems will have access to this information.
• CWF will provide the claims processing systems the QMB indicators if the dates of service coincide with a QMB coverage period (one of the occurrences) for the following claim types: Part B professional claims; Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) claims; and outpatient institutional Types of Bill (TOB) 012x, 013x, 014x, 022x, 023x, 034x, 071x, 072x, 074x, 075x, 076x, 077x, and 085x); home health claims (TOB 032x); and Skilled Nursing Facility (SNF) claims (based on occurrence code 50 date for revenue code 0022 lines on TOBs 018x and 021x).

• CWF will provide the claims processing systems the QMB indicator if the “through date” falls within a QMB coverage period (one of the occurrences) for inpatient hospital claims (TOB 011x) and religious non-medical health care institution claims (TOB 041x).

The QMB indicators will initiate new messages on the Remittance Advice that reflect the beneficiary’s QMB status and lack of liability for Medicare cost-sharing with three new Remittance Advice Remark Codes (RARC) that are specific to those enrolled in QMB. As appropriate, one or more of the following new codes will be returned:

• N781 – No deductible may be collected as patient is a Medicaid/Qualified Medicare Beneficiary. Review your records for any wrongfully collected coinsurance, deductible or co-payments.

• N782 – No coinsurance may be collected as patient is a Medicaid/Qualified Medicare Beneficiary. Review your records for any wrongfully collected coinsurance, deductible or co-payments.

• N783 – No co-payment may be collected as patient is a Medicaid/Qualified Medicare Beneficiary. Review your records for any wrongfully collected coinsurance, deductible or co-payments.

In addition, the MACs will include a Claim Adjustment Reason Code of 209 (“Per regulatory or other agreement. The provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to patient if collected. (Use only with Group code OA (Other Adjustment)).

Finally, CR 9911 will modify the MSN to inform beneficiaries if they are enrolled in QMB and cannot be billed for Medicare cost-sharing for covered items and services.

Additional Information


For more information regarding billing rules applicable to individuals enrolled in the QMB Program, see the MLN Matters article, SE1128, at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se1128.pdf.

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<td>November 16, 2017</td>
<td>The article was revised to reflect a revised CR9911 issued on November 15, 2017. In the article, the CR release date, transmittal number, and the Web address of CR9911 are revised. All other information remains the same.</td>
</tr>
<tr>
<td>July 24, 2017</td>
<td>The article was revised to add links to related MLN Matters Articles. SE1128 reminds all Medicare providers that they may not bill beneficiaries enrolled in the QMB program for Medicare cost-sharing. MM9817 states that CR 9817 instructs MACs to issue a compliance letter instructing named providers and suppliers to refund any erroneous charges and recall any past or existing billing with regard to improper QMB billing.</td>
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<tr>
<td>June 29, 2017</td>
<td>The article was revised to reflect a revised CR9911 issued on June 28, 2017. In the article, the CR release date, transmittal number, and the Web address of CR9911 are revised. Clarifications were also made to the second paragraph of the Background section.</td>
</tr>
<tr>
<td>May 1, 2017</td>
<td>The article was revised to reflect a revised CR9911 issued on April 28, 2017. In the article, the CR release date, transmittal number, and the Web address of CR9911 are revised.</td>
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<tr>
<td>February 3, 2017</td>
<td>Initial article released</td>
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PWK Fax/Mail Cover Sheets Revision
MLN Matters Number: MM10124
Related Change Request (CR) Number: 10124
Related CR Release Date: November 9, 2017
Effective Date: April 1, 2018
Related CR Transmittal Number: R19740TN
Implementation Date: April 2, 2018

PROVIDER TYPES AFFECTED
This MLN Matters® Article is intended for all physicians, providers, and suppliers who submit claims to Medicare Administrative Contractors (MACs), including Durable Medical Equipment (DME) MACs, and Home Health and Hospices (HH+H) MACs, for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED
Change Request (CR) 10124 alerts providers that their MAC will provide revised fax/mail cover sheets via hardcopy and/or electronic download. These revised documents are attached to CR10124. There are three paperwork (PWK) attachments to CR10124: (1) Medicare Part A Fax/Mail Cover Sheet (2) Medicare Part B Fax/Mail Cover Sheet and (3) Medicare DME MAC Fax/Mail Cover Sheet.

BACKGROUND
CR10124 revises the three PWK Fax/Mail Cover Sheets to remove Health Insurance Claim Number (HICN) from the forms and replace it with Medicare ID. HICN is being removed from the forms as part of the Medicare Access and CHIP Re-authorization Act (MACRA) of 2015, which requires removal of the Social Security Number-based HICN from Medicare cards within 4 years of enactment. These Fax/Mail Cover sheets are used so that providers are able to continue to submit electronic claims, which require additional documentation.

ADDITIONAL INFORMATION

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Claim Status Category Codes and Claim Status Codes Update
MLN Matters Number: MM10271
Related Change Request (CR) Number: 10271
Related CR Release Date: November 9, 2017
Effective Date: April 1, 2018
Related CR Transmittal Number: R3916CP
Implementation Date: April 2, 2018

PROVIDER TYPE AFFECTED
This MLN Matters® Article is intended for physicians, providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED
Change Request (CR) 10271 informs MACs about system changes to update, as needed, the Claim Status Codes and Claim Status Category Codes used for the Accredited Standards Committee (ASC) X12 276/277
Health Care Claim Status Request and Response and ASC X12 277 Health Care Claim Acknowledgment transactions. Make sure your billing staffs are aware of these changes.

BACKGROUND

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires all covered entities to use only Claim Status Category Codes and Claim Status Codes approved by the National Code Maintenance Committee in the ASC X12 276/277 Health Care Claim Status Request and Response transaction standards adopted under HIPAA for electronically submitting health care claims status requests and responses. These codes explain the status of submitted claim(s). Proprietary codes may not be used in the ASC X12 276/277 transactions to report claim status.

The National Code Maintenance Committee meets at the beginning of each ASC X12 trimester meeting (January/February, June, and September/October) and makes decisions about additions, modifications, and retirement of existing codes. The National Code Maintenance Committee has decided to allow the industry 6 months for implementation of newly added or changed codes.


Included in the code lists are specific details, including the date when a code was added, changed, or deleted. All code changes approved during the January 2018 committee meeting will be posted on these sites on or about February 1, 2018.

The Centers for Medicare & Medicaid Services (CMS) will issue notifications regarding the need for future updates to these codes. When instructed, MACs must update their claims systems to ensure that the current version of these codes is used in their claim status responses. MAC and shared systems changes will be made as necessary as part of a routine release to reflect applicable changes such as retirement of previously used codes or newly created codes.

These code changes are to be used in editing of all ASC X12 276 transactions processed on or after the date of implementation and to be reflected in the ASC X12 277 transactions issued on and after the date of implementation of Change Request (CR) 10271.

Note: References in CR 10271 to “277 responses” and “claim status responses” encompass both the ASC X12 277 Health Care Claim Status Response and the ASC X12 277 Healthcare Claim Acknowledgment transactions.

ADDITIONAL INFORMATION


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Coding and Billing Date of Service on Professional Claims Guidance - Rescinded

MLN Matters Number: SE17023 Rescinded
Article Release Date: October 2, 2017

This article is currently rescinded, but may be re-issued at a later date.

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<td>October 2, 2017</td>
<td>The article was rescinded, but may be re-issued at a later date.</td>
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<tr>
<td>September 19, 2017</td>
<td>Initial article released.</td>
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Observation and Inpatient E/M Common Denial Resolution Options

Receiving a denial for observation and inpatient evaluation and management (E/M) claim after another observation or inpatient E/M claim has been processed? A webpage has been created to offer providers options for such denied claims.

See the Observation and Inpatient (E/M) Common Denials and Resolutions webpage for a processing overview of related claims billed. To view options, locate the denied CPT code in bold, and review the options based on the previously processed code.

Telehealth Services: Elimination of GT Modifier

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

Provider Types Affected
This MLN Matters® Article is intended for providers who submit claims to Medicare Administrative Contractors (MACs) for telehealth services provided to Medicare beneficiaries.

Provider Action Needed
Change Request (CR) 10152 eliminates the requirement to use the GT modifier (via interactive audio and video telecommunications systems) on professional claims for telehealth services. Use of the telehealth Place of Service (POS) Code 02 certifies that the service meets the telehealth requirements.

Background
CR10152 revises the previous guidance that instructed practitioners to submit claims for telehealth services using the appropriate CPT or HCPCS code for the professional service along with the telehealth modifier GT (via interactive audio and video telecommunications systems). The GQ modifier is still required when applicable. As a result of the CY 2017 Physician Fee Schedule (PFS) final rule, CR9726 implemented payment policies regarding Medicare’s use of a new POS Code 02 to describe services furnished via telehealth. The new POS code became effective January 1, 2017. Use of the telehealth POS code certifies that the service meets the telehealth requirements.

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

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

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

Additional Information

To review the MLN Matters® article 9726 related to this CR you may go to:
Mammography HCPCS Codes, Waiver of Coinsurance and Deductible for Preventive and Other Services, and Addition of Anesthesia and Prolonged Preventive Services

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

PROVIDER TYPES AFFECTED
This MLN Matters Article is intended for providers submitting claims to Part A & B Medicare Administrative Contractors (MACs) for services furnished to Medicare beneficiaries.

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

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

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

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

These codes are being replaced by the following CPT codes:

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

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

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

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

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

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

In the Calendar Year (CY) 2018 Physician Fee Schedule (PFS) Final Rule, the Centers for Medicare & Medicaid Services (CMS) modified reporting and payment for anesthesia services furnished in conjunction with and in support of colorectal cancer screening services.

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

Anesthesia Services

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

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

ADDITIONAL INFORMATION


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<td>November 24, 2017</td>
<td>Initial article released.</td>
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NCCI PTP Edits, Version 24.0, Effective January 1, 2018 Quarterly Update

MLN Matters Number: MM10306
Related Change Request (CR) Number: CR10306
Related CR Release Date: September 29, 2017
Effective Date: January 1, 2018
Related CR Transmittal Number: R3869CP
Implementation Date: January 2, 2018

PROVIDER TYPES 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) 10306 informs the MACs about the update to the National Correct Coding Initiative (NCCI) procedure to procedure edits (PTP). This notice applies to Chapter 23, Section 20.9 of the Medicare Claims Processing Manual. Make sure your billing staffs are aware of these changes.

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 Part B claims.

Version 24.0 will include all previous versions and updates from January 1, 1996, to the present. In the past, CCI 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), on April 1, 2012, CMS consolidated these two edit files into the Column One/Column Two 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 One/Column Two 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 One/Column Two 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 One/Column Two Correct Coding edit file. Refer to the CMS NCCI webpage for additional information at http://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 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.

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HCPCS Codes Used for Home Health Consolidated Billing Enforcement – Annual Update

MLN Matters Number: MM10308
Related Change Request (CR) Number: 10308
Related CR Release Date: October 6, 2017
Effective Date: January 1, 2018
Related CR Transmittal Number: R3877CP
Implementation Date: January 2, 2018

PROVIDER TYPES AFFECTED

This MLN Matters® Article is intended for Home Health Agencies (HHAs) and other providers submitting claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries in a home health period of coverage.

PROVIDER ACTION NEEDED

Change Request (CR) 10308 provides the 2018 annual update to the list of Healthcare Common Procedure Coding System (HCPCS) codes used by Medicare systems to enforce consolidated billing of home health services. Make sure your billing staffs are aware of these updates.

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of HCPCS codes that are subject to the consolidated billing provision of the Home Health Prospective Payment System (HH PPS). With the exception of therapies performed by physicians, supplies incidental to physician services and supplies used in institutional settings, services appearing on this list that are submitted on claims to MACs will not be paid separately on dates when a beneficiary for whom such a service is being billed is in a home health episode (that is, under a home health plan of care administered by an HHA).

In such cases, Medicare will only directly reimburse the primary HHAs that have opened such episodes during the episode periods. Therapies performed by physicians, supplies incidental to physician services, and supplies used in institutional settings are not subject to HH consolidated billing.

The HH consolidated billing code lists are updated annually to reflect the yearly changes to the HCPCS code set itself. Additional updates may occur as frequently as quarterly in order to reflect the creation of temporary HCPCS codes (for example, “K” codes) throughout the calendar year. The new coding identified in each update describes the same services that were used to determine the applicable HH PPS payment rates. No additional services will be added by these updates. That is, new updates are required by changes to the coding system, not because the services subject to HH consolidated billing are being redefined.

Section 1842(b)(6) of the Social Security Act requires that payment for HH services provided under a HH plan of care is made to the HHA. This requirement is in Medicare regulations at 42 CFR 409.100 and in Medicare instructions in Chapter 10, Section 20 of the Medicare Claims Processing Manual.

The recurring updates in CR10308 provide annual HH consolidated billing updates effective January 1, 2018. The following HCPCS codes are added to the HH consolidated billing therapy code list:

- 97763 – Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes
  - This code replaces 97762.
- G0515 – Development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct (one-on-one) patient contact, each 15 minutes
  - This code replaces 97532.

ADDITIONAL INFORMATION

PET Radiopharmaceutical/Tracer Unclassified Codes

MLN Matters Number: MM10319
Related Change Request (CR) Number: 10319
Related CR Release Date: November 9, 2017
Effective Date: January 1, 2018
Related CR Transmittal Number: R3911CP
Implementation Date: December 11, 2017 – MACs; April 2, 2018 - FISS, 2018

PROVIDER TYPES 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
Positron Emission Tomography (PET) is a nuclear medicine imaging study used to detect normal and abnormal tissues. All PET scan services are billed using PET or PET/Computed Tomography (CT) Current Procedural Terminology (CPT) codes 78459, 78491, 78492, 78608, and 78811 through 78816. Each of these CPT codes always requires the use of a radiopharmaceutical code, also known as a tracer code. Therefore, an applicable tracer code, along with an applicable CPT code, is necessary for claims processing of any PET scan services.

While there are a number of PET tracers already billable for a diverse number of medical indications, there have been, and may be in the future, additional PET indications that might require a new PET tracer. Under those circumstances, the process to request/approve/implement a new code could be time-intensive.

To help alleviate inordinate spans of time between when a coverage determination is made and when it can be fully implemented via valid claims processing, the Centers for Medicare & Medicaid Services (CMS) has created two new PET radiopharmaceutical unclassified tracer codes that can be used temporarily pending the creation/approval/implementation of permanent CPT codes that would later specifically define their function.

Effective January 1, 2017, with the January 2017 quarterly Healthcare Common Procedure Coding System (HCPCS) update, the two temporary PET HCPCS codes are:

- A9597 - Positron emission tomography radiopharmaceutical, diagnostic, for tumor identification, not otherwise classified
- A9598 - Positron emission tomography radiopharmaceutical, diagnostic, for non-tumor identification, not otherwise classified

Make sure that your billing staffs are aware of these changes.

NOTE: HCPCS codes A9597 and A9598 are NOT to be reported for any CMS approved PET indication where a dedicated PET radiopharmaceutical is already assigned. In other words, HCPCS A9597 and A9598 are not replacements for currently approved PET radiopharmaceuticals A9515, A9526, A9552, A9555, A9580, A9586, A9587, or A9588.

BACKGROUND
Effective with dates of service on or after January 1, 2018, the above two HCPCS codes shall be used ONLY AS NECESSARY FOR AN INTERIM PERIOD OF TIME under the circumstances explained below:

- After U.S. Food and Drug Administration (FDA) approval of a PET oncologic indication, or,
- After CMS approves coverage of a new PET indication, BUT,
ONLY IF either of the above situations requires the use of a dedicated PET radiopharmaceutical/tracer that is currently non-existent.

Once permanent replacement codes are implemented via a subsequent CMS CR, that subsequent CR will also discontinue use of the temporary code for that PET particular indication.

Effective for claims with dates of service on and after January 1, 2018, MACs will ensure when PET tracer code A9597 or A9598 are present on a claim, that claim must also include:

- An appropriate PET HCPCS code, either 78459, 78491, 78492, 78608, 78811, 78812, 78813, 78814, 78815, or 78816
- If tumor-related, either the -PI or -PS modifier as appropriate
- If clinical trial-, registry-, or study-related outside of NCD220.6.17 PET for solid tumors, clinical trial modifier -Q0
- If Part A outpatient and study-related outside of NCD220.6.17 PET for solid tumors, also include condition code 30 and ICD-10 diagnosis Z00.6
- If clinical trial-, registry-, or study-related, all claims require the 8-digit clinical trial number

Effective for claims with dates of service on and after January 1, 2018, MACs for Part A shall line-item deny and MACs for Part B shall line-item reject, PET claims for A9597 or A9598 that do not include the above elements, as appropriate. When denying or rejecting line items, MACs will use the following remittance messages:

- Remittance Advice Remark Code (RARC) N386
- Claim Adjustment Reason Code (CARC) 50, 96, 16, and/or 119
- Group Code CO (Contractual Obligation) assigning financial liability to the provider

MACs will not search for and adjust previously processed claims but will adjust such claims that you bring to their attention.

ADDITIONAL INFORMATION


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Additional Information Required for Coverage and Pricing for Category III CPT Codes

The Additional Information Required for Coverage and Pricing for Category III CPT Codes has been created and published for notice under contract numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI) and 01312 (NV) and on our (Noridian) website.

Article Summary: The purpose of this article is to indicate for which Category III Codes Noridian Medical Directors have received sufficient information for making coverage and payment determinations. For the codes listed in Group 1, Noridian Medical Directors have received sufficient information to make these determinations. For Groups 2, 3 and 4, the Noridian Medical Directors have received sufficient information and coverage may be described in one of the Local Coverage Determinations (LCD) (listed elsewhere).

Effective Date: July 1, 2017

View the locally hosted Medicare Coverage Article PDF.

- Go to Noridian Medicare Coverage Articles webpage.
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
  - Locate and select above listed Medicare Coverage Article.

To view complete list of Noridian coverage articles:

- Go to the Noridian Medicare Coverage Articles webpage
- View complete list of Noridian coverage articles
- Access the CMS MCD to view a comprehensive revision history for this corresponding article
  - Scroll to bottom of webpage
  - Select state/contract of interest from Active, Future or Retired column (This link will redirect you to the CMS website.)
  - Once in the CMS MCD, select corresponding article title

Bariatric Surgery Coverage – R10

The following Noridian coverage requirements for the Bariatric Surgery For Treatment of Co-morbid Conditions National Coverage Determination (NCD) have been published under contract numbers: 01112 (NCA), 01182 (SCA) and 01212 (AS, GU, HI, NMI), 01312 (NV) in the CMS Medicare Coverage Database (MCD and on our (Noridian) website.

NCD Title: Bariatric Surgery For Treatment of Co-morbid Conditions (100.1)

Summary of Changes: This article has been updated to include, revise and/or remove ICD-10 codes.

- New ICD-10 codes:
  - E11.10 - Type 2 diabetes mellitus with ketoacidosis without coma
  - E11.11 - Type 2 diabetes mellitus with ketoacidosis with coma
  - I27.20 - Pulmonary hypertension, unspecified
  - I27.21 - Secondary pulmonary arterial hypertension
  - I27.22 - Pulmonary hypertension due to left heart disease
  - I27.23 - Pulmonary hypertension due to lung diseases and hypoxia
  - I27.24 - Chronic thromboembolic pulmonary hypertension
  - I27.29 - Other secondary pulmonary hypertension
  - I27.83 - Eisenmenger’s syndrome
  - I50.810 - Right heart failure, unspecified
• I50.811 - Acute right heart failure  
• I50.812 - Chronic right heart failure  
• I50.813 - Acute on chronic right heart failure  
• I50.814 - Right heart failure due to left heart failure  
• I50.82 - Biventricular heart failure  
• I50.83 - High output heart failure  
• I50.84 - End stage heart failure  
• I50.89 - Other heart failure  
• Revised ICD-10 codes:  
  • I50.1 - Left ventricular failure, unspecified  
  • I83.811 - Varicose veins of right lower extremity with pain  
  • I83.812 - Varicose veins of left lower extremity with pain  
  • I83.891 - Varicose veins of right lower extremity with other complications  
  • I83.892 - Varicose veins of left lower extremity with other complications  
• Deleted ICD-10 codes:  
  • I27.2 - Other secondary pulmonary hypertension  

Effective Date: October 1, 2017

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To view a complete list of all Noridian NCD coverage articles, go to the National Coverage Determination (NCD) webpage and select the title of interest.

To view a complete list of all CMS NCDs available, go to National Coverage Determinations (NCDs) Alphabetical Index.

Chemotherapy Administration - R9

The Chemotherapy Administration article has been created and published for notice under contract numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI) and 01312 (NV) and on our (Noridian) website.

Effective Date: October 1, 2017

Summary of Changes: Article updated the language in the Intramuscular and Subcutaneous Injections, Infusion Non-Chemotherapy, Chemotherapy Infusion and Prolonged Drug and Biological Infusions Using an External Pump sections.

Also updated the Infusions Non-Chemotherapy and Chemotherapy Administration sections to add newly approved drugs and update the HCPCS codes used to bill the following drugs:
• Added edaravone (J3490 (OPPS: C9399 until 09/01/2017; C9493 effective 10/01/2017)). This drug was FDA approved 05/01/2017.
• Updated avelumab HCPCS code to C9491 effective 10/01/2017,
• Added durvalumab (J9999 (OPPS:C9399 until 09/30/2017; C9492 effective 10/01/2017). This drug was FDA approved 05/01/2017.
• Updated crelizumab HCPCS code to C9494 effective 10/01/2017.
• Added daunorubicin and cytarabine (J9999 and C9399 for OPPS). This drug combination was FDA approved 08/03/2017.
• Added information regarding the use of the ZC modifier with HCPCS code Q5102 when the manufacturer is Merck/Samsung Bioepis.

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Chemotherapy Administration – R10

The Chemotherapy Administration coverage article has been revised and published for notice under contract numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI) and 01312 (NV).

Summary of Changes: Corrected the HCPCS code for durvalumab (Imfinzi™) from C9242 to C9492, updated the language in the first Paragraph in the Infusion Chemotherapy Section, removed out dated information, corrected spelling errors and added J9999 & C9399 in the OPPS setting for copanlisib (Aliqopa™) as approved in the Infusion Chemotherapy section.

Effective Date: October 1, 2017

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Chemotherapy Administration – R11

The Chemotherapy Administration coverage article has been revised and published for notice under contract numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI) and 01312 (NV).

Effective Date: January 1, 2018 unless specified

Summary of Changes: This Local Coverage Article updated with editorial changes made to the Intramuscular and Subcutaneous Injections narrative sections, the ICD-10 Paragraph 1 section, the Prolonged Drug and Biological Infusions Using an External Pump section and both the narrative and table sections of the Non-Chemotherapy Infusion and Infusions Chemotherapy. It has also been updated to include and/or remove CPT/HCPCS codes effective for multiple dates of service (DOS) and sections of the article text.

Intramuscular and Subcutaneous Injections section:

- Added:
  - Effective 7/13/17, J3590 (OPPS: C9399-effective 07/13/2017-12/31/2017 for injection guselkumab, 1mg (Tremfya™).
  - Effective 01/01/2018:
    - C9029 in the OPPS setting for Injection guselkumab, 1 mg (Tremfya™).
    - C9016 in the OPPS setting for Injection, triptorelin extended release, 3.75 mg (Triptodur™) in the narrative section.

- Deleted:
  - Unlisted codes for mepolizumab, 1mg (Nucala®). Effective 01/01/2017 this drug had to be billed with J2182.

Infusions Non-Chemotherapy:

- Added:
  - Effective 01/01/2017, J3590 (OPPS: C9490-Effective 01/01/2017-12/31/2017) for bezlotoxumab 10 mg (Zinplava™).
  - Effective 01/01/18:
    - J0565-Imjection bezlotoxumab 10 mg (Zinplava™).
    - J3358- Ustekinumab, for intravenous injection, 1 mg.

- Deleted:
  - Unlisted codes for reslizumab, 1mg (Cinqair®). Effective 01/01/2017 this drug had to be billed with J2182.
  - Deleted effective 12/31/2017:
    - C9490- Injection, bezlotoxumab, 10 mg (Zinplava™).
    - C9483- Injection, atezolizumab, 10 mg (Tecentriq™).

Chemotherapy Infusions section:

- Added:
  - Effective 08/17/2017, J9999 (OPPS: C9399-effective 08/17/2017-12/31/17) for Injection, inotuzumab ozogamicin, 0.1 mg (Besponsa™).
  - Effective 01/01/2018:
    - J9022- Injection, atezolizumab, 10 mg (Tecentriq™).
    - J9023- Injection, avelumab, 10 mg (Bavencio®).
    - C9028- Injection, inotuzumab ozogamicin, 0.1 mg (Besponsa™).
    - J9285- Injection, olaratumab, 10 mg (Lartruvo™).
• J2350- Injection, ocrelizumab, 1 mg (Ocrevus™).
• C9024- Injection, liposomal, 1 mg daunorubicin and 2.27 mg cytarabine

• Deleted:
  • Removed all the drugs with active J9XXX codes effective 01/01/2017.
  • Deleted effective 12/31/2017:
    • C9491- Injection, avelumab, 10 mg (Bavencio®).
    • C9485- Injection, olaratumab, 10 mg (Lartruvo™)
    • C9494- Injection, ocrelizumab, 1 mg (Ocrevus™).

Please note the dose and code change of J9203- Injection, gemtuzumab ozogamicin, 5 mg to J9300- Injection, gemtuzumab ozogamicin, 0.1mg.

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Coenzyme Q10 (Q10) Coding and Billing Guideline
The Coenzyme Q10 (Q10) Coding and Billing Guideline has been created and published for notice under contract numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI) and 01312 (NV) and on our (Noridian) website.

Article Summary: This article explains what procedure code to use and how to bill for a denial based on the Coenzyme Q10 (Q10) LCD L37066.

Effective Date: October 2, 2017

View the locally hosted Medicare Coverage Article PDF.
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DecisionDx-UM Billing Guidelines Article Retirement – Effective September 22, 2017

The following JE Local Coverage Article has been retired under contractor 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI) and 01312 (NV).

**Medicare Coverage Database Number:** A55423  
**Article Title:** DecisionDx-UM™ Billing Guidelines  
**Effective Date:** September 22, 2017  
**Summary:** Coverage articles may be retired due to lack of evidence of current problems or CMS may have issued guidance regarding national coverage. This article is being retired due to the Local Coverage Determination (LCD) MolDX: DecisionDX-UM (Uveal Melanoma) became effective September 22, 2017. Provider offices remain responsible for correct performance, coding, billing, and medical necessity under Medicare. This responsibility for correct claims submission is unchanged whether or not there is a coverage article in place.

To access the Noridian Retired coverage articles from our website, follow the instructions below.

- Go to [https://med.noridianmedicare.com/web/jeb/policies/coverage-articles](https://med.noridianmedicare.com/web/jeb/policies/coverage-articles)
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
  - On the “Medicare Coverage Articles” page, select the state of interest in the table under “Retired Articles.”
  - This link will redirect you to the CMS website.
  - Locate the above-listed CMS Medicare Coverage Database (MCD) number and article title and select the title of interest.

Home PT/INR Monitoring (G0249) Billing and Coding

The Home PT/INR Monitoring (G0249) Billing and Coding has been created and published for notice under contract numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI) and 01312 (NV) and on our (Noridian) website.

**Article Summary:** Noridian is issuing this coding and billing guidance as it relates to the National Coverage Determination for Home Prothrombin Time/International Normalized Ration (PT/INR) Monitoring for Anticoagulation Monitoring (NCD 190.11) and is in no way a change in coverage as outlined in the NCD and MLN Matters articles and is effective immediately.

**Effective Date:** October 9, 2017

- View the locally hosted Medicare Coverage article.
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
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Injectable Bulking Agents for the Treatment of Fecal Incontinence Article Retirement – Effective December 4, 2017

The following JE Local Coverage Article has been retired under contractor 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI) and 01312 (NV).

Medicare Coverage Database Number: A52921

Article Title: Injectable Bulking Agents for the Treatment of Fecal Incontinence

Effective Date: December 4, 2017

Summary: Coverage articles may be retired due to lack of evidence of current problems or CMS may have issued guidance regarding national coverage. The Noridian guidance in the retired article may still be helpful in assessing medical necessity. Where providers have adjusted their billing and coding practices to correspond to the guidance in a coverage article, they will want to be very careful in departing from these practices just because the article is retired. Provider offices remain responsible for correct performance, coding, billing, and medical necessity under Medicare. This responsibility for correct claims submission is unchanged whether there is a coverage article in place or not.

To access the Noridian Retired coverage articles from our website, follow the instructions below.

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Intraocular Bevacizumab Coding/Billing Guidelines – R7

The Intraocular Bevacizumab Coding/Billing Guidelines coverage article has been revised and published for notice under contract numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI) and 01312 (NV).

Summary of Changes: This LCD has been updated to include and/or remove ICD-10 codes.

New/Revised ICD-10 codes:
- H442A1 - Degenerative myopia with choroidal neovascularization, right eye
- H442A2 - Degenerative myopia with choroidal neovascularization, left eye
- H442A3 - Degenerative myopia with choroidal neovascularization, bilateral eye
- H442B1 - Degenerative myopia with macular hole, right eye
- H442B2 - Degenerative myopia with macular hole, left eye
- H442B3 - Degenerative myopia with macular hole, bilateral eye
- H442C1 - Degenerative myopia with retinal detachment, right eye
- H442C2 - Degenerative myopia with retinal detachment, left eye
- H442C3 - Degenerative myopia with retinal detachment, bilateral eye
- H442D1 - Degenerative myopia with foveoschisis, right eye
- H442D2 - Degenerative myopia with foveoschisis, left eye
- H442D3 - Degenerative myopia with foveoschisis, bilateral eye
- H442E1 - Degenerative myopia with other maculopathy, right eye
- H442E2 - Degenerative myopia with other maculopathy, left eye
• H442E3 - Degenerative myopia with other maculopathy, bilateral eye

**Revision Effective Date:** 10/01/2017

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**Lymphedema Decongestive Treatment – R1**

The Lymphedema Decongestive Treatment coverage article has been revised and published for notice under contract numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI) and 01312 (NV).

**Summary of Changes:** Article is updated to delete 29852, Application of vein wound compression system thigh and lower leg and 29853, Application of vein wound compression system upper arm and forearm per the 2018 Annual HCPCS/CPT Code Update.

**Effective Date:** January 1, 2018

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MolDX: BCR-ABL Billing and Coding Guidelines

The MolDX: BCR-ABL Billing and Coding Guidelines coverage article has been published for notice under contract numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI) and 01312 (NV).

Summary: To view billing and coding guidelines for MolDX: BCR-ABL.

Effective Date: December 1, 2017

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MolDX: Bladder Tumor Marker FISH Billing and Coding Guidelines – R2

The MolDX: Bladder Tumor Marker FISH Billing and Coding Guidelines coverage article has been revised and published for notice under contract numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI) and 01312 (NV).

Summary of Changes: Added MolDX in title, added coding instructions for “all other services that meet the code 88120 or 88121 by any provider type” and specified «identifier» as DEX Z-Code™ identifier in the test registration paragraph.

Effective Date: 10/01/2017

- View the locally hosted Medicare Coverage Article PDF.
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MolDX: CYP Gene Evidence Analysis Article Retirement – Effective August 24, 2017

The following JE Local Coverage Article has been retired under contractor 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI) and 01312 (NV).

Medicare Coverage Database Number: A54747
Article Title: MolDX: CYP Gene Evidence Analysis
Effective Date: August 24, 2017

Summary: This article is retired for future updates and reference revisions.

To access the Noridian Retired coverage articles from our website, follow the instructions below.

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MolDX: Know Error Billing and Coding Guidelines Update

The MolDX: Know error® Billing and Coding Guidelines coverage article has been published notice under contract numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI) and 01312 (NV).

Summary: To view billing and coding guidelines for MolDX: Know error®.
Effective Date: December 1, 2017

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MolDX: Mitochondrial Nuclear Gene Tests Billing and Coding Guidelines

The MolDX: Mitochondrial Nuclear Gene Tests Billing and Coding Guidelines coverage article has been published for notice under contract numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI) and 01312 (NV).

**Summary:** To view billing and coding guidelines for MolDX: Mitochondrial Nuclear Gene Tests.

**Effective Date:** December 1, 2017

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MolDX: myPap™ Billing and Coding Guidelines

The MolDX: myPap™ Billing and Coding Guidelines coverage article has been published for notice under contract numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI) and 01312 (NV).

**Summary:** To view billing and coding guidelines for MolDX: myPap™.

**Effective Date:** December 1, 2017

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  - Once in the CMS MCD, select corresponding article title
MolDX: OncoCEE™ Billing and Coding Guidelines

The MolDX: OncoCEE™ Billing and Coding Guidelines coverage article has been published for notice under contract numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI) and 01312 (NV).

Summary: To view billing and coding guidelines for MolDX: OncoCEE™.

Effective Date: December 1, 2017

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  - Once in the CMS MCD, select corresponding article title

MolDX: PreDx Billing and Coding Guidelines

The MolDX: PreDx Billing and Coding Guidelines coverage article has been published for notice under contract numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI) and 01312 (NV).

Summary: To view billing and coding guidelines for MolDX: PreDx®.

Effective Date: December 1, 2017

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- Go to the Noridian Medicare Coverage Articles webpage
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The following JE Local Coverage Article has been retired under contractor 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI) and 01312 (NV).

Medicare Coverage Database Number: A52888
Article Title: Obinutuzumab (GAZYVA™): Wastage Billing Instructions
Effective Date: December 4, 2017

Summary: Coverage articles may be retired due to lack of evidence of current problems or CMS may have issued guidance regarding national coverage. The Noridian guidance in the retired article may still be helpful in assessing medical necessity. Where providers have adjusted their billing and coding practices to correspond to the guidance in a coverage article, they will want to be very careful in departing from these practices just because the article is retired. Provider offices remain responsible for correct performance, coding, billing, and medical necessity under Medicare. This responsibility for correct claims submission is unchanged whether there is a coverage article in place or not.

To access the Noridian Retired coverage articles from our website, follow the instructions below.

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    - This link will redirect you to the CMS website.
  - Locate the above-listed CMS Medicare Coverage Database (MCD) number and article title and select the title of interest.

Ocular Photodynamic Therapy (OPT) with Verteporfin Article Retirement – Effective October 1, 2017

The following JE Local Coverage Article has been retired under contractor 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI) and 01312 (NV).

Medicare Coverage Database Number: A54129
Article Title: Ocular Photodynamic Therapy (OPT) with Verteporfin Article Retirement
Effective Date: October 1, 2017

Summary: This article is retired due to CMS issuing guidance regarding national coverage and contractor discretionary diagnosis codes that Noridian will allow. Where providers have adjusted their billing and coding practices to correspond to the guidance in a coverage article, they will want to be very careful in departing from these practices just because the article is retired. Provider offices remain responsible for correct performance, coding, billing, and medical necessity under Medicare. This responsibility for correct claims submission is unchanged whether there is a coverage article in place or not.

To access the Noridian Retired coverage articles from our website, follow the instructions below.

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    - This link will redirect you to the CMS website.
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Parenteral Iron Administration in Beneficiaries with Chronic Kidney Disease (CKD) with Iron Deficiency Anemia (IDA) or Reduced Iron Stores

Article Retirement – Effective January 14, 2018

The following JE Local Coverage Article has been retired under contractor 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI) and 01312 (NV).

Medicare Coverage Database Number: A54653

Article Title: Parenteral Iron Administration in Beneficiaries with Chronic Kidney Disease (CKD) with Iron Deficiency Anemia (IDA) or Reduced Iron Stores

Effective Date: January 14, 2018

Summary: Coverage articles may be retired due to lack of evidence of current problems or CMS may have issued guidance regarding national coverage. Effective January 14, 2018, this article will be retired and replaced with the “Parenteral Iron Administration Coverage in Non-Dialysis Usage” coverage article. The article will move from Active articles to Retired articles in the Medicare Coverage Database (MCD) after the article retirement date. The Noridian guidance in the retired article may still be helpful in assessing medical necessity. Where providers have adjusted their billing and coding practices to correspond to the guidance in a coverage article, they will want to be very careful in departing from these practices just because the article is retired. Provider offices remain responsible for correct performance, coding, billing, and medical necessity under Medicare. This responsibility for correct claims submission is unchanged whether or not there is a coverage article in place.

To access the Noridian Retired coverage articles from our website, follow the instructions below.

- Go to Medicare Coverage Articles
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
  - On the “Medicare Coverage Articles” page, select the state of interest in the table under “Retired Articles.”
    - This link will redirect you to the CMS website.
  - Locate the above-listed CMS Medicare Coverage Database (MCD) number and article title and select the title of interest.

Parenteral Iron Administration Coverage in Non-Dialysis

The Parenteral Iron Administration Coverage in Non-Dialysis article has been created and published for notice under contract numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI) and 01312 (NV) and on our (Noridian) website.

Article Summary: Noridian will cover the medically necessary and reasonable use of parenteral iron preparations in the following clinical presentations. This coverage article is separate from and does not address the use of parenteral iron preparations in the beneficiary with end stage renal disease on hemodialysis.

This article replaces the Parenteral Iron Administration in Beneficiaries with Chronic Kidney Disease (CKD) with Iron Deficiency Anemia (IDA) or Reduced Iron Stores article.

Effective Date: January 15, 2018

View the locally hosted Medicare Coverage Article PDF.

- Go to Noridian Medicare Coverage Articles webpage.
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
  - Locate and select above listed Medicare Coverage Article.

To view complete list of Noridian coverage articles:
• Go to the Noridian Medicare Coverage Articles webpage
• View complete list of Noridian coverage articles
• Access the CMS MCD to view a comprehensive revision history for this corresponding article
  • Scroll to bottom of webpage
  • Select state/contract of interest from Active, Future or Retired column (This link will redirect you to the CMS website.)
  • Once in the CMS MCD, select corresponding article title

**Positron Emission Tomography Scans Coverage – R11**

The following Noridian coverage requirements for the Positron Emission Tomography Scans National Coverage Determination (NCD) have been published under contract numbers 01112 (NCA), 01182 (SCA) and 01212 (AS, GU, HI, NMI), 01312 (NV) in the CMS Medicare Coverage Database (MCD and on our (Noridian) website.

**NCD Title:** Positron Emission Tomography (PET) Scans (220.6)

**Summary of Changes:** This coverage article has been updated to include, revise and/or remove ICD-10 codes and revisions required per Change Request 10184.

**Change Request 10184:**

**Added to List II, effective 10/1/2016:**

- C49.A1 - Gastrointestinal stromal tumor of esophagus
- C49.A2 - Gastrointestinal stromal tumor of stomach
- C49.A3 - Gastrointestinal stromal tumor of small intestine
- C49.A4 - Gastrointestinal stromal tumor of large intestine
- C49.A5 - Gastrointestinal stromal tumor of rectum
- C49.A9 - Gastrointestinal stromal tumor of other sites

**Deleted from List II, effective 10/1/2015:**

- C79.51 - Secondary malignant neoplasm of bone
- C79.52 - Secondary malignant neoplasm of bone marrow
- C80.0 - Disseminated malignant neoplasm, unspecified
- C80.1 - Malignant (primary) neoplasm, unspecified

**Tracer code A9599 is end dated 01/01/2018 per the Change Request 10184.**

**Contractor determined diagnoses for 78459, 78491, and 78492:**

**Added**

- I21.9 - Acute myocardial infarction, unspecified
- I21.A9 - Other myocardial infarction type
- I50.810 - Right heart failure, unspecified
- I50.811 - Acute right heart failure
- I50.812 - Chronic right heart failure
- I50.813 - Acute on chronic right heart failure
- I50.814 - Right heart failure due to left heart failure
- I50.82 - Biventricular heart failure
• I50.83 - High output heart failure
• I50.84 - End stage heart failure
• I50.89 - Other heart failure

Revised
• 150.1 - Left ventricular failure, unspecified

Deleted
• C96.2 - Malignant mast cell tumor

View the locally hosted Noridian Coverage Article PDF.

Go to https://med.noridianmedicare.com/web/jeb/policies/ncd
  • The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
  • Locate and select the above listed Coverage Article title

To view a complete list of all Noridian NCD coverage articles, go to the National Coverage Determination (NCD) webpage and select the title of interest.

To view a complete list of all CMS NCDs available, go to National Coverage Determinations (NCDs) Alphabetical Index.

Positron Emission Tomography Scans Coverage – R12

The following Noridian coverage requirements for the Positron Emission Tomography Scans National Coverage Determination (NCD) have been published under contract numbers 01112 (NCA), 01182 (SCA) and 01212 (AS, GU, HI, NMI), 01312 (NV) in the CMS Medicare Coverage Database (MCD and on our (Noridian) website.

NCD Title: Positron Emission Tomography (PET) Scans (220.6)

Summary of Changes: This coverage article has been updated to add ICD-10 codes per Change Request (CR) 10318. CR 10318:

• Added to List I, effective October 1, 2017:
  • R93.3 - Abnormal findings on diagnostic imaging of other parts of digestive tract
  • R93.41 - Abnormal radiologic findings on diagnostic imaging of renal pelvis, ureter, or bladder
  • R93.421 - Abnormal radiologic findings on diagnostic imaging of right kidney
  • R93.422 - Abnormal radiologic findings on diagnostic imaging of left kidney
  • R93.49 - Abnormal radiologic findings on diagnostic imaging of other urinary organs

• Added to List II, effective October 1, 2017:
  • R93.3 - Abnormal findings on diagnostic imaging of other parts of digestive tract
  • R93.41 - Abnormal radiologic findings on diagnostic imaging of renal pelvis, ureter, or bladder
  • R93.421 - Abnormal radiologic findings on diagnostic imaging of right kidney
  • R93.422 - Abnormal radiologic findings on diagnostic imaging of left kidney
  • R93.49 - Abnormal radiologic findings on diagnostic imaging of other urinary organs
  • R94.02 - Abnormal brain scan
  • Z85.830 – Personal history of malignant neoplasm of bone

Read the complete National Coverage Determination requirements article.

• The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
To view a complete list of all Noridian NCD coverage articles, go to the National Coverage Determination (NCD) webpage and select the title of interest.

To view a complete list of all CMS NCDs available, go to National Coverage Determinations (NCDs) Alphabetical Index.

**Reporting a Non-Covered Test Performed in Preparation for a Non-Covered Procedure**

The Reporting a Non-Covered Test Performed in Preparation for a Non-Covered Procedure article has been created and published for notice under contract numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI) and 01312 (NV) and on our (Noridian) website.

**Article Summary:** When a diagnostic test is necessary for the performance of a non-covered service, that test typically may not be covered. Noridian wishes to remind providers to appropriately report this as a non-covered test, by submitting the code with a GY modifier.

**Effective Date:** October 23, 2017

View the locally hosted Medicare Coverage Article PDF.

- Go to Noridian Medicare Coverage Articles webpage.
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
  - Locate and select above listed Medicare Coverage Article.

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  - Scroll to bottom of webpage
  - Select state/contract of interest from Active, Future or Retired column (This link will redirect you to the CMS website.)
  - Once in the CMS MCD, select corresponding article title

**Zika Virus Testing by PCR and ELISA Methods – R7**

The Zika Virus Testing by PCR and ELISA Methods coverage article has been revised and published for notice under contract numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI) and 01312 (NV).

**Summary of Changes:** Revision to article guidance and article text providing instructions for new 2018 CPT code billing.

Addition of CPT Codes:

- 87662: Zika virus, amplified probe technique
- 86794: Zika virus, IGM

**Effective Date:** January 1, 2018

View the locally hosted Medicare Coverage Article PDF.

- Go to Noridian Medicare Coverage Articles webpage.
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
  - Locate and select above listed Medicare Coverage Article.
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  - Scroll to bottom of webpage
  - Select state/contract of interest from Active, Future or Retired column (This link will redirect you to the CMS website.)
  - Once in the CMS MCD, select corresponding article title

**Rezum Billing and Coding Guidelines**

Effective January 1, 2018

The REZUM® System is an FDA approved device for the treatment of lower urinary tract symptoms secondary to benign prostatic hyperplasia (BPH). The technology uses radiofrequency (RF) to boil the water to create the steam that is injected to destroy the excess tissue. No radiofrequency is directly imparted to the prostate tissue.

Claims for procedures involving REZUM® steam injection shall be billed with CPT® code 53899. CPT® 53852 is NOT CORRECT for this procedure. The claim must indicate that the REZUM procedure was performed by including the words “Rezum procedure” in Item 19 on the CMS-1500 form or Loop 2400 segment SV101-7 for the 5010A1 837P electronic format for Part B claims. Failure to include this or similar verbiage as noted will result in a delay in adjudication.

On or after January 1, 2018 Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) facilities are to use HCPCS code C9748.

Noridian appreciates your cooperation in this matter.
HBO Therapy – Section C, Topical Application of Oxygen

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

PROVIDER TYPES AFFECTED

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

WHAT YOU NEED TO KNOW

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

BACKGROUND

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

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

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

ADDITIONAL INFORMATION


DOCUMENT HISTORY

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
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<tbody>
<tr>
<td>November 22, 2017</td>
<td>Initial article released.</td>
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Hurricane Harvey and Medicare Disaster Related Texas Claims – Fifth Revision

MLN Matters Number: SE17020 Revised  
Article Release Date: November 28, 2017

This article was revised on November 28, 2017, to advise providers that the public health emergency declaration and Section 1135 waiver authority expired on November 22, 2017. All other information remains the same.

PROVIDER TYPE AFFECTED

This MLN Matters Special Edition Article is intended for providers and suppliers who submit claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries in the State of Texas who were affected by Hurricane Harvey.

PROVIDER INFORMATION AVAILABLE

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

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

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

BACKGROUND

Section 1135 and Section 1812(f) Waivers

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

1. Change Request (CR) 6451 (Transmittal 1784, Publication 100-04) issued on July 31, 2009, applies to items and services furnished to Medicare beneficiaries within the State of Texas from August 25, 2017, for the duration of the emergency. In accordance with CR6451, use of the “DR” condition code and the “CR” modifier are mandatory on claims for items and services for which Medicare payment is conditioned on the presence of a “formal waiver” including, but not necessarily limited to, waivers granted under either Section 1135 or Section 1812(f) of the Act.

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

• The first listed file addresses policies and procedures that are applicable without any Section 1135 or other formal waiver. These policies are always applicable in any kind of emergency or disaster, including the current emergency in Texas.

• The second file addresses policies and procedures that are applicable only with approved Section 1135 waivers or, when applicable, approved Section 1812(f) waivers. These Q&As are applicable for approved
Section 1135 blanket waivers and approved individual 1135 waivers requested by providers and are effective August 25, 2017, for Texas.

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

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

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

**Blanket Waivers Issued by CMS**

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

**Skilled Nursing Facilities**

- **Section 1812(f):** Waiver of the requirement for a 3-day prior hospitalization for coverage of a skilled nursing facility (SNF) stay provides temporary emergency coverage of SNF services without a qualifying hospital stay, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of Hurricane Harvey in the State of Texas in 2017. In addition, for certain beneficiaries who recently exhausted their SNF benefits, it authorizes renewed SNF coverage without first having to start a new benefit period. (Blanket waiver for all impacted facilities)

- **42 CFR 483.20:** Waiver provides relief to Skilled Nursing Facilities on the timeframe requirements for Minimum Data Set assessments and transmission. (Blanket waiver for all impacted facilities)

**Home Health Agencies**

- **42 CFR 484.20(c)(1):** This waiver provides relief to Home Health Agencies on the timeframes related to OASIS Transmission. (Blanket waiver for all impacted agencies)


**Critical Access Hospitals**

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

**Housing Acute Care Patients In Excluded Distinct Part Units**

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

**Emergency Durable Medical Equipment, Prosthetics, Orthotics, and Supplies for Medicare Beneficiaries Impacted by an Emergency or Disaster**

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

**Application Deadline Extended for Reclassifications Submission to MGCRB**

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

**Deadline Extended for IPPS Wage Index Requests**

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

**Facilities Quality Reporting**

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

**Medicare-dependent small, rural hospitals (MDHs)**

In accordance with Waivers or Modifications of Requirements under Section 1135 of the Social Security Act issued August 26, 2017 by Secretary Price, CMS is modifying the September 1, 2017 deadline for Medicare-dependent small, rural hospitals (MDHs) to apply for sole community hospital (SCH) status in advance of the expiration of the MDH program with an effective date of an approval of SCH status that is the day following the expiration date of the MDH program (that is, September 30, 2017 under current law). CMS is currently granting a 31-day extension to the deadline at § 412.92(b)(2)(v) for the State of Texas. If a hospital located in these areas that is classified as an MDH applies for classification as an SCH under the provisions of § 412.92(b)(2)(v), and that hospital’s SCH status is approved, the effective date of approval of SCH status will be the day following the expiration date of the MDH program if such hospital applies for classification as a SCH not later than October 2, 2017.

**Low-volume hospital**

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

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

Replacement Prescription Fills

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

Moratoria on Part B Non-emergency Ambulance Suppliers

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

Requesting an 1135 Waiver

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

ADDITIONAL INFORMATION

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


DOCUMENT HISTORY

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
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<tbody>
<tr>
<td>November 28, 2017</td>
<td>The article was revised to advise providers that the public health emergency declaration and Section 1135 waiver authority expired on November 22, 2017. All other information remains the same.</td>
</tr>
<tr>
<td>September 19, 2017</td>
<td>The article was revised to include information about replacement prescription fills of covered Part B drugs. All other information remains the same.</td>
</tr>
<tr>
<td>September 7, 2017</td>
<td>The article was revised to include additional waiver information about emergency durable medical equipment, prosthetics, orthotics, and supplies for Medicare beneficiaries impacted</td>
</tr>
<tr>
<td>September 5, 2017</td>
<td>The article was revised on September 5, 2017, to include additional information about housing acute care patients in excluded distinct part units and lifting the temporary enrollment moratoria on Part B non-emergency ambulance suppliers in Texas. In addition, information has been added to the Facilities Quality Reporting Section and the second paragraph of the Provider Information Available section is modified to clarify that waivers prevent gaps in access to care.</td>
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Tropical Storm Harvey and Medicare Disaster Related Louisiana Claims – Fifth Revision

MLN Matters Number: SE17021 Revised
Article Release Date: November 28, 2017

This article was revised on November 28, 2017, to advise providers that the public health emergency declaration and Section 1135 waiver authority expired on November 24, 2017. All other information remains the same.

PROVIDER TYPES AFFECTED

This MLN Matters® Special Edition Article is intended for providers and suppliers who submit claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries in the State of Louisiana who were affected by Tropical Storm Harvey.

PROVIDER INFORMATION AVAILABLE

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

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

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

BACKGROUND

Section 1135 and Section 1812(f) Waivers

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

1. Change Request (CR) 6451 (Transmittal 1784, Publication 100-04) issued on July 31, 2009, applies to items and services furnished to Medicare beneficiaries within the State of Louisiana from August 27, 2017, for the duration of the emergency. In accordance with CR6451, use of the “DR” condition code and the “CR” modifier are mandatory on claims for items and services for which Medicare payment is conditioned on the presence of a “formal waiver” including, but not necessarily limited to, waivers granted under either Section 1135 or Section 1812(f) of the Act.

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

- The first listed file addresses policies and procedures that are applicable without any Section 1135 or other formal waiver. These policies are always applicable in any kind of emergency or disaster, including the current emergency in Louisiana.

- The second file addresses policies and procedures that are applicable only with approved Section 1135 waivers or, when applicable, approved Section 1812(f) waivers. These Q&As are applicable for approved Section 1135 blanket waivers and approved individual 1135 waivers requested by providers and are effective August 27, 2017, for Louisiana.

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

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

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

Blanket Waivers Issued by CMS

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

Skilled Nursing Facilities

- Section 1812(f): Waiver of the requirement for a 3-day prior hospitalization for coverage of a skilled nursing facility (SNF) stay provides temporary emergency coverage of SNF services without a qualifying hospital stay, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of Tropical Storm Harvey in the State of Louisiana in 2017. In addition, for certain beneficiaries who recently exhausted their SNF benefits, it authorizes renewed SNF coverage without first having to start a new benefit period. (Blanket waiver for all impacted facilities)

- 42 CFR 483.20: Waiver provides relief to Skilled Nursing Facilities on the timeframe requirements for Minimum Data Set assessments and transmission. (Blanket waiver for all impacted facilities)

Home Health Agencies

- 42 CFR 484.20(c)(1): This waiver provides relief to Home Health Agencies on the timeframes related to OASIS Transmission. (Blanket waiver for all impacted agencies)


Critical Access Hospitals

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

Housing Acute Care Patients In Excluded Distinct Part Units

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

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


Application Deadline Extended for Reclassifications Submission to MGCRB

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

Deadline Extended for IPPS Wage Index Requests

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

Facilities Quality Reporting

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

Medicare-dependent small, rural hospitals (MDHs)

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

Low-volume hospital

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

**Appeal Administrative Relief for Areas Affected by Tropical Storm Harvey**

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

**Replacement Prescription Fills**

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

**Requesting an 1135 Waiver**


**ADDITIONAL INFORMATION**


**DOCUMENT HISTORY**

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<tr>
<th>Date of Change</th>
<th>Description</th>
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<tr>
<td>November 28, 2017</td>
<td>The article was revised to advise providers that the public health emergency declaration and Section 1135 waiver authority expired on November 24, 2017. All other information remains the same.</td>
</tr>
<tr>
<td>September 19, 2017</td>
<td>The article was revised to include information regarding replacement prescription fills of covered Part B drugs. All other information remains the same.</td>
</tr>
<tr>
<td>September 7, 2017</td>
<td>The article was revised to include additional waiver information about emergency durable medical equipment, prosthetics, orthotics, and supplies for Medicare beneficiaries impacted by Hurricane Harvey. All other information remains the same.</td>
</tr>
<tr>
<td>September 5, 2017</td>
<td>The article was revised on September 5, 2017, to include additional information about housing acute care patients in excluded distinct part units. In addition, information has been added to the Facilities Quality Reporting Section on page 4 and the second paragraph of the Provider Information Available section is modified to clarify that waivers prevent gaps in access to care.</td>
</tr>
<tr>
<td>September 1, 2017</td>
<td>The article was revised to include additional waiver information for Medicare-dependent small, rural hospitals and for low-volume hospitals. Information regarding administrative relief related to timely filing of appeals was added. All other information remained the same.</td>
</tr>
<tr>
<td>August 31, 2017</td>
<td>Initial article released.</td>
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Hurricane Irma and Medicare Disaster Related United States Virgin Islands, Commonwealth of Puerto Rico and State of Florida Claims – Third Revision

MLN Matters Number: SE17022 Revised
Article Release Date: December 13, 2017

This article was revised on December 13, 2017, to advise providers that the public health emergency declaration and Section 1135 waiver authority expired on December 2, 2017, for Florida and on December 3, 2017, for the United States Virgin Islands and the Commonwealth of Puerto Rico. All other information remains the same.

PROVIDER TYPE AFFECTED

This MLN Matters® Special Edition Article is intended for providers and suppliers who submit claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries in the United States Virgin Islands, Commonwealth of Puerto Rico and State of Florida who were affected by Hurricane Irma.

PROVIDER INFORMATION AVAILABLE


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

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

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

BACKGROUND

Section 1135 and Section 1812(f) Waivers

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

1. Change Request (CR) 6451 (Transmittal 1784, Publication 100-04) issued on July 31, 2009, applies to items and services furnished to Medicare beneficiaries within the United States Virgin Islands and Commonwealth of Puerto Rico from September 5, 2017, and the State of Florida from September 4, 2017, for the duration of the emergency. In accordance with CR6451, use of the “DR” condition code and the “CR” modifier are mandatory on claims for items and services for which Medicare payment is conditioned...
on the presence of a “formal waiver” including, but not necessarily limited to, waivers granted under either Section 1135 or Section 1812(f) of the Act.

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

- The first listed file addresses policies and procedures that are applicable without any Section 1135 or other formal waiver. These policies are always applicable in any kind of emergency or disaster, including the current emergency in the United States Virgin Islands, Commonwealth of Puerto Rico and State of Florida.

- The second file addresses policies and procedures that are applicable only with approved Section 1135 waivers or, when applicable, approved Section 1812(f) waivers. These Q&As are applicable for approved Section 1135 blanket waivers and approved individual 1135 waivers requested by providers and are effective September 5, 2017, for the United States Virgin Islands and Commonwealth of Puerto Rico and September 4, 2017, for the State of Florida.

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

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

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

Blanket Waivers Issued by CMS

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

Skilled Nursing Facilities

- Section 1812(f): Waiver of the requirement for a 3-day prior hospitalization for coverage of a skilled nursing facility (SNF) stay provides temporary emergency coverage of SNF services without a qualifying hospital stay, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of Hurricane Irma in the United States Virgin Islands, Commonwealth of Puerto Rico and State of Florida in 2017. In addition, for certain beneficiaries who recently exhausted their SNF benefits, it authorizes renewed SNF coverage without first having to start a new benefit period. (Blanket waiver for all impacted facilities)

- 42 CFR 483.20: Waiver provides relief to Skilled Nursing Facilities on the timeframe requirements for Minimum Data Set assessments and transmission. (Blanket waiver for all impacted facilities)

Home Health Agencies

- 42 CFR 484.20(c)(1): This waiver provides relief to Home Health Agencies on the timeframes related to OASIS Transmission. (Blanket waiver for all impacted agencies)

Critical Access Hospitals

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

Housing Acute Care Patients In Excluded Distinct Part Units

CMS has determined it is appropriate to issue a blanket waiver to IPPS hospitals that, as a result of Hurricane Irma, need to house acute care inpatients in excluded distinct part units, where the distinct part unit’s beds are appropriate for acute care inpatient. The IPPS hospital should bill for the care and annotate the patient’s medical record to indicate the patient is an acute care inpatient being housed in the excluded
Care for Excluded Inpatient Psychiatric Unit Patients in the Acute Care Unit of a Hospital

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

Care for Excluded Inpatient Rehabilitation Unit Patients in the Acute Care Unit of a Hospital

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

Emergency Durable Medical Equipment, Prosthetics, Orthotics, and Supplies for Medicare Beneficiaries Impacted by an Emergency or Disaster

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


Facilities Quality Reporting

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

Appeal Administrative Relief for Areas Affected by Hurricane Irma

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

Replacement Prescription Fills

Medicare payment may be permitted for replacement prescription fills (for a quantity up to the amount originally dispensed) of covered Part B drugs in circumstances where dispensed medication has been lost or otherwise rendered unusable by damage due to the emergency.
Requesting an 1135 Waiver

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

ADDITIONAL INFORMATION

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


DOCUMENT HISTORY

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<tr>
<th>Date of Change</th>
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<tr>
<td>December 13, 2017</td>
<td>The article was revised to advise providers that the public health emergency declaration and Section 1135 waiver authority expired on December 2, 2017, for Florida and on December 3, 2017, for the United States Virgin Islands and the Commonwealth of Puerto Rico. All other information remains the same.</td>
</tr>
<tr>
<td>September 19, 2017</td>
<td>The article was revised to include new waivers regarding care for excluded inpatient psychiatric unit patients in the acute care unit of a hospital and care for excluded inpatient rehabilitation unit patients in the acute care unit of a hospital, to add information on replacement prescription fills of covered Part B drugs, and information on Facilities Quality Reporting. All other information remains the same.</td>
</tr>
<tr>
<td>September 8, 2017</td>
<td>Initial article released.</td>
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**Hurricane Irma and Medicare Disaster Related South Carolina and Georgia Claims – Third Revision**

**MLN Matters Number: SE17024 Revised**

**Article Release Date: December 13, 2017**

This article was revised on December 13, 2017, to advise providers that the public health emergency declaration and Section 1135 waiver authority expired on December 4, 2017, for South Carolina and on December 5, 2017, for Georgia. All other information remains the same.

**PROVIDER TYPES AFFECTED**

This MLN Matters® Special Edition Article is intended for providers and suppliers who submit claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries in the States of South Carolina and Georgia who were affected by Hurricane Irma.

**PROVIDER INFORMATION AVAILABLE**

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

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

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

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

BACKGROUND

Section 1135 and Section 1812(f) Waivers

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

1. Change Request (CR) 6451 (Transmittal 1784, Publication 100-04) issued on July 31, 2009, applies to items and services furnished to Medicare beneficiaries within the State of South Carolina from September 6, 2017, and the State of Georgia from September 7, 2017, for the duration of the emergency. In accordance with CR6451, use of the “DR” condition code and the “CR” modifier are mandatory on claims for items and services for which Medicare payment is conditioned on the presence of a “formal waiver” including, but not necessarily limited to, waivers granted under either Section 1135 or Section 1812(f) of the Act.

2. The most current information can be found at https://www.cms.gov/emergency. Medicare FFS Questions & Answers (Q&As) posted in the downloads section at the bottom of the Emergency Response and Recovery webpage and also referenced below are applicable for items and services furnished to Medicare beneficiaries within the States of South Carolina and Georgia. These Q&As are displayed in two files:

- The first listed file addresses policies and procedures that are applicable without any Section 1135 or other formal waiver. These policies are always applicable in any kind of emergency or disaster, including the current emergency in the States of South Carolina and Georgia.

- The second file addresses policies and procedures that are applicable only with approved Section 1135 waivers or, when applicable, approved Section 1812(f) waivers. These Q&As are applicable for approved Section 1135 blanket waivers and approved individual 1135 waivers requested by providers and are effective September 6, 2017, for the State South Carolina and September 7, 2017, for the State of Georgia.

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

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

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

Blanket Waivers Issued by CMS

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

Skilled Nursing Facilities

- Section 1812(f): Waiver of the requirement for a 3-day prior hospitalization for coverage of a skilled nursing facility (SNF) stay provides temporary emergency coverage of SNF services without a qualifying hospital stay, for those people who are evacuated, transferred, or otherwise dislocated as a result of
the effect of Hurricane Irma in the States of South Carolina and Georgia in 2017. In addition, for certain beneficiaries who recently exhausted their SNF benefits, it authorizes renewed SNF coverage without first having to start a new benefit period. (Blanket waiver for all impacted facilities)

- 42 CFR 483.20: Waiver provides relief to Skilled Nursing Facilities on the timeframe requirements for Minimum Data Set assessments and transmission. (Blanket waiver for all impacted facilities)

Home Health Agencies

- 42 CFR 484.20(c)(1): This waiver provides relief to Home Health Agencies on the timeframes related to OASIS Transmission. (Blanket waiver for all impacted agencies)

Critical Access Hospitals

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

Housing Acute Care Patients In Excluded Distinct Part Units

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

Care for Excluded Inpatient Psychiatric Unit Patients in the Acute Care Unit of a Hospital

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

Care for Excluded Inpatient Rehabilitation Unit Patients in the Acute Care Unit of a Hospital

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

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies for Medicare Beneficiaries Impacted by an Emergency or Disaster

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

Appeal Administrative Relief for Areas Affected by Hurricane Irma

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

Replacement Prescription Fills

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

Requesting an 1135 Waiver

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

ADDITIONAL INFORMATION

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


DOCUMENT HISTORY

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<tr>
<td>December 13, 2017</td>
<td>The article was revised to advise providers that the public health emergency declaration and Section 1135 waiver authority expired on December 4, 2017, for South Carolina and on December 5, 2017, for Georgia. All other information remains the same.</td>
</tr>
<tr>
<td>September 19, 2017</td>
<td>The article was revised to include new waivers regarding care for excluded inpatient psychiatric unit patients in the acute care unit of a hospital and care for excluded inpatient rehabilitation unit patients in the acute care unit of a hospital and to add information on replacement prescription fills of covered Part B drugs. All other information remains the same.</td>
</tr>
<tr>
<td>September 11, 2017</td>
<td>Initial article released.</td>
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Hurricane Maria and Medicare Disaster Related United States Virgin Islands and Commonwealth of Puerto Rico Claims - Revised

MLN Matters Number: SE17028 Revised

Article Release Date: October 2, 2017

The article was updated on October 2, 2017, to include the section on Applicability of Reporting Requirements for Inpatient Psychiatric Facilities, Skilled Nursing Facilities, Home Health Agencies, Hospices, Inpatient Rehabilitation Facilities, Ambulatory Surgical Centers, and Renal Dialysis Facilities Affected by Hurricane Maria. All other information remains the same.

PROVIDER TYPE AFFECTED

This MLN Matters® Special Edition Article is intended for providers and suppliers who submit claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries in the United States Virgin Islands and the Commonwealth of Puerto Rico who were affected by Hurricane Maria.

PROVIDER INFORMATION AVAILABLE

On September 18, 2017, pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act, President Trump declared that, as a result of the effects of Hurricane Maria, an emergency exists in the United States Virgin Islands and the Commonwealth of Puerto Rico. Also on September 19, 2017,
Secretary Price of the Department of Health & Human Services declared that a public health emergency exists in the United States Virgin Islands and the Commonwealth of Puerto Rico and authorized waivers and modifications under Section 1135 of the Social Security Act (the Act), retroactive to September 16, 2017, for the United States Virgin Islands and retroactive to September 17, 2017, for the Commonwealth of Puerto Rico.

On September 19, 2017, the Administrator of the Centers for Medicare & Medicaid Services (CMS) authorized waivers under Section 1812(f) of the Social Security Act for the United States Virgin Islands and the Commonwealth of Puerto Rico, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of Hurricane Maria in 2017.

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

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

**BACKGROUND**

**Section 1135 and Section 1812(f) Waivers**

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

1. Change Request (CR) 6451 (Transmittal 1784, Publication 100-04) issued on July 31, 2009, applies to items and services furnished to Medicare beneficiaries within the United States Virgin Islands from September 16, 2017, and the Commonwealth of Puerto Rico from September 17, 2017, for the duration of the emergency. In accordance with CR6451, use of the “DR” condition code and the “CR” modifier are mandatory on claims for items and services for which Medicare payment is conditioned on the presence of a “formal waiver” including, but not necessarily limited to, waivers granted under either Section 1135 or Section 1812(f) of the Act.

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

   - One file addresses policies and procedures that are applicable without any Section 1135 or other formal waiver. These policies are always applicable in any kind of emergency or disaster, including the current emergency in the United States Virgin Islands and the Commonwealth of Puerto Rico.
   - Another file addresses policies and procedures that are applicable only with approved Section 1135 waivers or, when applicable, approved Section 1812(f) These Q&As are applicable for approved Section 1135 blanket waivers and approved individual 1135 waivers requested by providers and are effective September 16, 2017, for the United States Virgin Islands and September 17, 2017, or the Commonwealth of Puerto Rico.

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

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

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

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

**Skilled Nursing Facilities**

- Section 1812(f): Waiver of the requirement for a 3-day prior hospitalization for coverage of a skilled nursing facility (SNF) stay provides temporary emergency coverage of SNF services without a qualifying hospital stay, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of Hurricane Maria in the United States Virgin Islands and the Commonwealth of Puerto Rico in 2017. In addition, for certain beneficiaries who recently exhausted their SNF benefits, it authorizes renewed SNF coverage without first having to start a new benefit period. (Blanket waiver for all impacted facilities)

- 42 CFR 483.20: Waiver provides relief to Skilled Nursing Facilities on the timeframe requirements for Minimum Data Set assessments and transmission. (Blanket waiver for all impacted facilities)

**Home Health Agencies**

- 42 CFR 484.20(c)(1): This waiver provides relief to Home Health Agencies on the timeframes related to OASIS Transmission. (Blanket waiver for all impacted agencies)

**Critical Access Hospitals**

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

**Housing Acute Care Patients In Excluded Distinct Part Units**

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

**Care for Excluded Inpatient Psychiatric Unit Patients in the Acute Care Unit of a Hospital**

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

**Care for Excluded Inpatient Rehabilitation Unit Patients in the Acute Care Unit of a Hospital**

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

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


Appeal Administrative Relief for Areas Affected by Hurricane Maria

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

Replacement Prescription Fills

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

Applicability of Reporting Requirements for Inpatient Psychiatric Facilities, Skilled Nursing Facilities, Home Health Agencies, Hospices, Inpatient Rehabilitation Facilities, Ambulatory Surgical Centers, and Renal Dialysis Facilities Affected by Hurricane Maria – This information added on October 2, 2017.

CMS is granting exceptions under certain Medicare quality reporting and value-based purchasing programs to inpatient psychiatric facilities, skilled nursing facilities, home health agencies, hospices, inpatient rehabilitation facilities, renal dialysis facilities, and ambulatory surgical centers located in areas affected by Hurricane Maria due to the devastating impact of the storm. These providers will be granted exceptions without having to submit an Extraordinary Circumstances Exceptions (ECE) request if they are located in one of the 78 Puerto Rico municipios or one of the three U.S. Virgin Islands county-equivalents, all of which have been designated by the Federal Emergency Management Agency (FEMA) as a major disaster municipio or county-equivalent.

The scope and duration of the exception under each Medicare quality reporting program is described in the memorandum that CMS posted on September 25, 2017, however, all of the exceptions are being granted to assist these providers while they direct their resources toward caring for their patients and repairing structural damages to facilities.

Requesting an 1135 Waiver

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

ADDITIONAL INFORMATION

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

### DOCUMENT HISTORY

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<td>October 2, 2017</td>
<td>The article was updated to include the section on Applicability of Reporting Requirements for Inpatient Psychiatric Facilities, Skilled Nursing Facilities, Home Health Agencies, Hospices, Inpatient Rehabilitation Facilities, Ambulatory Surgical Centers, and Renal Dialysis Facilities Affected by Hurricane Maria. All other information remains the same.</td>
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<tr>
<td>September 21, 2017</td>
<td>Initial article released.</td>
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### Hurricane Nate and Medicare Disaster Related Alabama, Florida, Louisiana and Mississippi Claims

**MLN Matters Number:** SE17034  
**Article Release Date:** October 11, 2017

#### PROVIDER TYPES AFFECTED

This MLN Matters® Special Edition Article is intended for providers and suppliers who submit claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries in the States of Alabama, Florida, Louisiana, and Mississippi, who were affected by Hurricane Nate.

#### PROVIDER INFORMATION AVAILABLE

Pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act, President Trump declared that, as a result of the effects of Hurricane Nate, an emergency exists in Alabama, Florida, Louisiana, and Mississippi.

On October 8, 2017, Acting Secretary Wright of the Department of Health & Human Services declared that a public health emergency exists in the States of Louisiana retroactive to October 5, 2017; Mississippi, and Alabama retroactive to October 6, 2017; and Florida retroactive to October 7, 2017, and authorized waivers and modifications under §1135 of the Social Security Act.

On October 10, 2017, the Administrator of the Centers for Medicare & Medicaid Services (CMS) authorized waivers under §1812(f) of the Social Security Act for the States of Louisiana retroactive to October 5, 2017; Mississippi, and Alabama retroactive to October 6, 2017; and Florida retroactive to October 7, 2017 for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of Hurricane Nate in 2017. These waivers will prevent gaps in access to care for beneficiaries impacted by the emergency. Providers do not need to apply for an individual waiver if a blanket waiver has been issued. Providers can request an individual Section 1135 waiver, if there is no blanket waiver, by following the instructions available at [https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Requesting-an-1135-Waiver-Updated-11-16-2016.pdf](https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Requesting-an-1135-Waiver-Updated-11-16-2016.pdf).

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

#### BACKGROUND

**Section 1135 and Section 1812(f) Waivers**

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

Change Request (CR) 6451 (Transmittal 1784, Publication 100-04) issued on July 31, 2009, applies to items and services furnished to Medicare beneficiaries within Alabama, Florida, Louisiana and Mississippi for the duration of the emergency. In accordance with CR6451, use of the “DR” condition code and the “CR” modifier are mandatory on claims for items and services for which Medicare payment is conditioned on the presence of a “formal waiver” including, but not necessarily limited to, waivers granted under either Section 1135 or Section 1812(f) of the Act.

The most current information can be found at [https://www.cms.gov/emergency](https://www.cms.gov/emergency) posted in the downloads section at the bottom of the Emergency Response and Recovery webpage.
Also referenced below are Q&As that are applicable for items and services furnished to Medicare beneficiaries within the Alabama, Florida, Louisiana and Mississippi. These Q&As are displayed in two files:

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

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

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

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

**Blanket Waivers for Alabama, Florida, Louisiana and Mississippi**

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

**Skilled Nursing Facilities**
- 1812(f): This waiver of the requirement for a 3-day prior hospitalization for coverage of a skilled nursing facility stay provides temporary emergency coverage of Skilled Nursing Facility (SNF) services without a qualifying hospital stay, for those people who are evacuated, transferred, or otherwise dislocated as result of the effect of Hurricane Nate in Alabama, Florida, Louisiana and Mississippi in 2017. In addition, for certain beneficiaries who recently exhausted their SNF benefits, it authorizes renewed SNF coverage without first having to start a new benefit period (Blanket waiver for all impacted facilities).
- 42 CFR 483.20: This waiver provides relief to Skilled Nursing Facilities on the timeframe requirements for Minimum Data Set assessments and transmission (Blanket waiver for all impacted facilities).

**Home Health Agencies**

42 CFR 484.20(c)(1): This waiver provides relief to Home Health Agencies on the timeframes related to OASIS Transmission (Blanket waiver for all impacted agencies).

**Critical Access Hospitals**

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

**Housing Acute Care Patients in Excluded Distinct Part Units**

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

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

- As a result of Hurricane Nate, CMS is temporarily extending the 10 business day deadline to provide notification of any subcontracting arrangements. During the temporary extension period, affected contract suppliers will have 30 business days to provide notice to the Competitive Bidding Implementation Contractor of any subcontracting arrangements. CMS will notify DMEPOS Competitive Bidding contract suppliers via e-mail when this temporary extension expires. All other competitive bidding program requirements remain in force. Note: CMS will provide notice of any changes to reporting timeframes for future events.


**Replacement Prescription Fills**

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

**Care for Excluded Inpatient Psychiatric Unit Patients in the Acute Care Unit of a Hospital**

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

**Care for Excluded Inpatient Rehabilitation Unit Patients in the Acute Care Unit of a Hospital**

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

These temporary emergency policies would apply to the timeframes specified in the waiver(s) issued under Section 1135 of the Act in connection with the effect of Hurricane Nate in Alabama, Florida, Louisiana and Mississippi. More information is available in the 1135 Waiver Letter, which is posted in the Downloads section at [https://www.cms.gov/About-CMS/Agency-Information/Emergency/Hurricanes.html](https://www.cms.gov/About-CMS/Agency-Information/Emergency/Hurricanes.html)

**Requesting an 1135 Waiver**


**ADDITIONAL INFORMATION**

The Centers for Disease Control and Prevention released ICD-10-CM coding advice to report healthcare encounters in the hurricane aftermath.
Medicare FFS Response to the 2017 California Wildfires

MLN Matters Number: SE17035
Article Release Date: October 18, 2017

PROVIDER TYPES AFFECTED

This MLN Matters® Special Edition Article is intended for providers and suppliers who submit claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries, who were affected by the 2017 wildfires in the State of California.

PROVIDER INFORMATION AVAILABLE

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


On October 17, 2017, the Administrator of the Centers for Medicare & Medicaid Services (CMS) authorized waivers under §1812(f) of the Social Security Act for the State of California retroactive to October 8, 2017 for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of wildfires. Providers can request an individual Section 1135 waiver by following the instructions available at https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Requesting-an-1135-Waiver-Updated-11-16-2016.pdf.

BACKGROUND

Section 1135 and Section 1812(f) Waivers

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

Change Request (CR) 6451 (Transmittal 1784, Publication 100-04) issued on July 31, 2009, applies to items and services furnished to Medicare beneficiaries within the State of California retroactive to October 8, 2017, for the duration of the emergency. In accordance with CR6451, use of the “DR” condition code and the “CR” modifier are mandatory on claims for items and services for which Medicare payment is conditioned on the presence of a “formal waiver” including, but not necessarily limited to, waivers granted under either Section 1135 or Section 1812(f) of the Act.

The most current information can be found at https://www.cms.gov/About-CMS/Agency-Information/Emergency/Wildfires.html.

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

- One file addresses policies and procedures that are applicable without any Section 1135 or other formal waiver. These policies are always applicable in any kind of emergency or disaster, including the current emergency.

- Another file addresses policies and procedures that are applicable only with approved Section 1135 waivers or, when applicable, approved Section 1812(f) waivers. These Q&As are applicable for approved individual 1135 waivers requested by providers for California.

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

a) Q&As applicable without any Section 1135 or other formal waiver are available at https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Consolidated_Medicare_FFS_Emergency_QsAs.pdf.
b) Q&As applicable only with a Section 1135 waiver or, when applicable, a Section 1812(f) waiver, are available at https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/MedicareFFS-EmergencyQsAs1135Waiver.pdf.

Waiver for California

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

Skilled Nursing Facilities

- 1812(f): This waiver of the requirement for a 3-day prior hospitalization for coverage of a Skilled Nursing Facility stay provides temporary emergency coverage of Skilled Nursing Facility (SNF) services without a qualifying hospital stay, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of the wildfires. In addition, for certain beneficiaries who recently exhausted their SNF benefits, it authorizes renewed SNF coverage without first having to start a new benefit period (Blanket waiver for all impacted facilities).

- In addition, the waiver provides temporary emergency coverage of SNF services that are not post-hospital SNF services under the authority in §1812(f) of the Social Security Act (the Act), for those people who are evacuated, transferred, or otherwise dislocated as a result of the effects in the State of California, in October 2017. In addition, this waiver provides authority under §1812(f) of the Act to provide coverage for extended care services which will not require a new spell of illness in order to renew provision of services by a SNF. These temporary emergency policies would apply to the timeframes specified in the waiver(s) issued under §1135 of the Act in connection with the effects of the wildfires in the State of California in October 2017. Accordingly, both the effective date and expiration date for these temporary emergency policies are the same as those specified pursuant to the §1135 waivers. Further, unlike the policies authorized directly under the §1135 waiver authority itself, the two policies described above would not be limited to beneficiaries who have been relocated within areas that have been designated as emergency areas. Instead, the policies would apply to all beneficiaries who were evacuated from an emergency area as a result of the effects of the wildfires in California in October 2017, regardless of where the “host” SNF providing post-disaster care is located.

Administrative Relief

Appeal Administrative Relief for Areas Affected by California Wildfires

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

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

Requesting an 1135 Waiver


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<td>October 18, 2017</td>
<td>Initial article released.</td>
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Medicare FFS Response to 2017 Southern California Wildfires

MLN Matters Number: SE17037
Article Revised Date: December 18, 2017
PROVIDER TYPES AFFECTED
This MLN Matters® Special Edition Article is intended for providers and suppliers who submit claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries who were affected by the December 2017 wildfires in the State of California.

PROVIDER INFORMATION AVAILABLE
Pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act, President Trump declared that, as a result of the effects of the December 2017 Wildfires, a major disaster exists in the State of California.


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

BACKGROUND
Section 1135 and Section 1812(f) Waivers
As a result of the aforementioned declaration, CMS has instructed MACs as follows:

Change Request (CR) 6451 (Transmittal 1784, Publication 100-04) issued on July 31, 2009, applies to items and services furnished to Medicare beneficiaries within the State of California retroactive to December 4, 2017, for the duration of the emergency. In accordance with CR6451, use of the “DR” condition code and the “CR” modifier are mandatory on claims for items and services for which Medicare payment is conditioned on the presence of a “formal waiver” including, but not necessarily limited to, waivers granted under either Section 1135 or Section 1812(f) of the Act.

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

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

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

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

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

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

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

Skilled Nursing Facilities

- **1812(f):** This waiver of the requirement for a 3-day prior hospitalization for coverage of a Skilled Nursing Facility stay provides temporary emergency coverage of Skilled Nursing Facility (SNF) services without a qualifying hospital stay, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of the wildfires. In addition, for certain beneficiaries who recently exhausted their SNF benefits, it authorizes renewed SNF coverage without first having to start a new benefit period (Blanket waiver for all impacted facilities).

- In addition, the waiver provides temporary emergency coverage of SNF services that are not post-hospital SNF services under the authority in §1812(f) of the Social Security Act (the Act), for those people who are evacuated, transferred, or otherwise dislocated as a result of the effects in the State of California, in December 2017. In addition, this waiver provides authority under §1812(f) of the Act to provide coverage for extended care services which will not require a new spell of illness in order to renew provision of services by a SNF. These temporary emergency policies would apply to the timeframes specified in the waiver(s) issued under §1135 of the Act in connection with the effects of the wildfires in the State of California in December 2017. Accordingly, both the effective date and expiration date for these temporary emergency policies are the same as those specified pursuant to the §1135 waivers. Further, unlike the policies authorized directly under the §1135 waiver authority itself, the two policies described above would not be limited to beneficiaries who have been relocated within areas that have been designated as emergency areas. Instead, the policies would apply to all beneficiaries who were evacuated from an emergency area as a result of the effects of the wildfires in California in December 2017, regardless of where the “host” SNF providing post-disaster care is located.

Administrative Relief

Appeal Administrative Relief for Areas Affected by California Wildfires

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

Requesting an 1135 Waiver


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

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<td>Initial article released</td>
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Do Not Forward Initiative Reminder

The Internet Only Manual (IOM) Medicare Claims Processing Manual, Publication 100-04 instructs Part A and Part B Medicare Administrative Contractors (A/B MACs) and carriers to use “return service requested” envelopes when mailing paper checks and remittance advices to providers.

When the post office returns a “return service requested” envelope, the A/B MAC/carrier applies a “do not forward” (DNF) flag to the provider’s Medicare enrollment file. The A/B MAC/carrier will not generate any additional checks for that provider until the provider sends a properly completed change of address form back to the A/B MAC/carrier. We are not required to contact the provider to notify them that the flag has been added to their file.

Upon verifying the new address, the A/B MAC/carrier removes the DNF flag and can again generate payments for the provider. Electronic Funds Transfer (EFT) is required; therefore, when the address change update is completed, the provider will be set up to use EFT and will no longer receive paper checks.

NOTE: Because many providers get paid through EFT, there may be cases where a provider does not have a correct address on file, but the A/B MAC/carrier continues to pay the provider through EFT. It is still the provider’s responsibility to submit and address change update so that remittance notices and special checks would be sent to the proper address.

Noridian encourages providers to enroll or make changes using Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for faster processing time. Applications and changes completed online currently have an average processing time of 10 days. All Medicare providers may use the new enrollment process on the CMS website https://pecos.cms.hhs.gov. To log into this internet-based PECOS, providers will use their NPI Userid and password.

Policy

Effective October 1, 2002, A/B MACs/carriers must use “return service requested” envelopes for hardcopy remittance advices and checks, with respect to providers that have elected to receive hardcopy remittance advices. (PM B-02-023, CR 2038 dated April 12, 2002; Transmittal 1794, CR 2684 dated May 2, 2003)

Implementation Process

• “Return service requested” envelopes are used for all hardcopy remittance advices starting October 1, 2002. These envelopes will be used for all providers.

• “Return service requested” envelopes will not be used for beneficiary correspondence, such as Medicare Summary Notices (MSNs) or for overpayment demand letters.

• When the post office returns a remittance advice due to an incorrect address, A/B MACs/carriers will follow the same procedures as followed for returned checks, that is:
  • Flag the provider’s file DNF.
  • A/B MAC/carrier staff will notify provider enrollment team.
  • A/B MAC/carriers will cease generating any further payments or remittance advice to that provider or supplier until furnished with a new, verified address.

  • When the provider establishes a new, verified address, A/B MACs/carriers will remove the DNF flag and pay the provider any funds which are still being held due to a DNF flag. A/B MAC/carriers must also reissue any remittance advices, which have been held.

  • Previously, CMS only required corrections to the “pay to” address. However, with the implementation of this initiative, CMS requires corrections to all addresses before the contractor can remove the DNF flag and begin paying the provider or supplier again. Therefore, A/B MAC/carriers cannot release any payments to DNF providers until the provider enrollment department has verified and updated all addresses for that provider’s location.
IRS-1099 Reporting

Provider or supplier checks returned and voided during the same year they were issued are not reported on the Internal Revenue Service (IRS) Form 1099 until the returned check is reissued (i.e., the DNF flag is removed and the A/B MAC/carrier reissues payment to the provider.) Checks returned and voided in the current year that were issued in prior years are not netted from the current year’s IRS Form 1099.

Monies withheld because a DNF flag exists on a provider or supplier record are not reported on IRS-1099s until the calendar year in which payment is made (i.e., the point at which the A/B MAC/carrier pays the provider once the DNF flag is removed.) If DNF amounts are erroneously included on IRS-1099 forms, A/B MACs/carriers will issue corrected IRS Form 1099s to affected providers.

Source: IOM Medicare Claims Processing Manual, Publication 100-04, Chapter 22, Section 50.1

Enrollment Application Status Search Tool Now Available

Have you submitted an enrollment application to Noridian and wish you could check its status without picking up the phone? You can!

Check out our newest web-based self-service tool on the Enrollment Application Status Search webpage. This search allows providers and suppliers to follow the application progress. Simply enter an Application/Reference Number or Web Tracking ID into its search field and select “View Application Status.”

If a match is identified, the results will vary depending on the application progression. The below indicates the high-level progression levels. Additional verbiage may be included, if/when necessary.

- Received
- In Progress
- Corrections Requested
- Completed
- Unable to Complete

For additional inquiries beyond an application status, contact the Provider Enrollment Contact Center.

New Specialties for Medicare Enrollment Effective October 2, 2017

Effective October 2, 2017, CMS has issued new specialty codes that will be used to describe and define specific/unique types of medicine in a physician’s practice on a Medicare enrollment form. The new specialties are as follows:

- Advanced Heart Failure and Transplant Cardiology (C7)
- Medical Toxicology (C8)
- Hematopoietic Cell Transplantation and Cellular Therapy (C9)

The 855I and 855O application will be updated in the future to reflect these new specialty codes.

If you are completing the application via the 855I paper application, watch Enrollment on Demand (EoD) for paper Initial Enrollment for Physicians who Reassign Benefits. In section 2D; select Undefined physician type and write in the new specialty. If the provider is enrolled with Medicare and needs to update their specialty, make sure to watch the EoD Reporting a Change, Group members.

If you are completing the initial application via Provider Enrollment, Chain, and Ownership System (PECOS) watch EoD for PECOS Initial Enrollment for Physicians who Reassign Benefits. If the provider is enrolled with Medicare and needs to update their specialty, make sure to watch the EoD How to Start a Change of Information PECOS Application.

If initially enrolling or wanting to update the current specialty to order, certify and prescribe, make sure to select the topic on the EoD webpage and view either the paper EOD or PECOS EoD that applies to the providers current specialty. In the specialty section, select undefined and enter the new specialty.
Open Enrollment Participation Program for 2018

Open enrollment is upon us! Medicare contractors conduct an open participation enrollment period, every year, to give eligible physicians, practitioners and suppliers an opportunity to enroll in Medicare as participating providers or terminate enrollment in the participation program.

Providers will receive a postcard in the mail stating that it is open enrollment time. This is generally from Mid-November to the end of December. For more information, review the [Open Enrollment page](#) on the Noridian Medicare website for details about this year’s open enrollment.

If a change is not needed to the current participation status, no action is needed. Providers current status will roll over automatically to the next calendar year. If a change is needed to be made, the request must be postmarked within the open enrollment dates. Hold billing until notified of status change. Noridian is unable to submit claims revisions on your behalf for this reason. This open enrollment cycle runs from November 8, 2017 through December 31, 2017.

When Medicare providers complete and sign the participation agreement (CMS-460 Form), the provider agrees to accept assignment for all covered services that are provided to Medicare patients. The [CMS Internet Only Manual (IOM), Publication 100-04, Chapter 1, Section 30.3.12](#) outlines the annual open enrollment process. The benefits of signing a participation agreement include:

- Higher Fee Schedules: The fee schedule amount is five percent higher than that for a non-participating provider.
- Payment Information Forwarded to Supplemental Insurers (Medigap): Claim payment information will be forwarded to the patient’s supplemental insurer if the name, address, and policy number of the Medigap insurer is shown on the claim form prefaced by the word “MEDIGAP”, “MG” or “MGAP.” (See the [CMS IOM, Publication 100-04, Medicare Claims Processing Manual, Chapter 28, Section 70.6](#), for more information regarding the eligibility-file based crossover process.)
- Medicare Directories: Listing in the Medicare Participation Physicians/Suppliers Directory (MEDPARD) that is posted on the contractor’s website.
- Direct Payment: Participants receive direct and timely reimbursement from Medicare.

**View More Information on Open Enrollment and Eligibility**

- [Medicare Participation](#)
- [Medicare Non-Participation](#)
- [Assignment vs. Non-assignment](#)
New Waived Tests – Revised

MLN Matters Number: MM10198 Revised
Related Change Request (CR) Number: 10198
Related CR Release Date: September 28, 2017
Effective Date: October 1, 2017
Related CR Transmittal Number: R3867CP
Implementation Date: October 2, 2017

This article was revised on September 28, 2017, to reflect a revised CR10198. In the article, the CR release date, transmittal number, and the Web address for accessing the CR are revised. All other information remains the same.

PROVIDER TYPE AFFECTED
This MLN Matters® Article is intended for clinical diagnostic laboratories submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED
Change Request (CR) 10198 informs MACs of new Clinical Laboratory Improvement Amendments of 1988 (CLIA) waived tests approved by the Food and Drug Administration (FDA). Since these tests are marketed immediately following approval, the Centers for Medicare & Medicaid Services (CMS) must notify the MACs of the new tests so that they can accurately process claims. CR10198 lists 17 newly added waived complexity tests.

BACKGROUND
The CLIA regulations require a facility to be appropriately certified for each test performed. To ensure that Medicare and Medicaid only pay for laboratory tests categorized as waived complexity under CLIA in facilities with a CLIA certificate or waiver, laboratory claims are currently edited at the CLIA certificate level.

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

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

- 87880QW, December 8, 2016, Quidel Sofia Strep A+ FIA (from throat swab only);
- 80305QW, April 28, 2017, Alere Toxicology Services Alere iCup Rx Multi-Drug Urine Test Cup;
- 80305QW, May 16, 2017, AssureTech Amphetamine Dip;
- 80305QW, May 16, 2017, AssureTech Oxazepam Panel Dip;
- 80305QW, May 16, 2017, AssureTech Cocaine Panel Dip;
- 80305QW, May 16, 2017, AssureTech Buprenorphine Panel Dip;
• 87804QW, May 30, 2017, Quidel Sofia 2 (Sofia Influenza A+B FIA); and

Note: MACs will not search their files to either retract payment or retroactively pay claims; however, MACs should adjust claims if they are brought to their attention.

ADDITIONAL INFORMATION


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Clinical Laboratory Fee Schedule Not Otherwise Classified, Not Otherwise Specified or Unlisted Service or Procedure Code Data Collection

MLN Matters Number: MM10232
Related Change Request (CR) Number: 10232
Related CR Release Date: October 13, 2017
Effective Date: January 16, 2018
Related CR Transmittal Number: R3881CP
Implementation Date: January 16, 2018

PROVIDER TYPES 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) 10232 instructs MACs to assure that providers submit private payor data on unique tests currently being paid as a Not Otherwise Classified (NOC) code, Not Otherwise Specified (NOS) code, or Unlisted Service or Procedure code. Make your billing staff aware of this change.

BACKGROUND

Section 216(a) of the Protecting Access to Medicare Act of 2014 (PAMA) added Section 1834A to the Social Security Act (the Act), which requires revisions to the payment methodology for clinical diagnostic laboratory tests paid under the Clinical Laboratory Fee Schedule (CLFS). PAMA requires reporting entities to report private payor payment rates for laboratory tests and the corresponding volumes of tests. In compliance with PAMA, the Centers for Medicare & Medicaid Services (CMS) must collect private payor data on unique tests currently being paid as a Not Otherwise Classified (NOC) code, Not Otherwise Specified (NOS) code, or Unlisted Service or Procedure code. In compliance with PAMA, CMS is collecting private payor data on unique tests currently being paid as a NOC code, NOS code, or unlisted service or procedure code. The update of the “Medicare Claims Processing Manual,” Chapter 26, “Completing and
Processing Form CMS-1500 Data Set,” clarifies how providers of service or suppliers should populate field 19 of the form when billing NOC codes. Specifically, when billing for unlisted laboratory tests using a NOC code, field 19 must be populated with the specific name of the laboratory test(s) and/or a short descriptor of the test(s).

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Laboratory NCD Edit Software for January 2018 – Revised

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

The article was revised on November 21, 2017, to reflect a revised CR10309 issued on November 21. In the article, the CR release date, transmittal number, and the Web address of the CR are revised. All other information remains the same.

PROVIDER TYPE AFFECTED

This MLN Matters® Article is intended for physicians, providers, and suppliers submitting claims to Medicare contractors (Regional Home Health Intermediaries (RHHIs) and A/B Medicare Administrative Contractors (A/B MACs)) for services to Medicare beneficiaries.

WHAT YOU NEED TO KNOW

This article is based on Change Request (CR) 10309 which informs MACs about the changes that will be included in the January 2018 quarterly release of the edit module for clinical diagnostic laboratory services. CR10309 applies to Chapter 16, Section 120.2, Publication 100-04. Make sure that your billing staffs are aware of these changes.

See the Background and Additional Information Sections of this article for further details regarding these changes.

BACKGROUND

CR10309 announces the changes that will be included in the January 2018 quarterly release of the edit module for clinical diagnostic laboratory services. NCDs for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee, and the final rule was published on November 23, 2001. Nationally uniform software was developed and incorporated in the Medicare shared systems so that laboratory claims subject to one of the 23 NCDs (Publication 100-03, Sections 190.12 - 190.34) were processed uniformly throughout the nation effective April 1, 2003.

In accordance with Chapter 16, Section 120.2, Publication 100-04, the laboratory edit module is updated quarterly as necessary to reflect ministerial coding updates and substantive changes to the NCDs developed through the NCD process. The changes are a result of coding analysis decisions developed under the procedures for maintenance of codes in the negotiated NCDs and biannual updates of the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes. CR 10309 communicates requirements to Shared System Maintainers (SSMs) and contractors, notifying them of...
changes to the laboratory edit module to update it for changes in laboratory NCD code lists for January 2018. Please access the link below for the NCD spreadsheets included with CR10309:


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

ADDITIONAL INFORMATION


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New Waived Tests

MLN Matters Number: MM10321
Related Change Request (CR) Number: 10321
Related CR Release Date: November 3, 2017
Effective Date: January 1, 2018
Related CR Transmittal Number: R3902CP
Implementation Date: January 2, 2018

PROVIDER TYPES AFFECTED

This MLN Matters Article is intended for clinical diagnostic laboratories submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

Change Request (CR) 10321 informs MACs of new Clinical Laboratory Improvement Amendments of 1988 (CLIA) waived tests approved by the Food and Drug Administration (FDA). Since these tests are marketed immediately after approval, the Centers for Medicare & Medicaid Services (CMS) must notify its MACs of the new tests so they can accurately process claims. Make sure your billing staffs are aware of these updates.

BACKGROUND

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

CR 10321 describes the latest tests approved by the FDA as waived tests under CLIA. The Current Procedural Terminology (CPT) codes for the new tests must have the modifier QW to be recognized as a waived test. However, the tests mentioned on the first page of the list found in the attachment CR10321 (that is, CPT codes 81002, 81025, 82270, 82272, 82962, 83026, 84830, 85013, and 85651) do not require a QW modifier to be recognized as a waived test.

The CPT code, effective date, and description for the latest tests approved by the FDA as waived tests include:

- 87807QW, June 30, 2017, Quidel Sofia 2 {Sofia RSV FIA}
- 82274QW, G0328QW, June 5, 2017, Henry Schein OneStep Pro+FIT (1)
The attachment to CR10321 contains the test name, manufacturer, and use for each of the above listed CPT codes. You should be aware that MACs will not search their files to either retract payment or retroactively pay claims; however, they should adjust claims that you bring to their attention.

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CLFS and Laboratory Services Subject to Reasonable Charge Payment – 2018 Annual Update

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

PROVIDER TYPES AFFECTED

This MLN Matters® Article is intended for clinical diagnostic laboratories that submit claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

WHAT YOU NEED TO KNOW

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

KEY POINTS OF CR10409

Fee Schedule through December 31, 2017

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

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

For cervical or vaginal smear tests (pap smears), the fee cannot be less than a national minimum payment amount, initially established at $14.60 and updated each year for inflation, as stated in Section 1833(h)(7) of the Act.
Fee Schedule Beginning January 1, 2018

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

Update to Fees

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

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

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

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

Access to Data File

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

Public Comments and Final Payment Determinations

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

Pricing Information

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

The fees for clinical laboratory travel codes P9603 and P9604 are updated on an annual basis. The clinical laboratory travel codes are billable only for traveling to perform a specimen collection for either a nursing home or homebound patient. If there is a revision to the standard mileage rate for CY 2018, CMS will issue a separate instruction on the clinical laboratory travel fees.

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

Mapping Information

- New code 81105 is priced at the same rate as code 81376.
- New code 81106 is priced at the same rate as code 81376.
• New code 81107 is priced at the same rate as code 81376.
• New code 81108 is priced at the same rate as code 81376.
• New code 81109 is priced at the same rate as code 81376.
• New code 81110 is priced at the same rate as code 81376.
• New code 81111 is priced at the same rate as code 81376.
• New code 81112 is priced at the same rate as code 81376.
• New code 81120 is priced at the same rate as code 81275.
• New code 81121 is priced at the same rate as code 81311.
• New code 81175 is priced at the same rate as code 81317.
• New code 81176 is priced at the same rate as code 81218.
• New code 81230 is priced at the same rate as code 81227.
• New code 81231 is priced at the same rate as code 81227.
• New code 81232 is priced at the same rate as code 81227.
• New code 81238 is priced at the same rate as code 81321.
• New code 81247 is priced at the same rate as code 81227.
• New code 81248 is priced at the same rate as code 81215.
• New code 81249 is priced at the same rate as code 81321.
• New code 81258 is priced at the same rate as code 81215.
• New code 81259 is priced at the same rate as code 81321.
• New code 81269 is priced at the same rate as code 81294.
• New code 81283 is priced at the same rate as code 81241.
• New code 81328 is priced at the same rate as code 81227.
• New code 81334 is priced at the same rate as code 81272.
• New code 81335 is priced at the same rate as code 81227.
• New code 81346 is priced at the same rate as code 81227.
• New code 81361 is priced at the same rate as code 81227.
• New code 81362 is priced at the same rate as code 81215.
• New code 81363 is priced at the same rate as code 81294.
• New code 81364 is priced at the same rate as code 81235.
• New code 81448 is priced at the same rate as code 81435.
• New code 81520 is priced at the same rate as code 0008M.
• New code 81521 is priced at the same rate as code 81519.
• New code 81541 is priced at the same rate as code 81519.
• New code 81551 is to be gapfilled.
• New code 86008 is priced at the same rate as code 86235.
• New code 86794 is priced at the same rate as code 86788.
• New code 87634 is priced at the same rate as code 87801.
• New code 87662 is priced at the same rate as code 87501.
• New code 0001U is to be gapfilled.
• New code 0002U is to be gapfilled.
• New code 0003U is priced at the same rate as 1.25 times code 0010M.
• New code 0005U is priced at the same rate as code 0010M.
• New code 0006U is priced at the same rate as code G0483.
• New code 0007U is priced at the same rate as code G0480.
• New code 0008U is priced at the same rate as code 81445.
• New code 0009U is to be gapfilled.
• New code 0010U is to be gapfilled.
• New code 0011U is priced at the same rate as code G0480.
• New code 0012U is to be gapfilled.
• New code 0013U is to be gapfilled.
• New code 0014U is to be gapfilled.
• New code 0016U is priced at the same rate as code 81206.
• New code 0017U is priced at the same rate as code 81270.
• New code G0499 is priced at the same rate as code 87340 plus 0.05 times code 87341 plus code 86704 plus 0.5 times code 86706.
• Reconsidered code 81327 is to be gapfilled.
• Existing code 80305 is priced at the same rate as code G0477.
• Existing code 80306 is priced at the same rate as code G0478.
• Existing code 80307 is priced at the same rate as code G0479.
• Existing code 81413 is priced at the same rate as code 81435.
• Existing code 81414 is priced at the same rate as code 81436.
• Existing code 81422 is priced at the same rate as code 81420.
• Existing code 81439 is priced at the same rate as code 81435.
• Existing code 81539 is priced at the same rate as code 0010M.
• Existing code 84410 is priced at the same rate as code 84402 plus code 84403.
• Existing code 87483 is priced at the same rate as code 87633.
• Existing code G0475 is priced at the same rate as code 87389.
• Existing code G0476 is priced at the same rate as code 87624.
• Existing code G0659 is priced at the same rate as code G0479.
• Existing code 80410 is priced at the same rate as 3 times code 82308.
• Existing code 80418 is priced at the same rate as 4 times code 82024 plus 4 times code 83002 plus 4 times code 83001 plus 4 times code 84146 plus 4 times code 83003 plus 4 times code 82533 plus 4 times code 84443.
• Existing code 80435 is priced at the same rate as 5 times code 82947 plus 5 times code 83003.
• Existing code 81316 is priced at the same rate as code 81315. Existing code 81326 is priced at the same rate as code 81322.
• Existing code 81425 is to be gapfilled.
• Existing code 81426 is to be gapfilled.
• Existing code 81427 is to be gapfilled.
• Existing code 81434 is priced at the same rate as code 81445.
• Existing code 81470 is to be gapfilled.
• Existing code 81471 is to be gapfilled.
• Existing code 81506 is priced at the same rate as code 82728 plus code 82947 plus code 83036 plus code 83525 plus code 86141 plus code 83520.
• Existing code 82286 is priced at the same rate as code 82310.
• Existing code 82387 is priced at the same rate as code 82373.
• Existing code 82759 is priced at the same rate as code 82963.
• Existing code 82979 is priced at the same rate as code 84220.
• Existing code 83662 is priced at the same rate as code 83663.
• Existing code 83857 is priced at the same rate as code 84165.
• Existing code 83987 is priced at the same rate as code 83986.
• Existing code 84085 is priced at the same rate as code 84220.
• Existing code 84485 is priced at the same rate as code 82977.
• Existing code 84577 is priced at the same rate as code 82710.
• Existing code 84580 is priced at the same rate as code 82615.
• Existing code 85170 is priced at the same rate as 0.8 times code 85175.
• Existing code 85337 is priced at the same rate as code 83520.
• Existing code 85400 is priced at the same rate as code 85410.
• Existing code 85530 is priced at the same rate as code 85520.
• Existing code 86327 is priced at the same rate as code 86320.
• Existing code 86821 is priced at the same rate as code 86822.
• Existing code 86829 is priced at the same rate as code 86828.
• Existing code 87152 is priced at the same rate as code 87158.
• Existing code 87267 is priced at the same rate as code 87271.
• Existing code 87475 is priced at the same rate as code 87480.
• Existing code 87485 is priced at the same rate as code 87480.
• Existing code 87495 is priced at the same rate as code 87797.
• Existing code 87528 is priced at the same rate as code 87480.
• Existing code 87537 is priced at the same rate as code 87534.
• Existing code 87557 is priced at the same rate as code 87592.
• Existing code 87562 is priced at the same rate as code 87592.
• Existing code 88130 is priced at the same rate as code 87209.
• Existing code 88245 is priced at the same rate as code 88248.
• Existing code 88741 is priced at the same rate as code 88740.
• Existing code 89329 is priced at the same rate as code 89331.
• Existing code 0002M is priced at the same rate as code 0003M.
• Existing code 0004M is to be gapfilled.
• Existing code 0006M is to be gapfilled.
• Existing code 0007M is to be gapfilled.
• Existing code 0009M is to be gapfilled.
• Existing code G0480 is priced at the same rate as 4 times code 82542 plus 0.75 times code 82542.
• Existing code G0481 is priced at the same rate as 4 times code 82542 plus 2.50 times code 82542.
• Existing code G0482 is priced at the same rate as 4 times code 82542 plus 4.25 times code 82542.
• Existing code G0483 is priced at the same rate as 4 times code 82542 plus 6.25 times code 82542.
• Existing code P2028 is priced at the same rate as code 82040.
• Existing code P2029 is priced at the same rate as code 82040.
• Existing code P2031 is priced at the same rate as code 82040.
• Existing code P2033 is priced at the same rate as code 82040.
• Existing code P2038 is priced at the same rate as code 82040.
• Existing code Q0113 is priced at the same rate as code 87172.
• New code 80305QW is priced at the same rate as code 80305.
• New code 87633QW is priced at the same rate as code 87633.
• New code 87801QW is priced at the same rate as code 87801.
• New code G0475QW is priced at the same rate as code G0475.
• New code 85025QW is priced at the same rate as code 85025.
The following existing codes are to be deleted:
• 0008M
• 83499
• 83992
• 84061
• 86185
• 86243
• 86378
• 86729
• 86822
• 87277
• 87470
• 87477
• 87515
• 88154

Laboratory Costs Subject to Reasonable Charge Payment in CY 2018

For outpatients, the following codes are paid under a reasonable charge basis (See Section 1842(b)(3) of the Act). In accordance with 42 CFR 405.502 https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/Downloads/405_502.pdf through 42 CFR 405.508, the reasonable charge may not exceed the lowest of the actual charge or the customary or prevailing charge for the previous 12-month period ending June 30, updated by the inflation-indexed update. The inflation-indexed update is calculated using the change in the applicable Consumer Price Index for the 12-month period ending June 30 of each year as set forth in 42 CFR 405.509(b)(1). The inflation-indexed update for CY 2018 is 1.60 percent.
Manual instructions for determining the reasonable charge payment are in the “Medicare Claims Processing Manual,” Chapter 23, Section 80 through 80.8 available at https://www.cms.gov/Regulations-and-Guidance/Guidance-Manuals/downloads/clm104c23.pdf. If there is sufficient charge data for a code, the instructions permit considering charges for other similar services and price lists.

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

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

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

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

NOTE: Biologic products not paid on a cost or prospective payment basis but are paid based on Section 1842(o) of the Act. The payment limits based on Section 1842(o), including the payment limits for codes P9041, P9045, P9046, and P9047, should be obtained from the Medicare Part B drug pricing files.

**Transfusion Medicine:**

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

Reproductive Medicine Procedures:
• 89250
• 89251
• 89253
• 89254
• 89255
• 89257
• 89258
• 89259
• 89260
• 89261
• 89264
• 89268
• 89272
• 89280
• 89281
• 89290
• 89291
• 89335
• 89337
Your MAC will not search their files to either retract payment or retroactively pay claims, however, will adjust claims that you bring to their attention.

ADDITIONAL INFORMATION


DOCUMENT HISTORY

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 15, 2017</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>
MEDICAL POLICIES

Immune Globulin Intravenous (IVIg) LCD – R7

The following JE Local Coverage Determination (LCD) has been revised under contractor numbers 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI), 01312 (NV).

Medicare Coverage Database (MCD) Number: L34314

LCD Title: Immune Globulin Intravenous (IVIg)

Effective Date: July 17, 2017

Summary of Changes: LCD is revised to add Z76.82, Awaiting organ transplant status. The letter e. Desensitization for a pre-kidney transplantation in patients with a panel reactive antibody (PRA) of 80% or below. Use in patients with a PRA of 81% or higher is considered to be experimental/investigational by this Contractor and is therefore not covered. Post transplantation to prevent rejection remains covered without regard to antibody levels. was added under Other Disorders in the Indications and Limitations of Coverage section. Additional sources of information were added and moved to the Bibliography section.

To access the Noridian Active LCDs from our website, follow the instructions below.

• Go to https://med.noridianmedicare.com/web/jeb/policies/lcd/active
  • The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
  • On the “Active LCDs” page, locate the above listed LCD title.
    • This link will direct you to the locally hosted copy of the Active LCD. You may also view the LCD on the CMS MCD by selecting the appropriate state link at the top of the page and locating the LCD title.

MolDX: AlloSure Donor-Derived Cell-Free DNA Test Final LCD – Effective December 11, 2017

The following Local Coverage Determination (LCD) has completed the Open Public and Contractor Advisory Committee (CAC) comment period and is now finalized under contractor numbers 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI) and 01312(NV).

Medicare Coverage Database (MCD) Number/Contractor Determination Number: L37303

LCD Title: MolDX: AlloSure® Donor-Derived Cell-Free DNA Test

Effective Date: December 11, 2017

Summary of LCD: This LCD provides limited coverage for the AlloSure donor-derived cell-free DNA test (CareDx, Inc., Brisbane, CA) to assess the probability of allograft rejection in kidney transplant recipients with clinical suspicion of rejection and to inform clinical decision-making about the necessity of renal biopsy in such patients at least 2 weeks post-transplant in conjunction with standard clinical assessment.

To access the Noridian Future Effective LCDs from our website, follow the instructions below.

• Go to https://med.noridianmedicare.com/web/jeb/policies/lcd/future
  • The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
  • On the “Future LCDs” page, select the coordinating state and locate the above listed CMS MCD number or LCD title.
    • This link will redirect you to the state specific Future Effective LCD on the CMS website.
**MolDX: Breast Cancer Assay: Prosigna LCD – R2**

The following JE Local Coverage Determination (LCD) has been revised under contractor numbers 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI), 01312 (NV).

**Medicare Coverage Database (MCD) Number:** L36380

**LCD Title:** MolDX: Breast Cancer Assay: Prosigna

**Effective Date:** January 1, 2018

**Summary of Changes:** This LCD has been updated to include CPT/HCPCS code 81520, oncology (breast), mrna gene expression profiling by hybrid capture of 58 genes (50 content and 8 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a recurrence risk score.

View the locally hosted Noridian Future Active LCD PDF.

- Go to [https://med.noridianmedicare.com/web/jeb/policies/lcd/active](https://med.noridianmedicare.com/web/jeb/policies/lcd/active)
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
  - Locate and select above listed LCD title

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**MolDX - CDD: ProMark Risk Score LCD – R1**

The following JE Local Coverage Determination (LCD) has been revised under contractor numbers 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI), 01312 (NV).

**Medicare Coverage Database (MCD) Number:** L36704

**LCD Title:** MolDX- CDD: ProMark Risk Score

**Effective Date:** January 1, 2018

**Summary of Changes:** Added additional information to Low, Intermediate, and High categories in Clinicopathologic Findings. Updated the NCCN Prostate Cancer Guidelines to 2017, V2.

To access the Noridian Active LCDs from our website, follow the instructions below.

- Go to [https://med.noridianmedicare.com/web/jeb/policies/lcd/active](https://med.noridianmedicare.com/web/jeb/policies/lcd/active)
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
  - On the “Active LCDs” page, locate the above listed LCD title.
  - This link will direct you to the locally hosted copy of the Active LCD. You may also view the LCD on the CMS MCD by selecting the appropriate state link at the top of the page and locating the LCD title.
MolDX: Circulating Tumor Cell Marker Assays LCD – R2

The following JE Local Coverage Determination (LCD) has been revised under contractor numbers 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI), 01312 (NV).

**Medicare Coverage Database (MCD) Number:** L35710

**LCD Title:** MolDX: Circulating Tumor Cell Marker Assays

**Effective Date:** July 20, 2017

**Summary of Changes:** Added MolDX into the title of the LCD and revised verbiage to be consistent with the MolDX Program. There is no change in coverage.

To access the Noridian Active LCDs from our website, follow the instructions below.


  The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).

- On the “Active LCDs” page, locate the above listed LCD title.
  - This link will direct you to the locally hosted copy of the Active LCD. You may also view the LCD on the CMS MCD by selecting the appropriate state link at the top of the page and locating the LCD title.

MolDX: EndoPredict Breast Cancer Gene Expression Test Final LCD – Effective January 30, 2018

The following Local Coverage Determination (LCD) has completed the Open Public and Contractor Advisory Committee (CAC) comment period and is now finalized under contractor numbers 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI) and 01312(NV).

**Medicare Coverage Database (MCD) Number/Contractor Determination Number:** L37295

**LCD Title:** MolDX: EndoPredict® Breast Cancer Gene Expression Test

**Effective Date:** January 30, 2018

**Summary of LCD:** This policy provides limited coverage for the EndoPredict® breast cancer gene expression test (Myriad Genetic Laboratories Inc., Salt Lake City, UT) for the management of post-menopausal women diagnosed with early-stage (TNM stage T1-3, N0-1) estrogen-receptor (ER) positive, Her2-negative breast cancer, who are either lymph node-negative or who have 1-3 positive nodes, and for whom treatment with adjuvant endocrine therapy (e.g., tamoxifen or aromatase inhibitors) is being considered. The test is used by physicians in the management of these patients by identifying those who have sufficiently low risk of distant recurrence (DR) at 10 years and may safely forego chemotherapy.

To access the Noridian Future Effective LCDs from our website, follow the instructions below.

- Go to [https://med.noridianmedicare.com/web/jeb/policies/lcd/future](https://med.noridianmedicare.com/web/jeb/policies/lcd/future)
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).

- On the “Future LCDs” page, select the coordinating state and locate the above listed CMS MCD number or LCD title.
  - This link will redirect you to the state specific Future Effective LCD on the CMS website.
MolDX: Genetic Testing for BCR-ABL Negative Myeloproliferative Disease LCD – R5

The following JE Local Coverage Determination (LCD) has been revised under contractor numbers 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI), 01312 (NV).

Medicare Coverage Database (MCD) Number: L36180

Effective Date: October 1, 2017


To access the Noridian Active LCDs from our website, follow the instructions below.

- Go to https://med.noridianmedicare.com/web/jeb/policies/lcd/active
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
  - On the “Active LCDs” page, locate the above listed LCD title.
  - This link will direct you to the locally hosted copy of the Active LCD. You may also view the LCD on the CMS MCD by selecting the appropriate state link at the left of the page and locating the LCD title.

MolDX: Molecular Diagnostic Tests (MDT) LCD – R4

The following JE Local Coverage Determination (LCD) has been revised under contractor numbers 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI), 01312 (NV).

Medicare Coverage Database (MCD) Number: L35160

LCD Title: MolDX: Molecular Diagnostic Tests (MDT)

Effective Date: January 01, 2018

Summary of Changes: This LCD has been updated to include and/or remove CPT/HCPCS codes.

New CPT/HCPCS codes

- 81175, 81176, 81230, 81231, 81232, 81238, 81247, 81248, 81249, 81258, 81259, 81269, 81283, 81328, 81334, 81335, 81346, 81361, 81362, 81363, 81364, 81448, 81520, 81521, 81541 and 81551 were added to code range 81161 - 81599 in Group 1.

View the locally hosted Noridian Active LCD PDF.

- Go to https://med.noridianmedicare.com/web/jeb/policies/lcd/active
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
  - Locate and select above listed LCD title
MolDX: Molecular RBC Phenotyping LCD – R2

The following JE Local Coverage Determination (LCD) has been revised under contractor numbers 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI), 01312 (NV).

Medicare Coverage Database (MCD) Number: L36167

LCD Title: MolDX: Molecular RBC Phenotyping

Effective Date: February 1, 2017

Summary of Changes: Added HCPCS code 0001U Red blood cell antigen typing, DNA, human erythrocyte antigen gene analysis of 35 antigens from 11 blood groups, utilizing whole blood, common RBC alleles reported.

To access the Noridian Active LCDs from our website, follow the instructions below.

- Go to https://med.noridianmedicare.com/web/jeb/policies/lcd/active.
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
  - On the “Active LCDs” page, locate the above listed LCD title.
  - This link will direct you to the locally hosted copy of the Active LCD. You may also view the LCD on the CMS MCD by selecting the appropriate state link at the top of the page and locating the LCD title.

MolDX: Prometheus IBD sgi Diagnostic Policy Final LCD – Effective January 30, 2018

The following Local Coverage Determination (LCD) has completed the Open Public and Contractor Advisory Committee (CAC) comment period and is now finalized under contractor numbers 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI) and 01312 (NV).

Medicare Coverage Database (MCD) Number/Contractor Determination Number: L37299

LCD Title: MolDX: Prometheus IBD sgi Diagnostic Policy

Effective Date: January 30, 2018

Summary of LCD: This is a non-coverage policy for the Prometheus IBD sgi Diagnostic test. The lab’s intended use of this test is to aid healthcare providers in the differentiating inflammatory bowel disease (IBD) vs. non-IBD, and Crohn’s disease (CD) vs ulcerative colitis (UC) in a comprehensive blood test. This test has no demonstrated clinical validity or utility at this time and is therefore non-covered.

To access the Noridian Future Effective LCDs from our website, follow the instructions below.

- Go to https://med.noridianmedicare.com/web/jeb/policies/lcd/future
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
  - On the “Future LCDs” page, select the coordinating state and locate the above listed CMS MCD number or LCD title.
  - This link will redirect you to the state specific Future Effective LCD on the CMS website.
**Nerve Conduction Studies and Electromyography LCD – R2**

The following JE Local Coverage Determination (LCD) has been revised under contractor numbers 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI), 01312 (NV).

**Medicare Coverage Database (MCD) Number:** L36524

**LCD Title:** Nerve Conduction Studies and Electromyography

**Effective Date:** October 1, 2017

**Summary of Changes:** This LCD has been updated to include and/or remove ICD-10 codes.

- **New ICD-10 codes**
  - E11.10 Type 2 diabetes mellitus with ketoacidosis without coma
  - E11.11 Type 2 diabetes mellitus with ketoacidosis with coma
  - G12.23 Primary lateral sclerosis
  - G12.24 Familial motor neuron disease
  - G12.25 Progressive spinal muscle atrophy
  - M33.03 Juvenile dermatomyositis without myopathy
  - M33.13 Other dermatomyositis without myopathy
  - M33.93 Dermatopolymyositis, unspecified without myopathy
  - M48.061 Spinal stenosis, lumbar region without neurogenic claudication
  - M48.062 Spinal stenosis, lumbar region with neurogenic claudication

- **Revised ICD-10 codes**
  - M33.01 Juvenile dermatomyositis with respiratory involvement
  - M33.02 Juvenile dermatomyositis with myopathy
  - M33.09 Juvenile dermatomyositis with other organ involvement
  - M33.11 Other dermatomyositis with respiratory involvement
  - M33.12 Other dermatomyositis with myopathy
  - M33.19 Other dermatomyositis with other organ involvement

- **Deleted ICD-10 codes**
  - M48.06 Spinal stenosis, lumbar region

View the locally hosted Noridian Active LCD PDF.

- Go to [https://med.noridianmedicare.com/web/jeb/policies/lcd/active](https://med.noridianmedicare.com/web/jeb/policies/lcd/active)
- The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
- Locate and select above listed LCD title
Non-Covered Services LCD - R18
The following JE Local Coverage Determination (LCD) has been revised under contractor numbers 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI), 01312 (NV).

Medicare Coverage Database (MCD) Number: L36219

LCD Title: Non-Covered Services

Effective Date: October 27, 2017

Summary of Changes: This LCD has been updated to remove a CPT code.

- Deleted CPT/HCPCS codes
  - 43210 – Esophagogastroduodenoscopy, flexible, transoral; with esophagogastic fundoplasty, partial or complete, includes duodenoscopy when performed

To access the Noridian Active LCDs from our website, follow the instructions below.

- Go to https://med.noridianmedicare.com/web/jeb/policies/lcd/active.
- The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
- On the “Active LCDs” page, locate the above listed LCD title.
- This link will direct you to the locally hosted copy of the Active LCD. You may also view the LCD on the CMS MCD by selecting the appropriate state link at the top of the page and locating the LCD title.

Pulmonary Function Testing LCD – R6
The following JE Local Coverage Determination (LCD) has been revised under contractor numbers 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI), 01312 (NV).

Medicare Coverage Database (MCD) Number: L34247

LCD Title: Pulmonary Function Testing

Effective Date: January 1, 2018

Summary of Changes: This LCD has been updated to include and remove CPT/HCPCS codes.

- New/Revised CPT/HCPCS codes
  - 94617 – Exercise test for bronchospasm, including pre- and postspirometry, electrocardiographic recording(s), and pulse oximetry describes the procedure used to assess for exercise-induced bronchospasm.
  - 94618 - Pulmonary stress testing (e.g., 6-minute walk test), including measurement of heart rate, oximetry, and oxygen titration, when performed, describes the typical simple pulmonary stress test.

- Deleted CPT/HCPCS codes
  - 94620 - Pulmonary stress testing; simple (e.g., 6-minute walk test, prolonged exercise test for bronchospasm with pre- and post-spirometry and oximetry)

View the locally hosted Noridian Active LCD PDF.

- Go to https://med.noridianmedicare.com/web/jeb/policies/lcd/active
- The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
- Locate and select above listed LCD title
Radiological Examination, Chest LCD – R9

The following JE Local Coverage Determination (LCD) has been revised under contractor numbers 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI), 01312 (NV).

Medicare Coverage Database (MCD) Number: L34317

LCD Title: Radiological Examination, Chest

Effective Date: January 1, 2018

Summary of Changes: This LCD has been updated to include CPT/HCPCS codes.

- New CPT/HCPCS codes
  - 71045: X-ray exam chest 1 view
  - 71046: X-ray exam chest 2 views
  - 71047: X-ray exam chest 3 views
  - 71048: X-ray exam chest 4+ views

- Deleted codes:
  - 71010: X-ray of chest, 1 view, front
  - 71015: X-ray of chest, stereo, front
  - 71020: X-ray of chest, 2 views, front and side
  - 71021: X-ray of chest, 2 views, front and side
  - 71022: X-ray of chest, 2 views, front and side
  - 71023: X-ray of chest, 2 views, front and side with fluoroscopy
  - 71030: X-ray of chest, minimum of 4 views
  - 71034: X-ray of chest, complete, minimum of 4 views
  - 71035: X-ray of chest, special views

View the locally hosted Noridian Future Active LCD PDF.

- Go to https://med.noridianmedicare.com/web/jeb/policies/lcd/active
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
  - Locate and select above listed LCD title

Special Histochemical Stains and Immunohistochemical Stains LCD – R3

The following JE Local Coverage Determination (LCD) has been revised under contractor numbers 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI), 01312 (NV).

Medicare Coverage Database (MCD) Number: L36351

LCD Title: Special Histochemical Stains and Immunohistochemical Stains

Effective Date: August 31, 2017

Summary of Changes: Corrected typographical errors in bullets and references to be consistent with the MolDX Contractor. Associated article A55802 Special Stains and Immunohistochemistry (IHC) Indications for Breast Pathology.

To access the Noridian Active LCDs from our website, follow the instructions below.

- Go to https://med.noridianmedicare.com/web/jeb/policies/lcd/active.
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
On the “Active LCDs” page, locate the above listed LCD title.

This link will direct you to the locally hosted copy of the Active LCD. You may also view the LCD on the CMS MCD by selecting the appropriate state link at the top of the page and locating the LCD title.

**Treatment of Varicose Veins of the Lower Extremities LCD – R9**

The following JE Local Coverage Determination (LCD) has been revised under contractor numbers 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI), 01312 (NV).

**Medicare Coverage Database (MCD) Number:** L34209

**LCD Title:** Treatment of Varicose Veins of the Lower Extremities

**Effective Date:** January 1, 2018

**Summary of Changes:** This LCD has been updated to include CPT/HCPCS codes.

- **New CPT/HCPCS codes**
  - 36465: Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring, single incompetent truncal extremity vein (e.g., great saphenous vein, accessory saphenous vein)
  - 36466: Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; multiple incompetent truncal veins (e.g. great saphenous vein, accessory saphenous vein), same leg.
  - 36482: Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (i.e., cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; first vein treated
  - 36483: Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (e.g., cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; subsequent vein(s) treated in a single extremity, each through separate access sites (list separately in addition to code for primary procedure)

- **Coverage Indications, Limitations and/or Medical Necessity**
  - Verbiage added to clarify that some of the new codes indicate totally new procedures and the new definitions of the first vein then the combining of the second and all other veins being included in the second code with the second code billable only once per day.

View the locally hosted Noridian Future Active LCD PDF.

- Go to [https://med.noridianmedicare.com/web/jeb/policies/lcd/active](https://med.noridianmedicare.com/web/jeb/policies/lcd/active)
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
- Locate and select above listed LCD title
MLN Connects – October 4, 2018

MLN Connects® for Thursday, October 5, 2017

View this edition as a PDF

News & Announcements

• National Partnership to Improve Dementia Care Achieves Goals to Reduce Unnecessary Antipsychotic Medications in Nursing Homes
• 2018 eCQM Value Set Addendum Available
• 2018 eCQM Logic Flows Available
• Health Services Research Health Equity Issue: Submit Abstracts by November 1
• Extension of Medicare IVIG Demonstration through December 31, 2020
• October is National Breast Cancer Awareness Month

Provider Compliance

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

Claims, Pricers & Codes

• FY 2018 IPPS and LTCH PPS Claims Hold

Upcoming Events

• 2016 Annual QRURs Webcast — October 19
• Definition of a Hospital: Primarily Engaged Requirement Call — November 2

Medicare Learning Network Publications & Multimedia

• Medicare Basics: Parts A and B Appeals Overview Video — New
• Updates to Medicare’s Cost Report Worksheet S-10 to Capture Uncompensated Care Data MLN Matters Article — New
• Qualified Medicare Beneficiary Program Call: Audio Recording and Transcript — New
• Hospice Quality Reporting Program Call: Audio Recording and Transcript — New
• Hurricane Maria and Medicare Disaster Related United States Virgin Islands and Commonwealth of Puerto Rico Claims MLN Matters Article — Updated
• Reading a Professional Remittance Advice Booklet — Reminder
• Reading an Institutional Remittance Advice Booklet — Reminder

MLN Connects – October 12, 2017

MLN Connects® for Thursday, October 12, 2017

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News & Announcements

• New Medicare Card Web Updates
• 2018 Medicare EHR Incentive Program Payment Adjustment Fact Sheet for Hospitals
• Qualifying APM Participant Look-Up Tool
• Hospice Quality Reporting Program: New and Updated Resources
• SNF Quality Reporting Program: Quick Reference Guide
• Protect Your Patients from Influenza this Season
Provider Compliance
• Cochlear Devices Replaced Without Cost: Bill Correctly — Reminder

Claims, Pricers & Codes
• Home Health Claims Will Be Returned When No OASIS Is Found

Upcoming Events
• 2016 Annual QRURs Webcast — October 19
• Definition of a Hospital: Primarily Engaged Requirement Call — November 2

Medicare Learning Network Publications & Multimedia
• PQRS Call: Audio Recording and Transcript — New

MLN Connects - October 19, 2017
MLN Connects® for Thursday, October 19, 2017

News & Announcements
• Preview Draft eCQM Specifications through November 13
• MIPS Virtual Group Election Period Ends December 1
• Quality Payment Program: New Resources
• SNF Quality Reporting Program Confidential Feedback Reports for Claims-Based Measures
• SNF Review and Correct Report Update
• Post-Acute Care Quality Reporting Programs FY 2018 APU: Successful Facilities
• New CMS Legionella Requirement for Hospitals, Critical Access Hospitals, and Nursing Homes

Provider Compliance
• Coudé Tip Catheters CMS Provider Minute Video - Reminder

Claims, Pricers & Codes
• October 2017 OPPS Pricer File
• Outpatient Claims: Correcting Deductible and Coinsurance for Code G0473

Upcoming Events
• Definition of a Hospital: Primarily Engaged Requirement Call - November 2
• New Medicare Card Project Special Open Door Forum - November 9
• SNF Value-Based Purchasing Program FY 2018 Final Rule Call - November 16

Medicare Learning Network Publications & Multimedia
• Medicare FFS Response to the 2017 California Wildfires MLN Matters Article - New
• Hurricane Nate and Medicare Disaster Related Alabama, Florida, Louisiana and Mississippi Claims MLN Matters Article - New
• Medicare Quarterly Provider Compliance Newsletter Educational Tool - New
• Physician Compare Call: Audio Recording and Transcript - New
• Prohibition on Billing Dually Eligible Individuals Enrolled in the QMB Program MLN Matters Article - Revised
• Critical Access Hospital Booklet - Revised
MLN Connects – October 26, 2017
MLN Connects® for Thursday, October 26, 2017
View this edition as a PDF

News & Announcements
• New Medicare Numbers/Cards: Coordination of Benefits
• Hospice QRP: Register for HEART Pilot Study by October 31
• MIPS: Participate in Field Testing of Episode-Based Cost Measures by November 15
• Physician Compare Preview Period Closes November 17

Provider Compliance
• Reporting Changes in Ownership — Reminder

Upcoming Events
• Definition of a Hospital: Primarily Engaged Requirement Call — November 2
• Preventive Care and Health Screenings for Persons with Disabilities Webinar — November 2
• SNF Value-Based Purchasing Program FY 2018 Final Rule Call — November 16
• Comparative Billing Report on Emergency Department Services Webinar — December 13

Medicare Learning Network Publications & Multimedia
• Quality Payment Program in 2017: MIPS APMs Web-Based Training Course — New
• HHA Star Rating Call: Audio Recording and Transcript — New
• Prohibition on Billing Dually Eligible Individuals Enrolled in the QMB Program MLN Matters Article — Revised
• General Equivalence Mappings FAQs Booklet — Revised
• Medicare Fraud & Abuse: Prevention, Detection, and Reporting Web-Based Training Course — Reminder

MLN Connects – November 2, 2017
MLN Connects® for Thursday, November 2, 2017
View this edition as a PDF

News & Announcements
• ESRD PPS: Updates to Policies and Payment Rates
• New Medicare Card: Provider Ombudsman Announced
• IRF and LTCH Quality Reporting Programs Submission Deadline: November 15
• Physician Compare Preview Period Extended to December 1
• Hospitals: Take Action before Meaningful Use Attestation Beginning January 2
• SNF Quality Reporting Program Submission Deadline Extended to May 15
• eCQM Value Set Addendum: Updated Technical Release Notes
• Administrative Simplification Enforcement and Testing Tool
• Antipsychotic Drug use in Nursing Homes: Trend Update
• CMS Offers Medicare Enrollment Relief for Americans Affected by Recent Disasters
• November is Home Care and Hospice Month
**Provider Compliance**
- Advanced Life Support Ambulance Services: Insufficient Documentation — Reminder

**Claims, Pricers & Codes**
- Outpatient Claims: Correcting Deductible and Coinsurance for Code G0473

**Upcoming Events**
- SNF Value-Based Purchasing Program FY 2018 Final Rule Call — November 16

**Medicare Learning Network Publications & Multimedia**
- QRUR Webcast: Audio Recording and Transcript — New
- ICD-10-CM/PCS the Next Generation of Coding Booklet — Revised
- Diagnosis Coding: Using the ICD-10-CM Web-Based Training Course — Reminder
- Medicare Home Health Benefit Web-Based Training Course — Reminder
- Dual Eligible Beneficiaries under Medicare and Medicaid Booklet — Reminder
- Resources for Medicare Beneficiaries Booklet — Reminder
- Medicare Ambulance Transports Booklet — Reminder
- SNF Billing Reference Booklet — Reminder
- Items and Services Not Covered under Medicare Booklet — Reminder
- Guidelines for Teaching Physicians, Interns, and Residents Fact Sheet — Reminder

**MLN Connects Special Edition – November 2, 2017**
- Physician Fee Schedule Final Policy, Payment, and Quality Provisions for CY 2018
- Hospital OPPS and ASC Payment System and Quality Reporting Programs Changes for 2018
- HHAs: Payment Changes for 2018
- Quality Payment Program Rule for Year 2

**Physician Fee Schedule Final Policy, Payment, and Quality Provisions for CY 2018**

On November 2, CMS issued a final rule that includes updates to payment policies, payment rates, and quality provisions for services furnished under the Medicare Physician Fee Schedule (PFS) on or after January 1, 2018.

The overall update to payments under the PFS based on the finalized CY 2018 rates will be +0.41 percent. This update reflects the +0.50 percent update established under the Medicare Access and CHIP Reauthorization Act of 2015, reduced by 0.09 percent, due to the misvalued code target recapture amount, required under the Achieving a Better Life Experience Act of 2014. After applying these adjustments, and the budget neutrality adjustment to account for changes in Relative Value Units, all required by law, the final 2018 PFS conversion factor is $35.99, an increase to the 2017 PFS conversion factor of $35.89.

The Final Rule Includes:
- Patients over Paperwork Initiative
- Changes in valuation for specific services
- Payment rates for nonexcepted off-campus provider-based hospital departments
- Medicare telehealth services
- Malpractice relative value units
- Care management services
- Improvement of payment rates for office-based behavioral health services
- Evaluation and management comment solicitation
- Emergency department visits comment solicitation
- Solicitation of public comments on initial data collection and reporting periods for Clinical Laboratory Fee Schedule
- Part B drugs: Payment for biosimilar biological products
- Part B drug payment: Infusion drugs furnished through an item of durable medical equipment
- New care coordination services and payment for rural health clinics and federally-qualified health centers
- Appropriate use criteria for advanced diagnostic imaging
- Medicare Diabetes Prevention Program expanded model
- Physician Quality Reporting System
- Patient relationship codes
- Medicare Shared Savings Program
- 2018 Value Modifier

For More Information:

Final Rule

Press Release: CMS Finalizes Policies that Reduce Provider Burden, Lower Drug Prices

See the full text of this excerpted CMS Fact Sheet (issued November 2).

Hospital OPPS and ASC Payment System and Quality Reporting Programs Changes for 2018

On November 1, CMS issued the CY 2018 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System final rule with comment period, which includes updates to the 2018 rates and quality provisions and other policy changes. CMS adopted a number of policies that will support care delivery; reduce burdens for health care providers, especially in rural areas; lower beneficiary out of pocket drug costs for certain drugs; enhance the patient-doctor relationship; and promote flexibility in healthcare.

CMS is increasing the OPPS payment rates by 1.35 percent for 2018. The change is based on the hospital market basket increase of 2.7 percent minus both a 0.6 percentage point adjustment for multi-factor productivity and a 0.75 percentage point adjustment required by law. After considering all other policy changes under the final rule, including estimated spending for pass-through payments, CMS estimates an overall impact of 1.4 percent payment increase for providers paid under the OPPS in CY 2018.

CMS updates ASC payments annually by the percentage increase in the Consumer Price Index for all urban consumers (CPI-U). The Medicare statute specifies a Multi-Factor Productivity (MFP) adjustment to the ASC annual update. For CY 2018, the CPI-U update is 1.7 percent. The MFP adjustment is 0.5 percent, resulting in a CY 2018 MFP-adjusted CPI-U update factor of 1.2 percent. Including enrollment, case-mix, and utilization changes, total ASC payments are projected to increase approximately 3 percent in 2018.

The Final Rule Includes:

- Patients over Paperwork Initiative
- Payment for drugs and biologicals purchased through the 340B drug pricing program
- Supervision of hospital outpatient therapeutic services
- Packaging of low-cost drug administration services
- Inpatient only list
- High cost/low cost threshold for packaged skin substitutes
- Revisions to the laboratory date of service policy
- Partial Hospitalization Program rate setting
- Comment solicitation on ASC payment reform
• ASC covered procedures list
• Hospital Outpatient Quality Reporting Program
• Ambulatory Surgical Center Quality Reporting Program

For More Information:
Final Rule
Press Release: CMS Finalizes Policies that Lower Out-of-Pocket Drug Costs and Increase Access to High-Quality Care
See the full text of this excerpted CMS Fact Sheet (issued November 1).

HHAs: Payment Changes for 2018
On November 1, CMS issued a final rule that updates the CY 2018 Medicare payment rates and the wage index for Home Health Agencies (HHAs) serving Medicare beneficiaries. The rule also finalizes proposals for the Home Health Value-Based Purchasing Model and the Home Health Quality Reporting Program.

CMS projects that Medicare payments to HHAs in CY 2018 will be reduced by 0.4 percent, or $80 million, based on the finalized policies. This decrease reflects the effects of a one percent home health payment update percentage ($190 million increase); a -0.97 percent adjustment to the national, standardized 60-day episode payment rate to account for nominal case-mix growth for an impact of -0.9 percent ($170 million decrease); and the sunset of the rural add-on provision ($100 million decrease).

The Final Rule Includes:
• Patients over Paperwork Initiative
• Annual home health payment update percentage
• Adjustment to reflect nominal case-mix growth
• Sunset of the rural add-on provision

For More Information:
Final Rule
Press Release: CMS Finalizes Policies that Lower Out-of-Pocket Drug Costs and Increase Access to High-Quality Care
See the full text of this excerpted CMS Fact Sheet (issued November 1).

Quality Payment Program Rule for Year 2
On November 2, CMS issued the final rule with comment for the second year of the Quality Payment Program (CY 2018), as required by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), as well as an interim final rule with comment. We finalized policies for Year 2 of the Quality Payment Program to further reduce your burden and give you more ways to participate successfully. We are keeping many of our transition year policies and making some minor changes.

The Final Rule Includes:
• Weighting the Merit-based Incentive Payment System (MIPS) Cost performance category to 10% of your total MIPS final score, and the Quality performance category to 50%
• Raising the MIPS performance threshold to 15 points in Year 2
• Allowing the use of 2014 Edition and/or 2015 Certified Electronic Health Record Technology (CEHRT) in Year 2 for the Advancing Care Information performance category, and giving a bonus for using only 2015 CEHRT
• Awarding up to 5 bonus points on your MIPS final score for treatment of complex patients
• Automatically weighting the Quality, Advancing Care Information, and Improvement Activities performance categories at 0% of the MIPS final score for clinicians impacted by Hurricanes Irma, Harvey and Maria and other natural disasters
• Adding 5 bonus points to the MIPS final scores of small practices
• Adding Virtual Groups as a participation option for MIPS
• Issuing an interim final rule with comment for extreme and uncontrollable circumstances where clinicians can be automatically exempt from these categories in the transition year without submitting a hardship exception application
• Decreasing the number of doctors and clinicians required to participate as a way to provide further flexibility by excluding individual MIPS eligible clinicians or groups with ≤$90,000 in Part B allowed charges or ≤200 Medicare Part B beneficiaries
• Providing more detail on how eligible clinicians participating in selected Advanced Alternative Payment Models (APMs) will be assessed under the APM scoring standard
• Creating additional flexibilities and pathways to allow clinicians to be successful under the All Payer Combination Option

For More Information:
Final Rule
Fact Sheet
Executive Summary
Press Release: CMS Finalizes Policies that Reduce Provider Burden, Lower Drug Prices
Quality Payment Program website
Register for a webinar on November 14

MLN Connects – November 9, 2017
MLN Connects® for Thursday, November 9, 2017
View this edition as a PDF

News & Announcements
• New Medicare Card: Help Notify Your Patients
• Medicare Diabetes Prevention Program Expanded Model Implementation
• Hospital Value-Based Purchasing Program Results for FY 2018
• Low Volume Appeals Settlements
• Hospice Item Set Data Freeze: November 15
• Draft 2018 CMS ORDA III Implementation Guide: Submit Comments by November 17
• CMS Innovation Center New Direction RFI: Submit Comments by November 20
• Therapeutic Shoe Inserts: Comment on DMEPOS Quality Standards through December 11
• Quality Payment Program Resources in New Location
• Post-Acute Care: Quality Reporting Program Quick Reference Guides Available
• Provider and Pharmacy Access during Public Health Emergencies
• Raising Awareness of Diabetes in November

Provider Compliance
• Proper Use of the KX Modifier for Part B Immunosuppressive Drug Claims

Upcoming Events
• Quality Payment Program Year 2 Overview Webinar — November 14
• SNF Value-Based Purchasing Program FY 2018 Final Rule Call — November 16
• Quality Payment Program Virtual Groups Train-the-Trainer Webinar — November 17
• Quality Payment Program Year 2 Final Rule Call — November 30
• Medicare Diabetes Prevention Program Model Expansion Call — December 5
• LTCH Quality Reporting Program In-Person Training — December 6 and 7

Medicare Learning Network Publications & Multimedia
• Quality Payment Program in 2017: Advanced Alternative Payment Models Web-Based Training Course — New
• Medicare FFS Response to the 2017 California Wildfires MLN Matters Article — Updated
• Prohibition on Billing Dually Eligible Individuals Enrolled in the QMB Program MLN Matters Article — Revised
• Transition to New Medicare Numbers and Cards Fact Sheet — Revised
• Hospital-Acquired Conditions and Present on Admission Indicator Reporting Provision Fact Sheet — Revised
• Remittance Advice Information: An Overview Booklet — Reminder

MLN Connects – November 16, 2017
MLN Connects® for Thursday, November 16, 2017
View this edition as a PDF

News & Announcements
• New Medicare Card: New Webpage Information
• CAHs: Deadline to Apply for a Hardship Exception is November 30
• Virtual Group for MIPS in 2018: Apply by December 31
• QMB Remittance Advice Issue
• IRF/LTCH Quality Measure Reports: Measures Added
• Hospice Quality Reporting Program: Quarterly Update
• Physician Compare: How to Update Your Listing
• Recognizing Lung Cancer Awareness Month and the Great American Smokeout

Provider Compliance
• Evaluation and Management: Correct Coding — Reminder

Upcoming Events
• Quality Payment Program Year 2 Final Rule Call — November 30
• Medicare Diabetes Prevention Program Model Expansion Call — December 5
• National Partnership to Improve Dementia Care and QAPI Call — December 14

Medicare Learning Network Publications & Multimedia
• Hospital Call: Audio Recording and Transcript — New
• Medicare and Medicaid Basics Booklet — Revised
• Looking for Educational Materials?
MLN Connects – November 22, 2017

MLN Connects® for Wednesday, November 22, 2017

View this edition as a PDF

News & Announcements

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

Provider Compliance

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

Upcoming Events

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

Medicare Learning Network Publications & Multimedia

• Medicare Fraud & Abuse Poster — New
• Medicare Fraud & Abuse: Prevention, Detection, and Reporting Booklet — Revised
• Medicare Disproportionate Share Hospital Fact Sheet — Revised
• ABCs of the Initial Preventive Physical Examination Educational Tool — Reminder
MLN Connects – November 30, 2017
MLN Connects® for Thursday, November 30, 2017
View this edition as a PDF

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

Provider Compliance
• Billing for Stem Cell Transplants — Reminder

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

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

MLN Connects – December 7, 2017
MLN Connects® for Thursday, December 7, 2017
View this edition as a PDF

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

Provider Compliance
• Hospital Discharge Day Management Services CMS Provider Minute Video — Reminder

Claims, Pricers & Codes
• January 2018 Average Sales Price Files Available

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

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

MLN Connects – December 14, 2017
MLN Connects® for Thursday, December 14, 2017
View this edition as a PDF

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

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

Claims, Pricers & Codes
• If You Submit Paper Claims: Avoid Crossover Issues

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

MLN Connects – December 21, 2017

View this edition as a PDF

News & Announcements
• 2018 Medicare EHR Incentive Program Payment Adjustment for Eligible Clinicians
• Physician Compare: 2016 Performance Information Available

Provider Compliance
• Medicare Hospital Claims: Avoid Coding Errors — Reminder

Upcoming Events
• Low Volume Appeals Settlement Option Call — January 9

Medicare Learning Network Publications & Multimedia
• Medicare FFS Response to the 2017 Southern California Wildfires MLN Matters Article — New
• Medicare Diabetes Prevention Program Model Call: Audio Recording and Transcript — New
• Hospice Payment System Booklet — Revised
• Ambulance Fee Schedule Fact Sheet — Revised
• Medicare Overpayments Fact Sheet — Revised
Eligibility Details Expanded in Portal – Now Including QMB Details

Qualified Medicare Beneficiaries (QMB)

Effective November 19, 2017, the Noridian Medicare Portal (NMP) offers Qualified Medicare Beneficiary (QMB) information on an eligibility inquiry. Low-income beneficiaries receive assistance with their Medicare premiums and cost-sharing through the QMB program. NMP will now display if the beneficiary is enrolled in this program.

If a beneficiary is a QMB, additional benefit information will be displayed on a green line in the Eligibility response.

Since Medicare providers cannot charge QMBs for any cost sharing, the portal will not display the Preventive Services or Next Eligible Date on the Preventive tab.

Date of Service Options for Eligibility Inquiry

Users now have three options to choose from for Date of Service under “Optional Details” when performing an Eligibility inquiry. The inquiry will default to a date range of 12 months if no other option is selected. The current date or a specific date range may be chosen to narrow down the results.
These updates are an addition to the previously published enhancements below.

Effective November 5, 2017, the Noridian Medicare Portal (NMP) offers additional beneficiary eligibility information including hospital spell dates, Part D enrollment, preventive service expanded for colorectal, alcohol and rehabilitation services, and Hospice occurrence counts. Noridian recommends entering ‘From’ and ‘To Dates’ when performing an Eligibility inquiry to receive the most accurate entitlement information.

Below is a brief description and screen shot to show where these enhancements can be seen.

**Hospital Benefit Information**

Hospital Benefits will offer the current years Part A Base Deductible, Part A Spell days remaining and the Earliest and Latest Billing Dates for Hospital spells.
Part D Enrollment Data
The following items for Part D Enrollment are available under the Eligibility tab of the response. If the beneficiary is not enrolled in Part D, these fields will remain blank.

- Contract Name
- Contract Number
- Contract Phone Number
- Contract Website
- Enrollment and Disenrollment Date
- Part D Enrollment Prescription Drug Coverage
- Contract Address

Preventive Services
The following Preventive Services CPT/HCPCS codes will be listed on the Preventive Services tab and provide the date the beneficiary is next eligible for that service.

- 81528
- G0297
- G0442
- G0443
- G0472
- G0473
- G0475
The Preventive Services tab now offers Pulmonary, Cardiac and Intensive Cardiac Rehabilitation Services. The following information is available:

- Professional Sessions Remaining
- Technical Sessions Remaining
- Professional Sessions Used
- Technical Sessions Used

Hospice Benefits

The Hospice Benefit has also been expanded to provide the Occurrence Count of each Hospice episode.
The CMS HIPAA Eligibility Transaction System (HETS) is the authoritative source for all eligibility inquiries performed in the portal (and IVR). Noridian hopes you find these enhancements valuable. We encourage you to complete the website satisfaction survey each time it is presented to you so we may continue to improve our portal services.

**NMP Appeals Documentation Size Increase**

Noridian has listened to provider concerns when attaching Appeals documentation. The file size providers were previously able to attach was up to 10MB. Now, providers can attach documents up to 70MB in size. Noridian is not able to provide a page count to equate to the file size, as it depends on formatting, images, and other factors that can quickly increase the size of a document.
OUTPATIENT THERAPY

Therapy Code List – 2018 Annual Update

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

PROVIDER TYPES AFFECTED

This MLN Matters® Article is intended for physicians, therapists, and other providers, including Comprehensive Outpatient Rehabilitation Facilities (CORFs), submitting claims to Medicare Administrative Contractors (MACs), including Home Health & Hospice MACs, for outpatient therapy services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

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

BACKGROUND

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

The policies implemented in CR10303 were discussed in CY 2018 Medicare Physician Fee Schedule (MPFS) rulemaking. CR10303 updates the therapy code list and associated policies for CY 2018, as follows:

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

• The Centers for Medicare & Medicaid Services (CMS) will add CPT code 97763 to the therapy code list and CPT code 97762 will be deleted.

• The panel also created, for CY 2018, CPT code 97127 to replace/delete CPT code 97532. CMS will recognize HCPCS code G0515, instead of CPT code 97127, and add HCPCS code G0515 to the therapy code list. CPT code 97127 will be assigned a Medicare Physician Fee Schedule (MPFS) payment status indicator of “I” to indicate that it is “invalid” for Medicare purposes and that another code is used for reporting and payment for these services.

• Just as its predecessor code was, CPT code 97763 is designated as “always therapy” and must always be reported with the appropriate therapy modifier, GN, GO or GP, to indicate whether it’s under...
a Speech-language pathology (SLP), Occupational Therapy (OT) or Physical Therapy (PT) plan of care, respectively.

- HCPCS code G0515 is designated as a “sometimes therapy” code, which means that an appropriate therapy modifier – GN, GO or GP, to reflect it’s under an SLP, OT, or PT plan of care – is always required when this service is furnished by therapists; and, when it’s furnished by or incident to physicians and certain Nonphysician Practitioners (NPPs), that is, nurse practitioners, physician assistants, and clinical nurse specialists when the services are integral to an SLP, OT, or PT plan of care. Accordingly, HCPCS code G0515 is sometimes appropriately reported by physicians, NPPs, and psychologists without a therapy modifier when it is appropriately furnished outside an SLP, OT, or PT plan of care. When furnished by psychologists, the services of HCPCS code G0515 are never considered therapy services and may not be reported with a GN, GO, or GP therapy modifier.

- The therapy code list is updated with one new “always therapy” code and one new “sometimes therapy” code, using their HCPCS/CPT long descriptors, as follows:
  - CPT code 97763 – This “always therapy” code replaces/deletes CPT code 97762.
  - CPT code 97763: Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes
  - HCPCS code G0515 – This “sometimes therapy” code replaces/deletes CPT code 97532.
  - HCPCS code G0515: Development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct (one-on-one) patient contact, each 15 minutes

ADDITIONAL INFORMATION


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Therapy Cap Values for CY 2018

MLN Matters Number: MM10341
Related Change Request (CR) Number: 10341
Related CR Release Date: November 9, 2017
Effective Date: January 1, 2018
Related CR Transmittal Number: R3918CP
Implementation Date: January 2, 2018

PROVIDER TYPES AFFECTED

This MLN Matters® Article is intended for physicians, therapists, and other providers submitting claims to Medicare Administrative Contractors (MACs), including Home Health & Hospice MACs, for outpatient therapy services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

Change Request (CR) 10341 provides the amounts for outpatient therapy caps for Calendar Year (CY) 2018. For physical therapy and speech-language pathology combined, the CY 2018 cap is $2,010. For occupational therapy, the CY 2018 cap is $2,010. Make sure that your billing staffs are aware of these therapy cap value updates.

BACKGROUND

The Balanced Budget Act of 1997, P.L. 105-33, Section 4541(c) applies, per beneficiary, annual financial limitations on expenses considered incurred for outpatient therapy services under Medicare Part B,
commonly referred to as “therapy caps.” The therapy caps are updated each year based on the Medicare Economic Index.

Section 5107 of the Deficit Reduction Act of 2005 required an exceptions process to the therapy caps for reasonable and medically necessary services. The exceptions process for the therapy caps has been continuously extended several times through subsequent legislation. Most recently, Section 202 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) extended the therapy caps exceptions process through December 31, 2017.

ADDITIONAL INFORMATION


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Suppression of the Standard Paper Remittance Advice (SPR) in 45 days if also Receiving Electronic Remittance Advice (ERA)

MLN Matters Number: MM10151 Revised
Related CR Release Date: December 21, 2017
Related CR Transmittal: R19900TN
Related Change Request (CR) Number: 10151
Effective Date: January 1, 2018
Implementation Date: January 2, 2018

This article was revised on December 22, 2017, to reflect the revised CR10151 issued on December 21, 2017. In the article, the CR release date, transmittal number, and the Web address for accessing the CR are revised. All other information remains the same.

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 10151 provides notice that beginning January 2, 2018, Medicare’s Shared System Maintainers (SSMs) must eliminate issuance of Standard Paper Remittance Advice (SPRs) to those providers/suppliers (or a billing agent, clearinghouse, or other entity representing those providers/suppliers) who also have been receiving Electronic Remittance Advice (ERA) transactions for 45 days or more. The shared system changes to suppress the distribution of SPRs were implemented in January 2006 per CR3991 (issued August 12, 2005, Transmittal 645). Make sure your billing staffs are aware of the suppression of the SPR.

BACKGROUND

The SPR is the hard copy version of an ERA. MACs, including Durable Medical Equipment (DME) MACs must be capable of producing SPRs for providers/suppliers who are unable or choose not to receive an ERA. The MACs and the DME MACs suppress distribution of SPRs if an Electronic Data Interchange (EDI) enrolled provider/supplier is also receiving ERAs for more than 31 days for Institutional Health Care Claims (837I) and 45 days for DME and Professional Health Care Claims (837P). Internet-Only-Manuals (IOMs), MLN Matters Article MM4376 provided information to the MACs regarding the receipt of SPR and ERA distribution time lines.

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


ADDITIONAL INFORMATION

Implement Operating Rules – Phase III ERA EFT: CORE 360 Uniform Use of CARC, RARC and CAGC Rule – Update from CAQH CORE

MLN Matters Number: MM10268
Related Change Request (CR) Number: 10268
Related CR Release Date: November 9, 2017
Effective Date: April 1, 2018
Related CR Transmittal Number: R3915CP
Implementation Date: April 2, 2018

PROVIDER TYPES AFFECTED

This MLN Matters® Article is intended for physicians, providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs), including Durable Medical Equipment Medicare Administrative Contractors (DME) MACs and Home Health & Hospice (HH&H) MACs for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

Change Request (CR) 10268 instructs MACs and Shared System Maintainers (SSMs) to update systems based on the CORE 360 Uniform Use of Claims Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC), and Claim Adjustment Group Code (CAGC) Rule publication. These system updates are based on the Committee on Operating Rules for Information Exchange (CORE) Code Combination List to be published on or about February 1, 2018. Make sure that your billing staff is aware of these changes.

BACKGROUND

The Department of Health and Human Services (DHHS) adopted the Phase III Council for Affordable Quality Healthcare (CAQH) CORE, EFT, and ERA Operating Rule Set that was implemented on January 1, 2014 under the Affordable Care Act.

The Health Insurance Portability and Accountability Act (HIPAA) amended the Social Security Act by adding Part C—Administrative Simplification—to Title XI, requiring the Secretary of DHHS to adopt standards for certain transactions to enable health information to be exchanged more efficiently and to achieve greater uniformity in the transmission of health information.

The Centers for Medicare & Medicaid Services (CMS) instructs MACs to conduct updates based on the code update schedule that results in publication three times per year – around March 1, July 1, and November 1. CR10268 deals with the regular update in CAQH CORE defined code combinations per Operating Rule 360 - Uniform Use of CARC and RARC (835) Rule.

CAQH CORE will publish the next version of the Code Combination List on or about February 1, 2018. This update is based on the CARC and RARC updates as posted at the Washington Publishing Company (WPC) website on or about November 1, 2017. This will also include updates based on Market Based Review that CAQH CORE conducts once a year to accommodate code combinations that are currently being used by Health Plans including Medicare as the industry needs them. You can find CARC and RARC updates at http://www.wpc-edi.com/reference and CAQH CORE defined code combination updates at http://www.caqh.org/CORECodeCombinations.php.
A discrepancy between the dates may arise as the WPC website is only updated three times per year and may not match the CMS release schedule. For CR10268, the MACs and the SSMs must get the complete list for both CARCs and RARCs from the WPC website to obtain the comprehensive lists for both code sets and determine the changes included on the code list since the last code update CR (CR10140).

Per the Affordable Care Act mandate, all health plans including Medicare must comply with CORE 360 Uniform Use of CARCs and RARCs (835) rule or CORE developed maximum set of CARC/RARC and CAGC combinations for a minimum set of four Business Scenarios. Medicare can use any code combination if the business scenario is not one of the four CORE defined business scenarios. With the four CORE defined business scenarios, Medicare must use the code combinations from the lists published by CAQH CORE.

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RARC, CARC, MREP and PC Print Update

MLN Matters Number: MM10270
Related Change Request (CR) Number: 10270
Related CR Release Date: November 9, 2017
Effective Date: April 1, 2018
Related CR Transmittal Number: R3910CP
Implementation Date: April 2, 2018

PROVIDER TYPES 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) 10270 updates the Remittance Advice Remark Codes (RARC) and Claims Adjustment Reason Code (CARC) lists and instructs Medicare Shared System Maintainers (SSMs) to update Medicare Remit Easy Print (MREP) and PC Print. Be sure your staffs are aware of these changes and obtain the updated MREP and PC Print software if they use that software.

BACKGROUND
The Health Insurance Portability and Accountability Act of 1986 (HIPAA) instructs health plans to be able to conduct standard electronic transactions adopted under HIPAA using valid standard codes. Medicare policy states that CARCs and RARCs, as appropriate, which provide either supplemental explanation for a monetary adjustment or policy information that generally applies to the monetary adjustment, are required in the remittance advice and coordination of benefits transactions.

The Centers for Medicare & Medicaid Services (CMS) instructs MACs to conduct updates based on the code update schedule that results in publication three times per year – around March 1, July 1, and November 1.

SSMs have the responsibility to implement code deactivation, making sure that any deactivated code is not used in original business messages and allowing the deactivated code in derivative messages. SSMs must make sure that Medicare does not report any deactivated code on or after the effective date for deactivation as posted on the Washington Publishing Company (WPC) website. If any new or
modified code has an effective date later than the implementation date specified in CR10270, MACs must implement on the date specified on the WPC website, available at: http://wpc-edi.com/Reference/.

A discrepancy between the dates may arise as the WPC website is only updated three times per year and may not match the CMS release schedule.

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HPSA Bonus Payments – 2018 Annual Update

MLN Matters Number: MM10317
Related Change Request (CR) Number: 10317
Related CR Release Date: September 29, 2017
Effective Date: January 1, 2018
Related CR Transmittal Number: R3870CP
Implementation Date: January 2, 2018

PROVIDER TYPE AFFECTED

This MLN Matters® Article is intended for physicians submitting claims to Medicare Administrative Contractors (MACs) for services provided in Health Professional Shortage Areas (HPSAs) to Medicare beneficiaries.

PROVIDER ACTION NEEDED

Change Request (CR) 10317 alerts you that the Centers for Medicare & Medicaid Services (CMS) will make the annual HPSA bonus payment file for 2018 available to your MAC to use for HPSA bonus payments on applicable claims with dates of service on or after January 1, 2018, through December 31, 2018. You should review the Physician Bonuses webpage at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HPSAPSAPhysicianBonuses/ each year to determine whether you need to add modifier AQ to your claim in order to receive the bonus payment, or to see if the ZIP code in which you rendered services will automatically receive the HPSA bonus payment. Make sure that your billing staffs are aware of these changes.

BACKGROUND

Section 413(b) of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 mandated an annual update to the automated HPSA bonus payment file. The HPSA ZIP code file is populated using the latest designations as close as possible to November 1 of each year. The HPSA ZIP code file shall be made available to your MAC in early December of each year. MACs will implement the HPSA ZIP code file and for claims with dates of service January 1 to December 31 of the following year, shall make automatic HPSA bonus payments to physicians providing eligible services in a ZIP code contained on the file.

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