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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 A News” Articles

The purpose of “Medicare A News” is to educate the Noridian Medicare Part A 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/index.html?redirect=/AboutWebsite/EmailUpdates/list.asp. Indicate that you wish to receive the CMS-QPU Listserv on the list of available publications.

The Quarterly Provider Update can be accessed on the CMS website at http://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/index.html?redirect=/QuarterlyProviderUpdates. We encourage you to bookmark this website and visit it often for this valuable information.

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 A/B 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 those or any other claims.

Additional Information


Effective Date: January 1, 2005

Implementation Date: January 4, 2005

2018 JF Part A Quarterly Ask-the-Contractor Teleconferences

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

- January 17, 2018
- May 16, 2018
- September 19, 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 A 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/jfa/education/act](https://med.noridianmedicare.com/web/jfa/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 A ACTs do not address Medicare Part B or Durable Medical Equipment (DME) inquiries. If you are interested in attending a Part B or a DME ACT, select the appropriate link below for more information.

| JF Part B | [https://med.noridianmedicare.com/web/jfb/education/act](https://med.noridianmedicare.com/web/jfb/education/act) |
| JD DME | [https://med.noridianmedicare.com/web/jddme/education/act](https://med.noridianmedicare.com/web/jddme/education/act) |
| JA DME | [https://med.noridianmedicare.com/web/jadme/education/act](https://med.noridianmedicare.com/web/jadme/education/act) |

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 next year.”
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.

For a fact sheet on the 2018 Medicare Parts A & B premiums and deductibles, please visit: [https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-11-17.html](https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-11-17.html).

**Resource:** CMS News: November 17, 2017

**Inpatient PPS Cost Outlier Decision Tree**

The Noridian Provider Contact Center (PCC) has created the Inpatient PPS Cost Outlier Decision Tree to help providers determine the proper billing of their inpatient prospective payment (PPS) outlier claims. By selecting the most appropriate answer to their claim-specific scenario, providers will be given guidance of how to correctly bill their claims, based on the answers selected.

**Medical Review: Education on Demand (EoD) – Now Available**

Noridian has added self-paced Medical Review education tutorials about Additional Documentation Requests. Providers have 45 days to respond to the ADR request. To assist providers and decrease the number of claims denied due to untimely response the following EoDs are available on the Education on Demand Tutorial web page under the topic “Medical Review”:

- Additional Documentation Request (ADR) Basics – 9:43 minutes
- How to Check DDE for Medical Review ADRs – 5:52 minutes
- How to Submit ADRs – 14:11 minutes
**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.

**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.

**New ST PEPPER Now Available**

New Program for Evaluating Payment Patterns Electronic Reports (PEPPERs) are now available for short-term acute care hospitals. PEPPERs are distributed by TMF® Health Quality Institute under contract with CMS. These reports summarize provider-specific data statistics for Medicare services that may be at risk for improper payments. Providers can use the data to support internal auditing and monitoring activities. The PEPPER files were recently distributed through a QualityNet secure file exchange to hospital QualityNet Administrators and user accounts with the PEPPER recipient role.

For more information, including guides, recorded training sessions, information about QualityNet accounts, frequently asked questions, and examples of how other hospitals are using PEPPER, visit [PEPPERresources.org](http://PEPPERresources.org). If you have questions or need help obtaining your report, visit the Help Desk. Send us your feedback or suggestions.

**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.
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/McrPartBDrugAvgSalesPrice/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](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**


**DOCUMENT HISTORY**

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Correction to Prevent Payment on Inpatient Information Only Claims for Beneficiaries Enrolled in Medicare Advantage Plans - Revised

MLN Matters Number: MM10238 Revised
Related CR Release Date: December 22, 2017
Related CR Transmittal Number: R3943CP
Related Change Request (CR) Number: 10238
Effective Date: April 1, 2015
Implementation Date: April 2, 2018

This article was revised on December 22, 2017, to reflect a revised CR10238 issued on December 22. In the article, a reference to a discharge date in the last paragraph of the Background section is changed to say admission/from date. Also, the CR release date, transmittal number, and the Web address of the CR are revised. All other information remains the same.

PROVIDER TYPES AFFECTED

This MLN Matters Article is intended for hospitals billing Medicare Administrative Contractors (MACs) for inpatient services provided to Medicare beneficiaries enrolled in a Medicare Advantage (MA) plan.

WHAT YOU NEED TO KNOW

Change Request (CR) 10238 instructs MACs to allow the Common Working File (CWF) to set edit 5233 on inpatient information only claims billed with condition codes 04 and 30 for Investigational Device Exemption (IDE) Studies and Clinical Studies Approved Under Coverage with Evidence Development (CED), which will in turn allow the Fiscal Intermediary Standard System (FISS) to zero out payment. CR 10238 contains no new policy. It improves the implementation of existing Medicare payment policies.

BACKGROUND

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, (Public Law: 99-272), provides for an additional payment to an urban hospital of 100 or more beds that serves a disproportionate share of low-income patients. Part of the calculation used to determine whether or not a hospital is eligible for Medicare Disproportionate Share Hospital (DSH) add-on payments is based on the percentage of days for which the beneficiary was entitled to Medicare Part A and received Supplemental Security Income (SSI) payments from the Social Security Administration (SSA).

The Centers for Medicare & Medicaid Services (CMS) uses claims data to calculate a hospital’s percentage of total Medicare days for which Medicare beneficiaries were simultaneously entitled to both SSI and Medicare. In order for MA enrolled inpatient days to be included in this Medicare/SSI fraction, the hospital must submit an informational only bill (Type of Bill (TOB) 11X) which includes Condition Code 04 to their MAC. CMS was notified that a CWF edit that is required to prevent payment on information only claims for MA beneficiaries for IDE studies and Clinical Studies Approved Under CED, which should be paid by the Medicare Advantage Plan, is bypassed for claims billed with condition code (CC) 30, thereby causing a Medicare Fee-for-Service (FFS) payment in error. To correct prior claims, hospitals should note that their MAC will reprocess inpatient information only claims with a payment greater than $0, condition codes 04 and 30, one of the approved IDE or CED study numbers listed in the spreadsheet attachment to CR 10238 and an admission/from date on or after April 1, 2015, and before March 31, 2018, within 90 days of the implementation date of CR 10238.
ADDITIONAL INFORMATION


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</tr>
<tr>
<td>October 27, 2017</td>
<td>Initial article released.</td>
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GME Payments to New Teaching Hospitals – Calculating Interim Rates – Revised

MLN Matters Number: MM10240 Revised
Related Change Request (CR) Number: N/A
Related CR Release Date: October 27, 2017
Effective Date: October 23, 2017
Related CR Transmittal Number: R1952OTN
Implementation Date: October 23, 2017

This article was revised on October 30, 2017, to reflect the revised CR10240 issued on October 27. The CR was re-issued to revise several policy statements and to address how to handle certain impacted claims.

PROVIDER TYPE AFFECTED

This MLN Matters Article is intended for teaching hospitals billing Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

Change Request (CR) 10240 provides instructions to the MACS on calculating interim rates for Graduate Medical Education (GME) payments to new teaching hospitals. Make sure your billing staffs are aware of this notification.

BACKGROUND

Section 1886(h) of the Social Security Act (the Act), currently implemented in the regulations at 42 Code of Federal Regulation (CFR) 413.75 through 413.83, establishes a methodology for determining payments to hospitals for the direct costs of approved GME programs. In general, Medicare direct GME payments are calculated by multiplying the hospital's updated Per Resident Amount (PRA) by the weighted number of Full-Time Equivalent (FTE) residents working in all areas of the hospital complex (and at nonprovider sites, when applicable), and the hospital’s ratio of Medicare inpatient days to total inpatient days.

Section 1886(d)(5)(B) of the Act, as implemented at 42 CFR 412.105, provides for a payment adjustment known as the Indirect Medical Education (IME) adjustment under the hospital Inpatient Prospective Payment System (IPPS) for hospitals that have residents in an approved GME program, in order to account for the higher indirect patient care costs of teaching hospitals relative to nonteaching hospitals. The hospital's IME adjustment applied to the Diagnosis Related Group (DRG) payments is calculated based on the ratio of the hospital's number of FTE residents training in the inpatient and outpatient departments of the IPPS hospital (and at nonprovider sites, when applicable), to the number of inpatient hospital beds. This ratio is referred to as the IME Intern-and-Resident-to-Bed (IRB) ratio.

Under section 1886(h)(4)(F) of the Act, for cost reporting periods beginning on or after October 1, 1997, a hospital's unweighted FTE count of residents for purposes of direct GME may not exceed the hospital’s unweighted FTE count for direct GME in its most recent cost reporting period ending on or before...
December 31, 1996. Under section 1886(d)(5)(B)(v) of the Act, a similar limit based on the FTE count for IME during that cost reporting period is applied effective for discharges occurring on or after October 1, 1997. Dental and pediatric residents are not included in this statutory cap.

Section 1886(h)(4)(H)(i) of the Act requires the Secretary to establish rules for calculating the direct GME caps for new teaching hospitals that are training residents in new medical residency training programs established on or after January 1, 1995. Under section 1886(d)(5)(B)(viii) of the Act, such rules also apply to the establishment of a hospital’s IME cap on the number of FTE residents training in new programs. The Centers for Medicare & Medicaid Services (CMS) implemented these statutory requirements in rules published in the following Federal Registers -- August 29, 1997 (62 FR 46002 through 46008), May 12, 1998 (63 FR 26323 through 26325 and 26327 through 26336), and August 27, 2009 (74 FR 43908 through 43919).

Current Regulations on New Program Caps

Generally, under existing regulations at 42 CFR 413.79(e)(1) (for direct GME) and 42 CFR 412.105(f)(1)(viii) (for IME), if a hospital did not train any allopathic or osteopathic residents in its most recent cost reporting period ending on or before December 31, 1996, and it begins to participate in training residents in a new medical residency training program (allopathic or osteopathic) on or after January 1, 1995, the hospital’s unweighted FTE resident cap (which would otherwise be zero) may be adjusted based on the sum of the product of the highest number of FTE residents in any program year during the fifth year of the first new program’s existence at all of the hospitals to which the residents rotate, the minimum accredited length for each type of program, and the ratio of the number FTE residents in the new program that trained at the hospital over the entire 5-year period to the total number of FTE residents in the program that trained at all hospitals over the entire 5-year period. The number of FTE resident cap slots that a teaching hospital receives for each new program may not exceed the number of accredited slots that are available for each new program. See the August 31, 2012 Federal Register (77 FR 53416) for details on how the cap calculation is made. Similar regulations apply for IME at 42 CFR 412.105(f)(1)(vii). In the August 22, 2014, Federal Register (79 FR 50104 through 50111), CMS again revised the regulations at 42 CFR 413.79(e)(1) for direct GME and 42 CFR 412.105(f)(1)(v)(D) for IME, to state that if a hospital begins training residents in a new program on or after October 1, 2012, the hospital’s FTE caps will take effect with the beginning of the hospital’s cost reporting period that coincides with or follows the start of the sixth program year of the first new program started. Also, under 42 CFR 413.79(d)(6) for direct GME and 42 CFR 412.105(f)(1)(v) and 412.105(a)(1)(ii) for IME, FTE residents in new programs are exempt from the application of the 3-year rolling average and the IME intern-and-resident-to-bed (IRB) ratio cap. For programs started after October 1, 2012, these exemptions are applicable during the cost reporting periods prior to the beginning of the cost reporting period that coincides with or follows the start of the sixth program year of the first new program started, in which the FTE cap is established.

Establishment of a Direct GME (DGME) Per Resident Amount (PRA)

Under section 1886(h)(3) of the Act, and implemented at 42 CFR §413.77(e)(1), if a hospital did not previously have a PRA established, but begins training in a cost reporting period beginning on or after July 1, 1985, the MAC establishes a PRA effective with the hospital’s first cost reporting period in which it participates in Medicare and has residents on duty during the first month of that cost reporting period. Effective for cost reporting periods beginning on or after October 1, 2006, if a hospital did not have residents on duty during the first month of that period, the MAC establishes a PRA using the information from the first cost reporting period immediately following the cost reporting period during which the hospital participates in Medicare and residents began training at the hospital.

As 42 CFR §413.77(e)(1) states, any GME costs incurred by the hospital in the cost reporting period prior to the PRA base period are reimbursed on a reasonable cost basis. For example, a hospital with a January 1 to December 31 cost reporting period starts to train residents in an approved residency program for the first time on July 1, 2017. The residents continue to train at the hospital in January 2018 and after. The hospital’s PRA would be established from and effective for direct GME payment during the January 2018 through December 2018 cost report, and the hospital would be paid based on Medicare’s share of the reasonable GME costs in the January 2017 through December 2017 cost report.

In order for a PRA to be established, the residents need not be in a newly approved residency program, nor must the hospital be the sponsor, nor incur costs. Rather, a hospital counts the respective share of the FTE resident that trains in its hospital, whether it employs the resident or not. (See the September 4, 1990 Federal Register, 55 FR 36064-5, which explains that regardless of who employs the resident, each
hospital would count the proportion of FTE time spent at its facility, both for the direct GME PRA base year, and in the payment years, while the hospital that incurs the costs of the resident in any year would claim those costs on its cost report. The MAC shall calculate and finalize the hospital’s final PRA as part of the settlement of the base year cost report. See below for instructions for establishing an interim rate PRA for purposes of paying the hospital an interim direct GME payment amount from approximately the time it starts to train residents in an approved program.

Resources for determining weighted average PRA include: –67 FR 50067 through 50069 (August 1, 2002); Determining hospital cost per FTE -- 54 FR 40286 (September 29, 1989), 55 FR 36063 through 36065 (September 4, 1990), HCFA Memorandum, BPO-F12, November 8, 1990, Questions and Answers Pertaining to Graduate Medical Education.

**When to Establish Interim Rates for a New Teaching Hospital Participating in a New Program(s)**

When a hospital that does not have FTE caps and/or a PRA approaches its MAC and requests in writing (email is sufficient) IME and DGME payments due to training residents for the first time in a new approved GME residency program, the MAC shall, in accordance with the regulations governing interim rate reviews at 42 CFR §412.116(c) and 42 CFR §413.60 and 42 CFR §413.64(a) through (e)

- Use the policy guidance in CR10240 to verify that the hospital does not already have a PRA and/or FTE resident caps established, and the hospital is actually training residents in a new approved program. (Refer to the August 27, 2009 FR, page 43908, to determine if an approved program meets the “new” criteria).

- Establish interim IME and DGME payment rates for the hospital at the earliest scheduled rate review after the hospital submits a written request for payment. MACs need not perform a special rate review exclusively for establishing interim IME and DGME rates; rather, MACs may choose to wait until the next regularly scheduled rate review following receipt of the written request from the hospital, and establish interim rates for IME and DGME payments at that time.

Alternatively, if the hospital is training residents for the first time but the residents are in an existing program, and the new teaching hospital has received IME and/or DGME cap slots from another hospital under a Medicare GME affiliation agreement (under 42 CFR 413.79(f)), if the hospital requests in writing (email is sufficient) IME and DGME payments, the MAC shall

- Establish interim IME and DGME rates for the hospital in accordance with the regulations governing interim rate reviews at 42 CFR §412.116(c) and 42 CFR §413.60 and 42 CFR §413.64(a) through (e).

- A hospital must provide the necessary documentation (discussed below) in order for the MAC to establish the interim rates.

**Documentation Required for Calculating Interim IME and DGME Rates for a New Teaching Hospital**

If a hospital requests in writing (email is sufficient) that a MAC establish interim IME and DGME rates due to training residents for the first time in either new or existing approved program(s), the MAC shall request the following documentation from the hospital:

**For IME and DGME:**

- Formal accreditation letter or proof of accreditation of the applicable program(s) by the relevant accrediting body.

- Number of accredited positions being trained in the program for the relevant cost reporting year for which interim rates are being established

- Rotation schedules, or similar documentation, indicating where the residents are training, from which to develop estimated FTE counts applicable to the requesting hospital. For IME, FTE residents training in locations specified in the regulations at 42 CFR §412.105(f)(1)(ii) (A)—(E) may be counted. For DGME, FTE residents training in accordance with the regulations at 42 CFR §413.78 may be counted. The MAC shall ensure that the number of FTE residents based on which the hospital is paid in a year does not exceed the number of accredited slots available to the hospital for the particular program year.

- If applicable, a copy of the Medicare GME Affiliation Agreement under 42 CFR §413.79(f).
For IME:

- Available bed count from the most recently submitted cost report, but modified if appropriate as part of the current interim rate review. Determine the available bed count in accordance with the instructions on the Medicare cost report, CMS Form 2552-10, Worksheet E, Part A, line 4.

- Timely submission of claims for receipt of IME payments on behalf of inpatient services provided to Medicare Fee for Service and Medicare Advantage beneficiaries, in accordance with 42 CFR 424.30 and 424.44.

For DGME:

- Medicare utilization – Determine the hospital’s Medicare utilization rate (or ratio of Medicare inpatient days to total inpatient days) in accordance with the instructions on the Medicare cost report, CMS Form 2552-10, Worksheet E-4, lines 26, 27, and 28, columns 1 and 2 for Part A and Part C, using the hospital’s most recently submitted cost report (but modified as appropriate as part of the current interim rate review).

- Timely submission of claims for receipt of IME payments on behalf of inpatient services provided to Medicare Fee for Service and Medicare Advantage beneficiaries, in accordance with 42 CFR 424.30 and 424.44.

- For the PRA, see below.

### Calculating an Interim Rate PRA

Under 42 CFR §413.77(e)(1)(i) and (ii), a new PRA is equal to the lower of the hospital’s actual cost per resident incurred in the base period, or the weighted mean average PRA of all of the other existing teaching hospitals located in the same core-based statistical area (CBSA) as the new teaching hospital. Under 42 CFR §413.77(e)(1)(ii)(A) or (B) there are less than 3 existing teaching hospitals with PRAs located in the same CBSA as the new teaching hospital with PRAs that can be used for the weighted average PRA calculation, the census region PRA is used (updated for inflation to the new teaching hospital’s base year cost reporting period).

Since the hospital’s actual cost per FTE resident information would not be available until the hospital files its base year cost report, and since determination of the weighted average PRA for the CBSA can be labor intensive, the MAC shall use the latest available census region PRA issued by CMS for the census region in which the new teaching hospital is located, updated for inflation to the base period of the new teaching hospital, for the purpose of calculating and paying DGME interim rates. However, once the hospital submits its base year cost report, the MAC shall calculate and assign the appropriate PRA to the new teaching hospital (as part of the normal cost report settlement process for the new teaching hospital). The MAC shall calculate the interim rate subsequently using the hospital’s permanently assigned PRA, updated with inflation.

The MAC shall update the IME field in its file and establish a direct GME pass-through payment to reflect the appropriate interim payments to the hospital. MACs may enter the IME intern and resident to bed (IRB) ratio effective with the date that the residents in the approved program began training at the hospital, and may either reprocess claims for any retroactive period, or may work with the hospital to hold claims until an IRB ratio is entered into its file, and then claims may be processed prospectively. Alternatively, MACs may enter a current or prospective effective date for the IRB ratio in its file and may manually compute and issue a lump sum interim payment for any retroactive period.

### ADDITIONAL INFORMATION


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<td>Article revised to reflect a re-issued CR, which revised several policy statements and addressed how to handle certain impacted claims.</td>
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<tr>
<td>September 26, 2017</td>
<td>Initial article released.</td>
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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**

HH PPS Rate Update for CY 2018

MLN Matters Number: MM10310
Related Change Request (CR) Number: 10310
Related CR Release Date: October 20, 2017
Effective Date: January 1, 2018
Related CR Transmittal Number: R3888CP
Implementation Date: January 2, 2018

PROVIDER TYPE AFFECTED

This MLN Matters Article is intended for Home Health Agencies (HHAs) billing Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

WHAT YOU NEED TO KNOW

Change Request (CR) 10310 updates the 60-day national episode rates, the national per-visit amounts, Low Utilization Payment Adjustment (LUPA) add-on amounts, the non-routine medical supply payment amounts, and the cost-per-unit payment amounts used for calculating outlier payments under the HH PPS for Calendar Year (CY) 2018. Be sure your billing staffs are aware of these changes.

BACKGROUND

The CY 2018 HH PPS rate update includes the third year of a 3-year phase-in of a reduction to the national, standardized 60-day episode payment amount to account for estimated case-mix growth unrelated to increases in patient acuity (that is, nominal case-mix growth) between CY 2012 and CY 2014. The nominal case-mix growth reduction is 0.97 percent. The changes described in MM10310 are implemented through the Home Health Pricer software used by Medicare contractor standard systems.

Market Basket Update

Section 411(d) of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) amended Section 1895(b)(3)(B) of the Social Security Act (the Act) such that, for home health payments for CY 2018, the market basket percentage increase shall be 1 percent. Section 1895(b)(3)(B) of the Act requires that the home health payment update be decreased by 2 percentage points for those HHAs that do not submit quality data as required by the Secretary of the Department of Health & Human Services (HHS). For HHAs that do not submit the required quality data for CY 2018, the home health payment update would be -1 percent (1 percent minus 2 percentage points).

National, Standardized 60-Day Episode Payment

As described in the CY 2018 HH PPS final rule, in order to calculate the CY 2018 national, standardized 60-day episode payment rate, the Centers for Medicare & Medicaid Services (CMS) applies a wage index budget neutrality factor of 1.0004 and a case-mix budget neutrality factor of 1.0160 to the previous calendar year’s national, standardized 60-day episode rate. To account for nominal case-mix growth from CY 2012 to CY 2014, CMS applies a payment reduction of 0.97 percent to the national, standardized 60-day episode payment rate. Lastly, the national, standardized 60-day episode payment rate is updated by the CY 2018 HH payment update percentage of 1 percent for HHAs that submit the required quality data and by 1 percent minus 2 percentage points, or -1 percent, for HHAs that do not submit quality data. These two-episode payment rates are shown in Tables 1 and 2. These payments are further adjusted by the individual episode’s case-mix weight and by the wage index.

Table 1: For HHAs that DO Submit Quality Data – National, Standardized 60-Day Episode Amount for CY 2018
National Per-Visit Rates

To calculate the CY 2018 national per-visit payment rates, CMS starts with the CY 2017 national per-visit rates. CMS applies a wage index budget neutrality factor of 1.0010 to ensure budget neutrality for LUPA per-visit payments after applying the CY 2018 wage index. The per-visit rates are then updated by the CY 2018 HH payment update of 1 percent for HHAs that submit the required quality data and by -1 percent for HHAs that do not submit quality data. The per-visit rates are shown in Tables 3 and 4.

Table 3: For HHAs that DO Submit Quality Data – CY 2018 National Per-Visit Amounts for LUPAs and Outlier Calculations

<table>
<thead>
<tr>
<th>HH Discipline Type</th>
<th>CY 2017 Per-Visit Payment</th>
<th>Wage Index Budget Neutrality Factor</th>
<th>CY 2018 HH Payment Update</th>
<th>CY 2018 Per-Visit Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Aide</td>
<td>$64.23</td>
<td>X 1.0010</td>
<td>X 1.01</td>
<td>$64.94</td>
</tr>
<tr>
<td>Medical Social Services</td>
<td>$227.36</td>
<td>X 1.0010</td>
<td>X 1.01</td>
<td>$229.86</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>$156.11</td>
<td>X 1.0010</td>
<td>X 1.01</td>
<td>$157.83</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>$155.05</td>
<td>X 1.0010</td>
<td>X 1.01</td>
<td>$156.76</td>
</tr>
<tr>
<td>Skilled Nursing</td>
<td>$141.84</td>
<td>X 1.0010</td>
<td>X 1.01</td>
<td>$143.40</td>
</tr>
<tr>
<td>Speech-Language Pathology</td>
<td>$168.52</td>
<td>X 1.0010</td>
<td>X 1.01</td>
<td>$170.38</td>
</tr>
</tbody>
</table>

Table 4: For HHAs that DO NOT Submit Quality Data – CY 2018 National Per-Visit Amounts for LUPAs and Outlier Calculations

<table>
<thead>
<tr>
<th>HH Discipline Type</th>
<th>CY 2017 Per-Visit Payment</th>
<th>Wage Index Budget Neutrality Factor</th>
<th>CY 2018 HH Payment Update</th>
<th>CY 2018 Per-Visit Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Aide</td>
<td>$64.23</td>
<td>X 1.0010</td>
<td>X 0.99</td>
<td>$63.65</td>
</tr>
<tr>
<td>Medical Social Services</td>
<td>$227.36</td>
<td>X 1.0010</td>
<td>X 0.99</td>
<td>$225.31</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>$156.11</td>
<td>X 1.0010</td>
<td>X 0.99</td>
<td>$154.70</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>$155.05</td>
<td>X 1.0010</td>
<td>X 0.99</td>
<td>$153.65</td>
</tr>
<tr>
<td>Skilled Nursing</td>
<td>$141.84</td>
<td>X 1.0010</td>
<td>X 0.99</td>
<td>$140.56</td>
</tr>
<tr>
<td>Speech-Language Pathology</td>
<td>$168.52</td>
<td>X 1.0010</td>
<td>X 0.99</td>
<td>$167.00</td>
</tr>
</tbody>
</table>
Non-Routine Supply Payments

Payments for Non-Routine Supplies (NRS) are computed by multiplying the relative weight for a particular NRS severity level by an NRS conversion factor. To determine the CY 2018 NRS conversion factors, CMS updates the CY 2017 NRS conversion factor by the CY 2018 HH payment update of 1 percent for HHAs that submit the required quality data and by -1 percent for HHAs that do not submit quality data. CMS does not apply any standardization factors as the NRS payment amount calculated from the conversion factor is neither wage nor case-mix adjusted when the final payment amount is computed. The NRS conversion factor for CY 2018 payments for HHAs that do submit the required quality data is shown in Table 5a and the payment amounts for the various NRS severity levels are shown in Table 5b. The NRS conversion factor for CY 2018 payments for HHAs that do not submit quality data is shown in Table 6a and the payment amounts for the various NRS severity levels are shown in Table 6b.

Table 5a: CY 2018 NRS Conversion Factor for HHAs that DO Submit the Required Quality Data

<table>
<thead>
<tr>
<th>CY 2017 NRS Conversion Factor</th>
<th>CY 2018 HH Payment Update</th>
<th>CY 2018 NRS Conversion Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>$52.50</td>
<td>X 1.01</td>
<td>$53.03</td>
</tr>
</tbody>
</table>

Table 5b: CY 2018 Relative Weights and Payment Amounts for the 6-Severity NRS System for HHAs that DO Submit Quality Data

<table>
<thead>
<tr>
<th>Severity Level</th>
<th>Points (Scoring)</th>
<th>Relative Weight</th>
<th>CY 2018 NRS Payment Amounts</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>0.2698</td>
<td>$14.31</td>
</tr>
<tr>
<td>2</td>
<td>1 to 14</td>
<td>0.9742</td>
<td>$51.66</td>
</tr>
<tr>
<td>3</td>
<td>15 to 27</td>
<td>2.6712</td>
<td>$141.65</td>
</tr>
<tr>
<td>4</td>
<td>28 to 48</td>
<td>3.9686</td>
<td>$210.45</td>
</tr>
<tr>
<td>5</td>
<td>49 to 98</td>
<td>6.1198</td>
<td>$324.53</td>
</tr>
<tr>
<td>6</td>
<td>99+</td>
<td>10.5254</td>
<td>$558.16</td>
</tr>
</tbody>
</table>

Table 6a: CY 2018 NRS Conversion Factor for HHAs that DO NOT Submit the Required Quality Data

<table>
<thead>
<tr>
<th>CY 2017 NRS Conversion Factor</th>
<th>CY 2018 HH Payment Update Percentage Minus 2 Percentage Points</th>
<th>CY 2018 NRS Conversion Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>$52.50</td>
<td>X 0.99</td>
<td>$51.98</td>
</tr>
</tbody>
</table>

Table 6b: CY 2018 Relative Weights and Payment Amounts for the 6-Severity NRS System for HHAs that DO NOT Submit Quality Data

<table>
<thead>
<tr>
<th>Severity Level</th>
<th>Points (Scoring)</th>
<th>Relative Weight</th>
<th>CY 2018 NRS Payment Amounts</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>0.2698</td>
<td>$14.02</td>
</tr>
<tr>
<td>2</td>
<td>1 to 14</td>
<td>0.9742</td>
<td>$50.64</td>
</tr>
<tr>
<td>3</td>
<td>15 to 27</td>
<td>2.6712</td>
<td>$138.85</td>
</tr>
<tr>
<td>4</td>
<td>28 to 48</td>
<td>3.9686</td>
<td>$206.29</td>
</tr>
<tr>
<td>5</td>
<td>49 to 98</td>
<td>6.1198</td>
<td>$318.11</td>
</tr>
<tr>
<td>6</td>
<td>99+</td>
<td>10.5254</td>
<td>$547.11</td>
</tr>
</tbody>
</table>

Sunset of the Rural Add-On Provision

Section 210 of MACRA extended the rural add-on of a 3-percent increase in the payment amount for HH services provided in a rural area for episodes and visits ending before January 1, 2018. Therefore, for episodes and visits that end on or after January 1, 2018, a rural add-on payment will not apply.

Methodology for Calculating Outlier Payments

In the CY 2017 HH PPS final rule (81 FR 76702), CMS finalized changes to the methodology used to calculate outlier payments, using a cost-per-unit approach rather than a cost-per-visit approach. This change
in methodology allows for more accurate payment for outlier episodes, accounting for both the number of visits during an episode of care and also the length of the visits provided. Using this approach, CMS now converts the national per-visit rates into per 15-minute unit rates. These per 15-minute unit rates are used to calculate the estimated cost of an episode to determine whether the claim will receive an outlier payment and the amount of payment for an episode of care. The cost-per-unit payment rates used for the calculation of outlier payments are shown in Tables 7a and 7b. The Fixed Dollar Loss (FDL) ratio remains 0.55 and the loss-sharing ratio remains 0.80.

Table 7a - Cost-Per-Unit Rates for Calculating Outlier Payments for HHAs that DO Submit Required Quality Data

<table>
<thead>
<tr>
<th>HH Discipline</th>
<th>Average Minutes per Visit</th>
<th>CY 2018 Per-Visit Payment</th>
<th>Cost per Unit (1 unit = 15 minutes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Aide</td>
<td>63.0</td>
<td>$64.94</td>
<td>$15.46</td>
</tr>
<tr>
<td>Medical Social Services</td>
<td>56.5</td>
<td>$229.86</td>
<td>$61.02</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>47.1</td>
<td>$157.83</td>
<td>$50.26</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>46.6</td>
<td>$156.76</td>
<td>$50.46</td>
</tr>
<tr>
<td>Skilled Nursing</td>
<td>44.8</td>
<td>$143.40</td>
<td>$48.01</td>
</tr>
<tr>
<td>Speech-Language Pathology</td>
<td>48.1</td>
<td>$170.38</td>
<td>$53.13</td>
</tr>
</tbody>
</table>

Table 7b - Cost-Per-Unit Rates for Calculating Outlier Payments for HHAs that DO NOT Submit Required Quality Data

<table>
<thead>
<tr>
<th>HH Discipline</th>
<th>Average Minutes per Visit</th>
<th>CY 2018 Per-Visit Payment</th>
<th>Cost per Unit (1 unit = 15 minutes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Aide</td>
<td>63.0</td>
<td>$63.65</td>
<td>$15.15</td>
</tr>
<tr>
<td>Medical Social Services</td>
<td>56.5</td>
<td>$225.31</td>
<td>$59.82</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>47.1</td>
<td>$154.70</td>
<td>$49.27</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>46.6</td>
<td>$153.65</td>
<td>$49.46</td>
</tr>
<tr>
<td>Skilled Nursing</td>
<td>44.8</td>
<td>$140.56</td>
<td>$47.06</td>
</tr>
<tr>
<td>Speech-Language Pathology</td>
<td>48.1</td>
<td>$167.00</td>
<td>$52.08</td>
</tr>
</tbody>
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ADDITIONAL INFORMATION


DOCUMENT HISTORY

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<tr>
<th>Date of Change</th>
<th>Description</th>
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<tr>
<td>November 9, 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
- File: July 2017 ASP and ASP NOC --Effective for Dates of Service: July 1, 2017, through September 30, 2017
- File: April 2017 ASP and ASP NOC --Effective for Dates of Service: April 1, 2017, through June 30, 2017
- File: January 2017 ASP and ASP NOC --Effective for Dates of Service: January 1, 2017, through March 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

DOCUMENT HISTORY

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
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<tbody>
<tr>
<td>October 6, 2017</td>
<td>Initial article released.</td>
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</table>
Home Health Consolidated Billing Enforcement HCPCS Codes Quarterly Update

MLN Matters Number: MM10374
Related Change Request (CR) Number: 10374
Related CR Release Date: November 17, 2017
Effective Date: April 1, 2018
Related CR Transmittal Number: R3923CP
Implementation Date: April 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 home health services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

This article is based on Change Request (CR) 10374, which provides the quarterly update of HCPCS codes used for HH consolidated billing effective April 1, 2018. Make sure that your billing staffs are aware of these changes.

BACKGROUND

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

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 your MAC 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).

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 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.

Effective April 1, 2018, the following HCPCS code is added to the HH consolidated billing non-routine supply code list as a result of CR10374:

• A4575 Topical hyperbaric oxygen chamber, disposable (Hyperbaric o2 chamber disps)

No HCPCS codes are added to the HH consolidated billing therapy code list in this update.

ADDITIONAL INFORMATION


DOCUMENT HISTORY

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>November 17, 2017</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>
January 2018 Integrated Outpatient Code Editor (I/OCE) Specifications Version 19.0

MLN Matters Number: MM10385
Related CR Release Date: December 22, 2017
Related CR Transmittal Number: R3940CP
Related Change Request (CR) Number: 10385
Effective Date: January 1, 2018
Implementation Date: January 2, 2018

PROVIDER TYPE AFFECTED
This MLN Matters Article is intended for physicians, providers, and suppliers billing Medicare Administrative Contractors (MACs), including the Home Health and Hospice MACs, for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED
Change Request (CR) 10385 provides the Integrated Outpatient Code Editor (I/OCE) instructions and specifications for the Integrated OCE that Medicare uses under the Outpatient Perspective Payment (OPPS) and Non-OPPS for hospital outpatient departments, community mental health centers, all non-OPPS providers, and for limited services when provided in a Home Health Agency (HHA) not under the Home Health Prospective Payment System or to a hospice patient for the treatment of a non-terminal illness. Make sure your billing staffs are aware of these changes.

BACKGROUND
CR10385 informs MACs, as well as the Fiscal Intermediary Shared System (FISS) maintainer of the updates to the I/OCE for January 1, 2018. The I/OCE routes all institutional outpatient claims (which includes non-OPPS hospital claims) through a single integrated OCE. The Centers for Medicare & Medicaid Services (CMS) will post the I/OCE specifications at https://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/index.html.

The following table summarizes the modifications of the I/OCE for the January 2018 V19.0. Readers should also read through the entire document attached to CR10385 and note the highlighted sections, which also indicate changes from the prior release of the software. Some I/OCE modifications in the update may be retroactively added to prior releases. If so, the retroactive date appears in the ‘Effective Date’ column.
<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Edits Affected</th>
<th>Modification</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/1/2018</td>
<td></td>
<td>Updates to the following tables (additional details included in the tables listed in the attachment to CR10385):</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Table 1: IOCE Control Block</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Add Value Codes and Value Code Amounts, up to 36</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Increase the number of Condition Codes to 30</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Increase the number of Occurrence Codes to 30</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Remove the following fields: Ndxptr, Nsgptr, NCCptr, NOccptr, CodeTypePtr</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Modify the Comments for the following fields: Dxeditptr, Proceditptr, Mdeditptr, Dteditptr, Rceditptr, APCptr, Claimptr</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Table 5: Claim Return Buffer</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Add Payer Condition Code field</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Table 7: APC Return Buffer</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Add HCPCS Modifier field</td>
</tr>
<tr>
<td>1/1/2016</td>
<td></td>
<td>Update program logic for drug HCPCS lines with Status Indicator (SI) of G or K to return the Payment Ambulatory Payment Classification (APC) (see processing logic and Appendix E of the attachment to CR10385).</td>
</tr>
<tr>
<td>1/1/2018</td>
<td></td>
<td>Update Appendix K to note the deletion of composite APC 8001.</td>
</tr>
<tr>
<td>1/1/2018</td>
<td></td>
<td>Implement program logic for payment reduction of x-rays taken using computed radiography technology. HCPCS codes reporting modifier FY are assigned new payment adjustment flag value 22 (CAA Section 502b reduction on computed radiography) (see special processing section and Appendix G). Note: Currently the list of HCPCS codes affected by this logic is the same as that used with modifier FX.</td>
</tr>
<tr>
<td>1/1/2018</td>
<td></td>
<td>Implement program logic for OPPS claims to assign aHCPCS level modifier to the line level output when drug HCPCS with SI = K are reported with new modifier JG. The IOCE adds modifier V3 to the line in the new ‘HCPCS modifier’ field of the program output (see processing logic and Table 7).</td>
</tr>
<tr>
<td>1/1/2017</td>
<td>102</td>
<td>Implement new edit 102: Modifiers PO/PN not allowed on the same line (Return to Provider (RTP)). Edit criteria: A claim line has both modifiers PO and PN present (see processing logic, Tables 4 and 5, and Appendix F(a) – Edits by Bill Type).</td>
</tr>
<tr>
<td>7/24/2017</td>
<td>103</td>
<td>Implement new edit 103: Modifier reported prior to FDA approval date (Line Item Denial (LID)). Edit criteria: A modifier is reported prior to the mid-quarter activation date (see processing logic, Tables 4 and 5, and Appendix F(a) – Edits by Bill Type).</td>
</tr>
<tr>
<td>1/1/2017</td>
<td></td>
<td>Modify program logic for conditional packaging of laboratory services. Laboratory services with SI = Q4 have the SI changed to A if present with an OPPS procedure that has final SI = Q1 with a line item action flag of 2 or 3 applied (see processing logic).</td>
</tr>
<tr>
<td>6/5/2017</td>
<td>68</td>
<td>Implement mid-quarter NCD approval edit for procedure code 0421T.</td>
</tr>
<tr>
<td>1/1/2018</td>
<td></td>
<td>Update program logic for Federally Qualified Health Center (FQHC) claims for new Chronic Care Management codes G0511, G0512. If either code is reported, assign Payment Indicator = 2 and bypass edits 88 and 89 if no FQHC payment code is reported (see Appendix M).</td>
</tr>
<tr>
<td>Date</td>
<td>Events</td>
<td></td>
</tr>
<tr>
<td>------------</td>
<td>------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>4/1/2011</td>
<td>Update program logic for services that may be subject to deductible or deductible/coinsurance waiver. If the services are packaged with SI = N and the line item charges = 0.00, do not assign payment adjustment flags 4, 9 or 10 (see processing logic where payment adjustment flags 4, 9 or 10 are applicable and Appendix G).</td>
<td></td>
</tr>
<tr>
<td>1/1/2018</td>
<td>Add the following new modifiers to the valid</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• FY: Computed radiography x-ray</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• JG: 340B Acquired Drug</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• TB: Tracking 340b acquired drug</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• X1: Continuous/broad services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• X2: Continuous/focused services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• X3: Episodic/broad services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• X4: Episodic/focused services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• X5: Svc req by another clinician</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• 96: Habilitative services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• modifier list:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• 97: Rehabilitative services</td>
<td></td>
</tr>
<tr>
<td>1/1/2018</td>
<td>Update Appendix D to reference HCPCS codes that have SI values different from its APC SI value and impact to discounting (see Appendix D).</td>
<td></td>
</tr>
<tr>
<td>10/1/2017</td>
<td>Update program logic for Partial Hospitalization Program (PHP) claims to return Payer-defined Condition Codes in the following instances:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Return condition code MP if the PHP claim represents the initial admit week claim</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Return condition code MQ if the PHP claim represents the final discharge week claim</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Note: edit 95 is not returned on an initial admit week or a final discharge week of a PHP claim (see processing logic).</td>
<td></td>
</tr>
<tr>
<td>1/1/2018</td>
<td>Update program logic for critical care ancillary services to discontinue the modifier 59 logic exception for code 36600; code no longer identified as critical care ancillary service (see processing logic).</td>
<td></td>
</tr>
<tr>
<td>1/1/2018</td>
<td>Add new payment adjustment flag value 22 (see Appendix G).</td>
<td></td>
</tr>
</tbody>
</table>
FYI

1/1/2018

Update the following lists for the release (see quarterly data files):

- Comprehensive APC ranking
- Complexity adjusted comprehensive APC code pairs
- Critical care ancillary services (conditional packaging)
- Procedure and sex conflict (edit 8)
- Bilateral procedure editing
- Blood clotting factor and biologic response HCPCS (edit 99 exclusions)
- Blood products (edit 73, code updates)
- Skin substitute lists (edit 87 code updates, see Appendix O)
- Coinsurance/Deductible N/A list (code updates, Appendix O, Preventive Services)
- Device Offset Code Pairs (code pair updates for pass through device offset logic)
- Device-Procedural; terminated device procedures for offset (edit 92, code updates)
- Pass-through drugs and biological APC offset amounts
- Pass-through skin substitute products (code updates)
- Radiation HCPCS for Section 603 (code updates)
- CT Scan HCPCS subject to NEMA (code updates)
- X-ray list for modifiers FX/FY (code updates)
- Non-covered services lists (SI = E1, for edits 9, 28, 50, code updates)
- Separate payment not provided list (SI = E2, edit 13)
- Non-reportable for OPPS list (SI = B, edit 62)
- Services not billable to MAC list (SI = M, edit 72)
- FQHC non-covered list (code updates for FQHC and RHC claims)
- FQHC flu vaccine list (code updates for FQHC claims)
- FQHC Chronic Care Management (new codes for new list)

1/1/2018

Make all HCPCS/APC/SI changes as specified by CMS (quarterly data files).

1/1/2018

Implement version 24.0 institutional providers).

ADDITIONAL INFORMATION


DOCUMENT HISTORY

<table>
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<tr>
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<td>December 22, 2017</td>
<td>Initial article released.</td>
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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.

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


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<td>December 26, 2017</td>
<td>Initial article released</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 beneficiary 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


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<td>December 8, 2017</td>
<td>Initial document released.</td>
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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 caused unforeseen issues 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 programs for these costs, but States can limit Medicare cost-sharing payments under certain circumstances.

**Billing of QMBs Is Prohibited by Federal Law**

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

1. 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.

2. Providers and suppliers may also verify beneficiaries’ QMB status through State online Medicaid eligibility systems in the State in which the person is a resident or by asking beneficiaries for other proof, such as their Medicaid identification card or documentation of their QMB status. Ensure that
billing procedures and third-party vendors exempt individuals enrolled in the QMB program from
Medicare charges and that you remedy billing problems should they occur. If you have erroneously billed
individuals enrolled in the QMB program, recall the charges (including referrals to collection agencies)
and refund the invalid charges they paid.

3. Determine the billing processes that apply to seeking payment for Medicare cost-sharing from the
States in which the beneficiaries you serve reside. Different processes may apply to Original Medicare
and MA services provided to individuals enrolled in the QMB program. For Original Medicare claims,
nearly all States have electronic crossover processes through the Medicare Benefits Coordination &
Recovery Center (BCRC) to automatically receive Medicare-adjudicated claims.

- If a claim is automatically crossed over to another payer, such as Medicaid, it is customarily noted on
the Medicare RA.

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

**Important Reminders Concerning QMB Billing Requirements**

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

1. All Original Medicare and MA providers and suppliers—not only those that accept Medicaid—must abide
by the billing prohibitions.

2. 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.

3. 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>
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<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>
</tbody>
</table>
QMB Plus  ≤100% of FPL  Determined by State  Part A***  Meets financial and other criteria for full Medicaid benefits  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)

* 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

Document History

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</tr>
<tr>
<td>November 3, 2017</td>
<td>Article revised to show the HETS QMB release will be in November 2017. All other information remains the same.</td>
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<tr>
<td>October 18, 2017</td>
<td>The article was revised to indicate that the Provider Remittance Advice and the Medicare Summary Notice for beneficiaries identifies the QMB status of beneficiaries and exemption from cost-sharing for Part A and B claims processed on or after October 2, 2017, and to recommend how providers can use these and other upcoming system changes to promote compliance with QMB billing requirements. All other information remains the same.</td>
</tr>
<tr>
<td>August 23, 2017</td>
<td>The article was revised to highlight upcoming system changes that identify the QMB status of beneficiaries and exemption from Medicare cost-sharing, recommend key ways to promote compliance with QMB billing rules, and remind certain types of providers that they may seek reimbursement for unpaid deductible and coinsurance amounts as a Medicare bad debt.</td>
</tr>
<tr>
<td>May 12, 2017</td>
<td>This article was revised on May 12, 2017, to modify language pertaining to billing beneficiaries enrolled in the QMB program. All other information is the same.</td>
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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.

**DOCUMENT HISTORY**

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<tr>
<th>Date of Change</th>
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<tr>
<td>November 8, 2017</td>
<td>The article was reissued to clarify information in the initial release. The title of the article was also changed to better reflect the information.</td>
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<tr>
<td>October 3, 2017</td>
<td>Rescinded</td>
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<tr>
<td>September 19, 2017</td>
<td>Initial article issued</td>
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**Medicare’s Cost Report Worksheet S-10 Updated to Capture Uncompensated Care Data**

MLN Matters Number: SE17031
Article Release Date: September 29, 2017

**PROVIDER TYPE AFFECTED**

This MLN Matters® Special Edition article is intended for all 1886(d) hospitals, including 1886(d) Puerto Rico hospitals, eligible to receive uncompensated care payments.

**WHAT YOU NEED TO KNOW**

This article is intended to provide additional guidance to 1886(d) hospitals by summarizing revisions and clarifications to the instructions for the Worksheet S-10 of the Medicare cost report. The Worksheet S-10 data is used in the computation of Factor 3 in the calculation of the uncompensated care payment for 1886(d) hospitals under the Social Security Act (SSA) eligible to receive such payments. The revisions and clarifications to the Worksheet S-10 are provided to ensure appropriate reporting of uncompensated care costs and to achieve proper Medicare reimbursement. Examples are also provided in this article as additional guidance.

The Centers for Medicare & Medicaid Services (CMS) provided an extension to allow all Inpatient Prospective Payment Systems (IPPS) hospitals to submit an amended cost report with revised Worksheet S-10 data for Fiscal Year (FY) 14 and FY 15 by October 31, 2017. The resubmission of data is not required; providers may choose to resubmit if they have additional data for lines 20, 22, 25 and 26.

**BACKGROUND**

Section 1886(r) of the Act, as added by Section 3133 of the Affordable Care Act, requires that, for FY 2014 and each subsequent fiscal year, subsection (d) hospitals that would otherwise have received a Disproportionate Share Hospital (DSH) payment made under Section 1886(d)(5)(F) of the Act will receive two separate payments, a DSH payment and a payment for the hospital’s proportion of uncompensated care.

In the 2018 Medicare IPPS final rule (82 Fed. Reg. 37990, August 14, 2017), CMS indicated that it would begin to incorporate data from Worksheet S-10 in the computation of Factor 3 for the calculation of
hospitals’ share of uncompensated care payments for fiscal year 2018. As part of CMS’ continued desire to
work with its stakeholders regarding the reporting of uncompensated care and to achieve greater clarity of
the data needed to compute Factor 3, CMS has clarified the instructions and line item descriptions on the
Worksheet S-10.

In Transmittal 10, CMS clarified that hospitals may include discounts given to uninsured patients who meet
the hospital’s charity care criteria. In Transmittal 11, CMS further clarified that full or partial discounts given
to uninsured patients who meet the hospital’s charity care policy or financial assistance policy/uninsured
discount policy (hereinafter referred to as Financial Assistance Policy or FAP) may be included on line 20,
column 1 of the Worksheet S-10. These clarifications apply to cost reporting periods beginning on or after
October 1, 2013.

CMS also modified the application of the cost-to-charge-ratio (CCR). The CCR will not be applied to the
deductible and coinsurance amounts for insured patients approved for charity care and non-reimbursed
Medicare bad debt. The CCR will be applied to uninsured patients approved for charity care or an uninsured
discount, non-Medicare bad debt, and charges for non-covered days exceeding a length of stay limit
imposed on patients covered by Medicaid or other indigent care programs.

**SUMMARY OF MODIFICATIONS TO THE WORKSHEET S-10 AND EXAMPLES**

The following were implemented for Worksheet S-10: 1) a revision to the instructions for Electronic Health
Records (EHR) incentive payments to apply to subsection (d) Puerto Rico hospitals for cost reporting
periods beginning on or after October 1, 2016; and effective for cost reporting periods beginning on or after
October 1, 2013: 2) a clarification of the definition of charity care that includes the addition of uninsured
discounts reported on line 20; 3) a clarification that Medicare and non-Medicare hospital bad debt reported
on line 26 must be net of recoveries; 4) the addition of line 27.01, Medicare allowable bad debts for the
hospital, that will be used to compute the non-Medicare bad debt separately from the non-reimbursed
Medicare bad debt; 5) modifications to the calculation of costs for both insured charity care charges not
subject to the CCR, and insured non-covered days beyond a length-of-stay limit subject to the CCR; and,
6) modifications to the calculation of non-Medicare bad debt subject to the CCR and non-reimbursed
Medicare bad debt (deductible and coinsurance) not subject to the CCR. The modifications to the
calculations will be applied to all cost reports, however providers will not be required to amend their cost
report in order to benefit from these modifications.

Examples for the Worksheet S-10, Uncompensated and Indigent Care Data

For examples 1 through 3 only, assume the following facts: A hospital has a charity care policy which
determines charity care on a “sliding scale” basis and may forgive anywhere from 25% to 100% of the
patient’s liability. An insured patient owes the hospital $100.00 for a deductible on an allowable hospital
service. The insured patient applies for charity care and the hospital determines that he qualifies for charity
care at 25%. The cost reporting period is on or after October 1, 2016.

Example 1: Unpaid Insured Patient’s Liability

The hospital deems $25.00 of the patient’s $100.00 liability as charity care and records this $25.00 on
line 20, column 2. The remaining $75.00 is a patient liability. The $75.00 remaining patient liability may
subsequently be determined by the hospital to be classified as charity care or a hospital bad debt, but not
both. (It is generally assumed that insured persons are not eligible for charity care, however an insured
person can qualify for charity care for the portion of the charges that represents the patient liability pursuant
to the hospital’s charity care policy).

Example 2: Partial Payment of Insured Patient’s Liability

The hospital deems $25.00 of the patient’s $100.00 liability as charity care and records this $25.00 on
line 20, column 2. The patient pays $35.00 of the $75.00 patient liability. The hospital can determine the
remaining $40.00 patient liability to qualify as charity care or a bad debt, but not both. If the $40.00 is
determined to be charity care, it is recorded on line 20, column 2. If it is determined to be a bad debt, it is
recorded on line 26 as a hospital bad debt.

Example 3: Partial Payment of Insured Patient’s Liability, a Medicare Beneficiary

The hospital deems $25.00 of the patient’s $100.00 liability as charity care and records this $25.00 on line
20, column 2. The hospital makes reasonable collection efforts to collect the remaining $75.00 patient
liability. The patient pays $35.00 of the $75.00 patient liability. The hospital determines the unpaid $40.00
patient liability to be a Medicare bad debt. The $40.00 unpaid patient liability would be recorded on line 26 as a hospital bad debt and be reflected on line 27.01 as the Medicare allowable bad debt. The Medicare reimbursable bad debt, $26.00, would be reflected on line 27 (assuming a 65% bad debt limitation pursuant to 42 CFR 413.89(h)).

Example 4: Uninsured Patient, Sliding Scale Charity Care, Partial Payment of Patient Liability with Remaining Amount of Patient Liability Unpaid, Cost Reporting Periods Beginning on or After October 1, 2016

A hospital has a charity care policy which determines charity care on a “sliding scale” basis and may forgive anywhere from 25% to 100% of the patient’s liability. An uninsured patient owes the hospital $1,000.00 for an allowable hospital service. The patient applies for charity care, and the hospital determines that the uninsured patient qualifies for charity care at 60%. The hospital records the $600.00 charity care amount on line 20, column 1. The remaining $400.00 is the patient’s liability. The uninsured patient pays $100.00 toward his liability. If the patient does not pay the remaining $300.00 and the hospital determines the unpaid patient liability to be a bad debt, the hospital would record the $300.00 on line 26 as a hospital bad debt. The $100.00 payment made by the patient does not get recorded anywhere on the Worksheet S-10 because it was not a payment toward the amount deemed charity care; it was a payment toward the non-charity care patient liability.

Example 5: Uninsured Patient, Sliding Scale Charity Care, Partial Payment of Patient Liability with Remaining Amount of Patient Liability Unpaid, Cost Reporting Periods Beginning Prior to October 1, 2016

A hospital has a charity care policy which determines charity care on a “sliding scale” basis and may forgive anywhere from 25% to 100% of the patient’s liability. An uninsured patient owes the hospital $1,000.00 for an allowable hospital service. The patient applies for charity care, and the hospital determines that the uninsured patient qualifies for charity care at 60%. The hospital records the entire $1,000.00 charge as charity care on line 20, column 1. The remaining $400.00 is the patient’s liability and must be recorded on line 22 as this is a patient liability for which the hospital expects to receive payment. The uninsured patient pays $100.00 toward his $400.00 liability. The $100.00 patient payment does not get recorded on Worksheet S-10 because the $400.00 full patient liability was already recorded as an expected payment on line 22. If the $300.00 balance remains unpaid and the hospital determines it to be a bad debt, it can be recorded as a hospital bad debt on line 26.

Example 6: Uninsured Patient, Sliding Scale Charity Care, Partial Payment of Patient Liability with Remaining Amount of Patient Liability Unpaid, Cost Reporting Periods Beginning Prior to October 1, 2016 with Patient Liability Payment Made in a Cost Reporting Period that Began on or After October 1, 2016

A hospital has a charity care policy which determines charity care on a “sliding scale” basis and may forgive anywhere from 25% to 100% of the patient’s liability. In a cost reporting period that began prior to October 1, 2016, an uninsured patient owes the hospital $1,000.00 for an allowable hospital service. The patient applies for charity care, and the hospital determines that the uninsured patient qualifies for charity care at 60%. The hospital records the entire $1,000.00 charge as charity care on line 20, column 1. The remaining $400.00 is the patient’s liability, however the provider did not record the payment/expected payment on line 22 as required. Several months later, in a cost reporting period that began on or after October 1, 2016, the uninsured patient made a payment of $100.00. This $100.00 payment must be recorded on line 22 as a reduction of an amount previously deemed charity care.

Example 7: Uninsured Patient Qualifies to Receive an Uninsured Patient Discount Pursuant to Hospital’s FAP, Cost Reporting Periods Beginning on or After October 1, 2016

An uninsured patient owes the hospital $100.00 for an allowable hospital service. The uninsured patient does not qualify for charity care. The hospital has a FAP which automatically gives a 30% discount to all uninsured patients who meet the hospital’s FAP. The uninsured patient meets the hospital’s FAP and the hospital writes off $30.00 as an uninsured discount on line 20, column 1. The remaining $70.00 is a patient liability. If the $70.00 patient liability remains uncollected and the hospital determines it to be a bad debt, it is recorded on line 26 as a hospital bad debt. (If the cost reporting period began prior to October 1, 2016 using the same scenario above, the full charges of $100.00 would be written off on line 20, column 1. The hospital would record $70.00 on line 22 as an expected payment. If the $70.00 patient liability remains uncollected and the hospital determines it to be a bad debt, it is recorded on line 26 as a hospital bad debt).
Example 8: Calculating the Cost of Insured Patients Approved for Charity Care When Line 20, Column 2 Includes Charges for Patient Days Beyond the Length-Of-Stay Limit for Medicaid or Another Indigent Care Program

Charges for patient days beyond the length of the stay limit are recorded on line 20, column 2. At the end of the fiscal year when preparing its cost report, a hospital, whose CCR is 0.31, has accrued charges for patient days beyond the length-of-stay limit imposed on patients covered by Medicaid in the amount of $10,000 and is reported on line 20, column 2. The hospital also has $550,000 in charity care charges for deductible and co-insurance amounts on line 20, column 2. The net amount reported on line 20, column 2 is $560,000, ($550,000 + $10,000). The hospital answers “yes” to line 24 and reports $10,000 on line 25. When calculating the cost of insured patients approved for charity care on line 21, column 2, the hospital must multiply line 25, $10,000, by the CCR, 0.31 on line 1 and add it to the result of line 20, column 2, $560,000 minus line 25, $10,000.

\[
\text{($560,000 - \$10,000) + ($10,000 \times 0.31)}
\]

\[
= \$550,000 + \$3,100
\]

\[
= \$553,100 \text{ line 21, column 2}
\]

**ADDITIONAL INFORMATION**

Additional information regarding uncompensated care and the Worksheet S-10 can be found in the 2018 IPPS Final Rule at 82 Fed. Reg. 37990 (August 14, 2017). The following resources are available to find additional information regarding instructions to the Worksheet S-10 for uncompensated care, see “Provider Reimbursement Manual” Transmittal 11 containing updates to CMS Pub. 15-2, Chapter 40, Section 4012.

**DOCUMENT HISTORY**

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<th>Date of Change</th>
<th>Description</th>
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<tr>
<td>September 29, 2017</td>
<td>Initial article released.</td>
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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)) 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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<td>October 27, 2017</td>
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</table>
CAH System Edit Change - New vs Established Patient

A system edit has been retired that was rejecting some “new patient” claims from Critical Access Hospitals (CAHs), when a patient was established with the hospital or hospital system within a three-year period. The CAHs were then resubmitting the claims and receiving payment at the “established” patient rate. If impacted, CAHs will need to cancel the established patient claims, and resubmit the claims with the “new patient” codes.

If you have questions, please contact our Provider Contact Center.
CLAIM SUBMISSION

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 (TOB 041x).

• 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


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<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>
</tr>
<tr>
<td>February 3, 2017</td>
<td>Initial article released</td>
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CWF to Modify Provider Queries to Only Accept NPI as Valid Provider Number – Revised

MLN Matters Number: MM10098 Revised
Related Change Request (CR) Number: CR10098
Related CR Release Date: November 9, 2017
Effective Date: January 1, 2018
Related CR Transmittal Number: R1976OTN
Implementation Date: January 2, 2018

This article was revised on November 13, 2017, to reflect a revised CR10098 issued on November 9. In the article, the CR release date, transmittal number, and Web address of CR are revised. All other information remains the same.

PROVIDER TYPES AFFECTED

This MLN Matters® Article is intended for physicians, providers, and suppliers querying Medicare’s Common Working File (CWF) for checking eligibility and entitlement status for Medicare beneficiaries.

PROVIDER ACTION NEEDED

This article is based on Change Request (CR) 10098, which informs the MACs about modifications to the CWF Provider Queries, ELGA, ELGH, HIQA, HIQH, and HUQA, to only accept the National Provider Identifier (NPI) as a valid Provider Number. Make sure that your billing staffs are aware of these changes.

BACKGROUND

Providers, clearinghouses, and/or third-party vendors, herein referred to as “Trading Partners,” verify an individual’s Medicare eligibility and entitlement status prior to and/or while the individual is receiving services before billing Medicare for services rendered to Medicare beneficiaries using HIPAA Eligibility Transaction System (HETS) and/or CWF.

Within CWF, Trading Partners use CWF Provider Queries, ELGA, ELGH, HIQA, HIQH, and HUQA. Currently, Trading Partners are allowed to use either legacy Provider Numbers (CMS Certification Number (CCN) or Unique Physician Identification Number (UPIN)) or NPI on CWF Provider Queries.

The Centers for Medicare & Medicaid Services (CMS) is requiring CWF to modify CWF Provider Queries to only accept NPI as a valid Provider Number.

ADDITIONAL INFORMATION


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<td>July 28, 2017</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: R1974OTN
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


DOCUMENT HISTORY

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>November 13, 2017</td>
<td>Initial Article Released</td>
</tr>
</tbody>
</table>

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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<table>
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<tbody>
<tr>
<td>November 13, 2017</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>

MolDX Billing Reminders

Noridian would like to remind providers of MolDX billing that was published August 4, 2015.

All Part A laboratory service providers in Jurisdictions E and F providing Molecular Diagnostic Testing (MDT) must register those MDT procedures/services with Palmetto GBA doing business as the CMS MolDX Contractor and the Diagnostics ExchangeTM (DEX), an online registry and submit coverage requests to Palmetto GBA PRIOR to consideration for reimbursement. Effective January 1, 2018, failure to submit the DEX Z-CodeTM per the MolDX code ranges will result in the claim being Returned to Provider (RTP). A test description will no longer be accepted to identify the specific test billed.

For correct claims adjudication for the applicable services, enter the following information for each test submitted on the claim:

- Enter claim line number of the performed test
- Enter registered test DEX Z-CodeTM
Correct FISS Remarks Samples:

<table>
<thead>
<tr>
<th>Sample Description</th>
<th>Line</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sample 1: ID for a test on line number one</td>
<td>Line 1- ZB123</td>
</tr>
<tr>
<td>Sample 2: IDs for two molecular tests on line one and line two</td>
<td>Line 1- ZB123</td>
</tr>
<tr>
<td></td>
<td>Line 2- ZD456</td>
</tr>
</tbody>
</table>

For more information regarding MolDX please visit the [Palmetto GBA MolDx](https://www.palmettogba.com/) website.
CODING

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:

Document History
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<th>Date of Change</th>
<th>Description</th>
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<tr>
<td>December 4, 2017</td>
<td>Initial Article Released</td>
</tr>
</tbody>
</table>
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


DOCUMENT HISTORY

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<th>Date of Change</th>
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<td>November 24, 2017</td>
<td>Initial article released.</td>
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I/OCE Specifications Version 18.3 - October 2017 – Revised

MLN Matters Number: MM10230 Revised
Related Change Request (CR) Number: 10230
Related CR Release Date: November 3, 2017
Effective Date: October 1, 2017
Related CR Transmittal Number: R3907CP
Implementation Date: October 2, 2017

This article was revised on November 3, 2017, to reflect the revised CR10230 issued on that same date. In the article, the modification table was updated to include the revisions to several age and gender edits (row 1 of the table) and to add reference to the conditional bilateral list in row 10 of the table. Also, 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 physicians, providers and suppliers billing Medicare Administrative Contractors (MACs), including the Home Health and Hospice MACs, for services provided to Medicare beneficiaries.
**PROVIDER ACTION NEEDED**

Change Request (CR) 10230 provides the Integrated Outpatient Code Editor (I/OCE) instructions and specifications that will be used under the Outpatient Prospective Payment System (OPPS) and Non-OPPS for hospital outpatient departments, community mental health centers, all non-OPPS providers, and for limited services when provided in a Home Health Agency (HHA) not under the Home Health PPS or to a hospice patient for the treatment of a non-terminal illness. This update relates to Chapter 4, Section 40.1 of the “Medicare Claims Processing Manual” (Pub. 100-04). Make sure your billing staffs are aware of these updates.

**BACKGROUND**

CR10230 informs MACs, as well as the Fiscal Intermediary Shared System (FISS) maintainer that the I/OCE is being updated for October 1, 2017. The I/OCE routes all institutional outpatient claims (which includes non-OPPS hospital claims) through a single integrated OCE.


The following table summarizes the modifications of the I/OCE for the October 2017 v18.3 release. Note that some I/OCE modifications may be retroactively added to prior releases. If so, the retroactive date appears in the “Effective Date” column.

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Edits Affected</th>
<th>Modification</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/1/2017</td>
<td>2,3</td>
<td>Revisions to several age and gender edits (details in Summary of Data Changes of CR10230).</td>
</tr>
<tr>
<td>10/1/2017</td>
<td>1, 2, 3, 5, 86</td>
<td>Updated diagnosis code editing for validity, age, gender and manifestation based on the FY 2018 ICD-10-CM code revisions to the Medicare Code Editor (MCE).</td>
</tr>
<tr>
<td>10/1/2017</td>
<td>29</td>
<td>Updated the mental health diagnosis list based on the FY 2018 ICD-10-CM code revisions.</td>
</tr>
<tr>
<td>10/1/2017</td>
<td>95</td>
<td>Modify the effective date for edit 95 to 10/1/2017.</td>
</tr>
<tr>
<td>4/1/2017</td>
<td>30, 95</td>
<td>Update the list of add-on procedure codes that are not counted towards the daily and weekly requirements for number of Partial Hospitalization Program (PHP) services. Procedure codes 90833, 90836 and 90838 are removed from the list; 90785 remains (see special processing logic, Appendix C-a flowchart and Appendix O of CR10230).</td>
</tr>
<tr>
<td>7/1/2017</td>
<td>22</td>
<td>Add ZC (Merck/ Samsung Bioepis) to the list of valid modifiers.</td>
</tr>
<tr>
<td>7/1/2017</td>
<td>94</td>
<td>Add modifier ZC as a biosimilar manufacturer modifier applicable for HCPCS QS102.</td>
</tr>
<tr>
<td>10/1/2016</td>
<td>99</td>
<td>Add HCPCS J2505 (Injection, pegfilgrastim 6mg) to the list of HCPCS excepted from requiring an OPPS procedure on the same claim (see special processing logic).</td>
</tr>
<tr>
<td>7/1/2017</td>
<td>41, 65</td>
<td>Add new revenue code 1006 to the list of valid revenue codes and to the list of revenue codes not recognized by Medicare.</td>
</tr>
</tbody>
</table>
**CODING**

<table>
<thead>
<tr>
<th>Date</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/1/2017</td>
<td></td>
<td>Update the following lists for the release (see quarterly data files): Conditional bilateral list (R1 – code added to list)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Edit 99 exclusion list (add new codes to exception list)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Comprehensive Ambulatory Payment Classification (APC) ranking</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Comprehensive APC Code Pairs (correction to two APC Pairs missing complexity-adjusted APC assignment retroactive for 2016 service dates)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>New data file report for Comprehensive APCs (includes list of procedures, rank and flag for eligibility of complexity-adjusted APC)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Device-procedure list (edit 92)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Terminated device-procedures for device credit (Device offset amount corrections; updated code list)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Non-standard CT Scan (updated code list)</td>
</tr>
<tr>
<td>5/25/2017</td>
<td>68</td>
<td>Implement NCD mid-quarter effective editing for procedure code 93668.</td>
</tr>
<tr>
<td>4/3/2017</td>
<td>68</td>
<td>Implement NCD mid-quarter effective editing for HCPCS A4575 and E0446.</td>
</tr>
<tr>
<td>10/1/2017</td>
<td></td>
<td>Make all HCPCS/APC/SI changes as specified by CMS (quarterly data files).</td>
</tr>
<tr>
<td>10/1/2017</td>
<td>20, 40</td>
<td>Implement version 23.3 of the NCCI (as modified for applicable outpatient institutional providers).</td>
</tr>
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</table>

**ADDITIONAL INFORMATION**


**DOCUMENT HISTORY**

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<td>November 3, 2017</td>
<td>This article was revised to reflect the revised CR10230 issued on that same date. In the article, the modification table was updated to include the revisions to several age and gender edits (row 1 of the table) and to add reference to the conditional bilateral list in row 10 of the table. Also, the CR release date, transmittal number and the Web address for accessing the CR are revised. All other information remains the same.</td>
</tr>
<tr>
<td>August 29, 2017</td>
<td>Initial article released</td>
</tr>
</tbody>
</table>
PR Services Addition to Chapter 19, Indian Health Services

MLN Matters Number: MM10276
Related Change Request (CR) Number: 10276
Related CR Release Date: October 27, 2017
Effective Date: For dates of service on or after January 1, 2010
Related CR Transmittal Number: R3897CP
Implementation Date: April 2, 2018

PROVIDER TYPE AFFECTED

This MLN Matters Article is intended for physicians and other providers billing Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries in the Indian Health Service (IHS).

PROVIDER ACTION NEEDED

Effective January 1, 2010, MACs will pay medically necessary IHS claims containing Healthcare Common Procedure Coding System (HCPCS) code G0424 (Pulmonary rehabilitation, including exercise (includes monitoring), one hour, per session, up to two sessions per day) when billing for Pulmonary Rehabilitation (PR) services, including exercise and monitoring.

PR is a multi-disciplinary program of care for patients with chronic respiratory impairment. It is an evidence-based, multidisciplinary, and comprehensive intervention for patients with chronic respiratory diseases who are symptomatic and often have decreased daily life activities; and is individually tailored and designed to optimize physical and social performance and autonomy.

The Medicare Improvements for Providers and Patients Act of 2008 (MIPPA) added payment and coverage improvements for patients with chronic obstructive pulmonary disease and other conditions, and now provides a covered benefit for a comprehensive PR program under Medicare Part B effective January 1, 2010. This law provides a single PR program, which was codified in the Medicare Physician Fee Schedule (MPFS) final rule at 42 Code of Federal Regulation (CFR) 410.47, which you can find at. https://www.gpo.gov/fdsys/granule/CFR-2010-title42-vol2/CFR-2010-title42-vol2-sec410-47.

CR10276 provides that, effective January 1, 2010, MIPPA provisions added a physician-supervised, comprehensive PR program, which includes the following mandatory components:

- Physician-prescribed exercise
- Education or training
- Psychosocial assessment
- Outcomes assessment
- An individualized treatment plan

As specified at 42 CFR 410.47(f), pulmonary rehabilitation program sessions are limited to a maximum of two (2) one (1)-hour sessions per day for up to 36 sessions, with the option for an additional 36 sessions if medically necessary.

Effective January 1, 2010, IHS providers are paid, for PR services, separately from the All Inclusive Rate (AIR). Your MACs will pay IHS claims for PR services containing HCPCS code G0424 and revenue code 0948 (Pulmonary Rehabilitation Services) on Types of Bill (TOB) 12X (Hospital Inpatient Part B) and 13X (Hospital Outpatient) under the Medicare Physician Fee Schedule (MPFS), and TOB 85X (Critical Access Hospital Outpatient) based on reasonable cost. These services are paid separately from the All Inclusive Rate.

MACs will accept the inclusion of the KX modifier on the IHS claim lines as an attestation that further treatment beyond the 36 sessions is medically necessary up to a total of 72 sessions for a beneficiary. PR services may be billed on IHS claims with or without a clinic visit. MACs will deny your PR claims that exceed 72 sessions.
ADDITIONAL INFORMATION

The official instruction, CR10276, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3897CP.pdf. You will find the revised “Medicare Claims Processing Manual,” Chapter 19 (Indian Health Services), Sections 100.11 as an attachment to the CR.

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<tbody>
<tr>
<td>November 1, 2017</td>
<td>Initial article released.</td>
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</tbody>
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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: R1975OTN
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:


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**


**DOCUMENT HISTORY**

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<td>Initial article released.</td>
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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/implemention 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


**DOCUMENT HISTORY**

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<tr>
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**Medicare Does Not Pay Acute-Care Hospitals for Outpatient Services They Provide to Beneficiaries in a Covered Part A Inpatient Stay at Other Facilities – Revised**

MLN Matters Number: SE17033 Revised
Article Release Date: December 13, 2017

This article was revised on December 13, 2017, to include a reference and link to a recent report from the Office of the Inspector General on this issue in the Additional Information section of this article. All other information remains the same.

**PROVIDER TYPES AFFECTED**

This article is intended for providers billing Medicare Administrative Contractors (MACs) under Medicare Part A for inpatient hospital services provided to Medicare beneficiaries and for acute-care hospitals providing outpatient services to beneficiaries who are inpatients of Long Term Care Hospitals (LTCHs) Inpatient Rehabilitation Facilities (IRFs), Inpatient Psychiatric Facilities (IPFs), and Critical Access Hospitals (CAHs). This article does not present any new or revised policy. Instead, it serves to remind hospitals of proper billing of services for beneficiaries in a covered Part A inpatient stay.

**WHAT YOU NEED TO KNOW**

Generally, Medicare should not pay an acute-care hospital for services (for example, outpatient surgery or lab work) furnished to a beneficiary at that facility when the beneficiary is still an inpatient of another facility. Acute-care hospitals, under arrangements with the LTCH, IRF, IPF, and/or CAH, should look to the LTCH,
IRF, IPF, and/or CAH for payment for the outpatient services it provides to the beneficiary while an inpatient of that other facility. Additionally, acute care hospitals should not charge beneficiaries for outpatient deductibles and coinsurance payments as a result of such services.

Medicare system edits examine claims history for the presence of a covered Part A inpatient stay when also processing an outpatient claim for a date of service when the beneficiary was an inpatient. If Medicare paid for an inpatient stay for the same date of service as the incoming outpatient claim, Medicare edits will appropriately deny payment for the outpatient services. There are occasions when Medicare may get an outpatient claim before getting an inpatient claim. In these cases, after paying the inpatient claim, the MACs will recover the outpatient payment from the provider and direct the provider to refund to the beneficiary any inappropriately collected coinsurance and/or deductible for the outpatient services. Hospitals should review the policies restated in this article to bill correctly in these situations.

**BACKGROUND**

Section 1812 of the Social Security Act (the Act) states that inpatient hospital services provided to Medicare beneficiaries are paid under Medicare Part A. These include inpatient stays at LTCHs, IPFs, IRFs, and CAHs (the Act § 1861). All items and non-physician services provided during a Part A inpatient stay must be provided directly by the inpatient hospital or under arrangements with another provider and billed to Medicare by the inpatient hospital through its Part A claim. Specifically, subject to the conditions, limitations, and exceptions set forth in 42 CFR 409.10, the term “inpatient hospital or inpatient CAH services” means the following services furnished to an inpatient of a participating hospital or of a participating CAH:

- Bed and board
- Nursing services and other related services
- Use of hospital or CAH facilities
- Medical social services
- Drugs, biologicals, supplies, appliances, and equipment
- Certain other diagnostic or therapeutic services
- Medical or surgical services provided by certain interns or residents-in-training
- Transportation services, including transport by ambulance

These services include all inpatient hospital services, which do not include certain physician services, physician assistant services, nurse practitioner and clinical nurse specialist services, certified nurse midwife services, qualified psychologist services, and the services of an anesthetist (42 CFR 409.10(a) and (b)). This provision applies to all hospitals, regardless of whether they are subject to a Prospective Payment System (PPS).

Federal regulations state that Medicare does not pay any provider other than the inpatient hospital for services provided to the beneficiary while the beneficiary is an inpatient of the hospital (42 CFR 412.50(b)). In addition, 42 CFR 412.509(b) states that Medicare does not pay any provider or supplier other than the LTCH for inpatient hospital services furnished to a Medicare beneficiary who is an inpatient of the LTCH. Likewise, 42 CFR 412.604(e) informs IRFs that in furnishing services either directly or under arrangement, the Medicare payments are payment in full for all inpatient services.

As stated in Federal requirements, all items and non-physician services provided during a Medicare Part A inpatient stay must be provided directly by the inpatient hospital or under arrangements with the inpatient hospital and another provider. Federal regulations define “arrangements” as those “which provide that Medicare payment made to the provider that arranged for the services discharges the liability of the beneficiary or any other person to pay for those services” (42 CFR 409.3).

These requirements are clearly stated in the Medicare Claims Processing Manual, Chapter 3, Section 10.4, which states that “All items and non-physician services furnished to inpatients must be furnished directly by the hospital or billed through the hospital under arrangements. This provision applies to all hospitals, regardless of whether they are subject to PPS.” The following medical items, supplies, and services furnished to inpatients are covered under Part A.
Consequently, they are covered by the prospective payment rate or reimbursed as reasonable costs under Part A to hospitals excluded from PPS.

- Laboratory services (excluding anatomic pathology services and certain clinical pathology services)
- Pacemakers and other prosthetic devices including lenses, and artificial limbs, knees, and hips
- Radiology services including computed tomography (CT) scans furnished to inpatients by a physician’s office, other hospital, or radiology clinic
- Total parenteral nutrition (TPN) services
- Transportation, including transportation by ambulance, to and from another hospital or freestanding facility to receive specialized diagnostic or therapeutic services not available at the facility where the patient is an inpatient

The hospital must include the cost of these services in the appropriate ancillary service cost center, that is, in the cost of the diagnostic or therapeutic service. It must not show them separately under revenue code 0540. The following are exceptions:

- Pneumococcal Vaccine - is payable under Part B only and is billed by the hospital using the ASC X12 837 institutional claim format or on the Form CMS-1450.

- Ambulance Service - For purposes of this section “hospital inpatient” means a beneficiary who has been formally admitted. It does not include a beneficiary who is in the process of being transferred from one hospital to another. Where the patient is transferred from one hospital to another, and is admitted as an inpatient to the second, the ambulance service is payable under only Part B. If transportation is by a hospital owned and operated ambulance, the hospital bills separately using the ASC X12 837 institutional claim format or on Form CMS-1450 as appropriate. Similarly, if the hospital arranges for the ambulance transportation with an ambulance operator, including paying the ambulance operator, it bills separately. However, if the hospital does not assume any financial responsibility, the billing is to the A/B MAC (B) by the ambulance operator or beneficiary, as appropriate. If an ambulance is used for the transportation of a hospital inpatient to another facility for diagnostic tests or special treatment, the ambulance trip is considered part of the Diagnosis Related Group (DRG), and not separately billable, if the resident hospital is under PPS.

- Part B Inpatient Services - Where Part A benefits are not payable, payment may be made to the hospital under Part B for certain medical and other health services.

- Anesthetist Services “Incident to” Physician Services - If a physician’s practice was to employ anesthetists and to bill on a reasonable charge basis for these services and that practice was in effect as of the last day of the hospital’s most recent 12-month cost reporting period ending before September 30, 1983, the physician may continue that practice through cost reporting periods beginning October 1, 1984. However, if the physician chooses to continue this practice, the hospital may not add costs of the anesthetist’s service to its base period costs for purposes of its transition payment rates. If it is the existing or new practice of the physician to employ Certified Registered Nurse Anesthetists (CRNAs) and other qualified anesthetists and include charges for their services in the physician bills for anesthesiology services for the hospital’s cost report periods beginning on or after October 1, 1984, and before October 1, 1987, the physician may continue to do so.

Another major exception is that the pneumococcal vaccine (as noted above), influenza virus vaccine, and hepatitis B vaccine and their administration are covered only under Medicare Part B, regardless of the setting in which they are furnished, even when provided to an inpatient during a hospital stay covered under Part A. See the Medicare Claims Processing Manual, Chapter 18, Section 10.1.

Pneumococcal and hepatitis B vaccine services must be provided directly or arranged for by the hospital in order to be covered when furnished to a hospital inpatient as noted in the Medicare Benefit Policy Manual, Chapter 15, Section 250. This section of the manual also notes other services which, when provided to a hospital or SNF inpatient, are covered under Part B, even though the patient has Part A coverage for the hospital or SNF stay. Those services are (in addition to those already mentioned previously):

- Qualified clinical psychologist services furnished after December 31, 1990
- Screening mammography services
- Screening pap smears and pelvic exams
CODING

- Screening glaucoma services
- Colorectal screening
- Bone mass measurements
- Prostate screening

The Medicare Benefit Policy Manual, Chapter 6, Section 10 states that payment may be made under Part B for physician services and for the nonphysician medical and other health services as provided in this section when furnished by a participating hospital (either directly or under arrangements) to an inpatient of the hospital, but only if payment for these services cannot be made under Part A. The same manual section also states that in all hospitals, all other services provided to a hospital inpatient must be treated as an inpatient hospital service to be paid for under Part A, if Part A coverage is available and the beneficiary is entitled to Part A. This is because every hospital must provide directly or arrange for any nonphysician service rendered to its inpatients, and a hospital can be paid under Part B for a service provided in this manner only if Part A coverage does not exist.

The Centers for Medicare & Medicaid Services (CMS) has edits to detect these situations and requires the MACs to recover inappropriate payments and to have the acute care hospitals refund to beneficiaries any inappropriately collected deductible or coinsurance payments.

ADDITIONAL INFORMATION

A recent report by the Office of the Inspector General, Medicare Inappropriately Paid Acute-Care Hospitals for Outpatient Services They Provided to Beneficiaries Who Were Inpatients of Other Facilities, found Medicare overpaid acute-care hospitals for certain outpatient services. Review the entire report: https://oig.hhs.gov/oas/reports/region9/91602026.pdf.

The Acute Care Hospital IPPS Fact Sheet is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AcutePaymtSysfctsht.pdf. This fact sheet includes information on what is covered for beneficiaries in an inpatient stay. On page 3 of this fact sheet (Basis for IPPS Payment), CMS points out that the claim for the patient’s inpatient stay must include all outpatient diagnostic services and admission-related outpatient nondiagnostic services. Further, this portion of the fact sheet notes that providers must not bill these services separately to Medicare Part B.

The MLN booklet, Items and Services not Covered by Medicare, (available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Items-and-Services-Not-Covered-Under-Medicare-Booklet-ICN906765.pdf) provides more details and states that in general, non-physician services furnished to Part A and Part B hospital inpatients and Part A SNF inpatients not provided directly or under arrangement are not covered by Medicare. This booklet also provides details on exceptions to this policy.


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<td>December 13, 2017</td>
<td>The article was revised to include a reference and link to a recent report from the Office of the Inspector General on this issue in the Additional Information section of this article. All other information remains the same.</td>
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<tr>
<td>December 6, 2017</td>
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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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<td>November 21, 2017</td>
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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: 02101 (AK), 02201 (ID), 02301(OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601 (WY) in the CMS Medicare Coverage Database (MCD) 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

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**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: 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601 (WY) 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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• Go to [https://med.noridianmedicare.com/web/jfa/policies/ncd](https://med.noridianmedicare.com/web/jfa/policies/ncd)
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To view a complete list of all Noridian NCD coverage articles, go to [the National Coverage Determination (NCD) webpage](https://med.noridianmedicare.com/web/jfa/policies/ncd) and select the title of interest.

To view a complete list of all CMS NCDs available, go to [National Coverage Determinations (NCDs) Alphabetical Index](https://med.noridianmedicare.com/web/jfa/policies/ncd).

**Chemotherapy Administration - R9**

The Chemotherapy Administration article has been created and published for notice under contract numbers: 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601 (WY) in the CMS Medicare Coverage Database (MCD) 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 09/0/2017; 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: 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601 (WY).

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: 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601.

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 01/01/2018:
    - 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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• 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

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: 02101 (AK), 02201 (ID), 02301(OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601 (WY).

Article Summary: This article explains what procedure code to use and how to bill for a denial based on the Coenzyme Q10 (Q10) LCD L37068.

Effective Date: October 2, 2017

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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.

**DecisionDx-UM Billing Guidelines Article Retirement – Effective September 22, 2017**

The following JF Local Coverage Article has been retired under contractor 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT), 03601 (WY).

**Medicare Coverage Database Number:** A55424

**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.

- 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: 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601 (WY) in the CMS Medicare Coverage Database (MCD) 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).
  - Locate and select above listed Medicare Coverage Article.

Injectable Bulking Agents for the Treatment of Fecal Incontinence Article Retirement – Effective December 4, 2017

The following JF Local Coverage Article has been retired under contractor 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT), 03601 (WY).

**Medicare Coverage Database Number:** A52922

**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.

- 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.
Intraocular Bevacizumab Coding/Billing Guidelines – R7

The Intraocular Bevacizumab Coding/Billing Guidelines coverage article has been revised and published for notice under contract numbers: 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601 (WY).

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

View the complete Noridian coverage article.
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Lymphedema Decongestive Treatment – R3

The Lymphedema Decongestive Treatment coverage article has been revised and published for notice under contract numbers: 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601.

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
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: 02101 (AK), 02201 (ID), 02301(OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601.

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

**Effective Date:** December 1, 2017

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  - Select state/contract of interest from Active, Future or Retired column (This link will redirect you to the CMS website.)
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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: 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601.

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: October 1, 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 JF Local Coverage Article has been retired under contractor 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT), 03601 (WY).

Medicare Coverage Database Number: A54748

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.

- 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.”
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  - Locate the above-listed CMS Medicare Coverage Database (MCD) number and article title and select the title of interest.
MolDX: Know Error Billing and Coding Guidelines Update

The MolDX: Know Error® Billing and Coding Guidelines coverage article has been published for notice under contract numbers: 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601.

**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: 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601.

**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: 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601.

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

**Effective Date:** December 1, 2017

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**MolDX: OncoCEE™ Billing and Coding Guidelines**

The MolDX: OncoCEE™ Billing and Coding Guidelines coverage article has been published for notice under contract numbers: 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601.

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

**Effective Date:** December 1, 2017

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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
MolDX: PreDx Billing and Coding Guidelines

The MolDX: PreDx Billing and Coding Guidelines coverage article has been published for notice under contract numbers: 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601.

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

Effective Date: December 1, 2017

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  - Once in the CMS MCD, select corresponding article title

Non-Coverage of Transoral Incisionless Fundoplication Article Retirement – Effective October 27, 2017

The following JF Local Coverage Article has been retired under contractor 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT), 03601 (WY).

Medicare Coverage Database Number: A52893

Article Title: Non-Coverage of Transoral Incisionless Fundoplication

Effective Date: October 27, 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 retired due to the removal of the CPT Code 43210 from Group 1 listed in the Local Coverage Determination (LCD) Non-Covered Services effective 10/27/2017. 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/jfa/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.

The following JF Local Coverage Article has been retired under contractor 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT), 03601 (WY).

Medicare Coverage Database Number: A52895

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 JF Local Coverage Article has been retired under contractor 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT), 03601 (WY).

Medicare Coverage Database Number: A52796

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.

- 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 in Beneficiaries with Chronic Kidney Disease (CKD) with Iron Deficiency Anemia (IDA) or Reduced Iron Stores Article Retirement – Effective January 14, 2018

The following JF Local Coverage Article has been retired under contractor 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT), 03601 (WY).

Medicare Coverage Database Number: A54654

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).
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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.

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: 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601 (WY) in the CMS Medicare Coverage Database (MCD) 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

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  - Select state/contract of interest from Active, Future or Retired column (This link will redirect you to the CMS website.)
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**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 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601 (WY) 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/jfa/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 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601 (WY) 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. CR10318:

• 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 organ
  • 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: 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601 (WY) in the CMS Medicare Coverage Database (MCD) 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.

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

**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: 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601.

**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
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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</tbody>
</table>
DISASTER CLAIMS

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](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 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

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<thead>
<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 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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</tbody>
</table>
**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](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](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](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](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 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 a 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**

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>
<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](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](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 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
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.

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>
<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. 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 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 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.


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<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>
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<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>
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<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-EmergencyQAs1135Waiver.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.

**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.

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:

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 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) waivers. 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
- 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 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.

- For more information refer to the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies for Medicare Beneficiaries Impacted by an Emergency or Disaster fact sheet at https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Emergency-DME-Beneficiaries-Hurricanes.pdf

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 IPSS 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 IPSS 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

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.
DISASTER CLAIMS

DOCUMENT HISTORY

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SE17035, SE 17035, 17035, California Wildfires, CA fire, fires, California fires, disaster claims, California disaster claims

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.
DISASTER CLAIMS

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>
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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>December 18, 2017</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](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.
TDAPA for Patients with AKI

**MLN Matters Number:** MM10281  
**Related Change Request (CR) Number:** 10281  
**Related CR Release Date:** October 27, 2017  
**Effective Date:** April 1, 2018  
**Related CR Transmittal Number:** R1941OTN  
**Implementation Date:** April 1, 2018

**PROVIDER TYPE AFFECTED**

This MLN Matters Article is intended for dialysis facilities submitting claims to Medicare Administrative Contractors (MACs) provided to Medicare beneficiaries with Acute Kidney Injury (AKI).

**PROVIDER ACTION NEEDED**

This article is based on Change Request (CR) 10281, which updates the AKI payment policy regarding Transitional Drug Add-on Payment Adjustments (TDAPA). Please make sure your billing staffs are aware of these updates.

**BACKGROUND**

On June 29, 2015, the Trade Preferences Extension Act of 2015 (TPEA) (Pub. L. 114-27) was enacted. Section 808(a) of the TPEA amended Section 1861(s)(2)(F) of the Social Security Act (the Act) to provide coverage for renal dialysis services furnished on or after January 1, 2017, by a renal dialysis facility or a provider of services paid under Section 1881(b)(14) of the Act to an individual with AKI.

Section 808(b) of the TPEA amended Section 1834 of the Act by adding a new Subsection r that provides for payment for renal dialysis services furnished by renal dialysis facilities or providers of services paid under Section 1881(b)(14) of the Act to individuals with AKI at the End Stage Renal Disease (ESRD) Prospective Payment System (PPS) base rate, beginning January 1, 2017. Thus, beginning January 1, 2017, ESRD facilities can furnish dialysis to AKI patients. The AKI provision is available at [https://www.congress.gov/bill/114th-congress/house-bill/1295/text#tocHEE69B51CC87340E2B2AB6A4FA73D2A82](https://www.congress.gov/bill/114th-congress/house-bill/1295/text#tocHEE69B51CC87340E2B2AB6A4FA73D2A82).

The provision provides Medicare payment to hospital-based and freestanding ESRD facilities, for renal dialysis services furnished to pediatric and adult beneficiaries with AKI. Medicare will pay ESRD facilities for the dialysis treatment using the ESRD PPS base rate adjusted by the applicable geographic adjustment factor, that is, the ESRD PPS wage index. In addition to the actual dialysis treatment, the ESRD PPS base rate includes payment for other items and services considered to be renal dialysis services as defined in 42 CFR §413.171 and there will be no separate payment for those services.

Renal dialysis services, as defined in 42 CFR §413.171, are also considered renal dialysis services for patients with AKI. As such, no separate payment would be made for renal dialysis drugs, biologicals, laboratory services, and supplies that are included in the ESRD PPS base rate when they are furnished by an ESRD facility to an individual with AKI.

Other items and services that are furnished to beneficiaries with AKI that are not considered to be renal dialysis services but are related to their dialysis as a result of their AKI, would be separately payable. This includes drugs, biologicals, laboratory services, and supplies that ESRD facilities are certified to furnish and that would otherwise be furnished to a beneficiary with AKI in a hospital outpatient setting.


These policies include:
- The identification of services considered to be AKI using revenue codes, HCPCS codes, and CPT codes
- Treatment settings
- Treatment limits
- Rules for separately billable items and services
CR9814 excluded AKI claims from receiving the ESRD network fee reduction, while CR9987 updated the claims submission policies for Erythropoietin Stimulating Agents (ESAs) for AKI patients. MLN Matters article MM9814 is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9814.pdf.

Under the ESRD PPS drug designation process, CMS provides payment using a TDAPA for new injectable or intravenous drugs and biologicals that qualify under 42 CFR 413.234(c)(1). TDAPA is a payment policy under the ESRD PPS and is only applicable for ESRD beneficiaries. TDAPA is not applicable to the per treatment payment amount that is paid to ESRD facilities for furnishing dialysis to individuals with AKI.

Effective January 1, 2018, TDAPA (as outlined in CR10065, see related MLN Matters article at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10065.pdf) will make payment to ESRD facilities for furnishing calcimimetics, that is, J0604 - Cinacalcet, oral, 1 mg, (for ESRD on dialysis) and J0606 - Injection, etelcalcetide, 0.1 mg to ESRD beneficiaries, ESRD facilities will not be responsible for furnishing calcimimetics to individuals with AKI. Sensipar (HCPCS code J0604) remains payable under part D for AKI beneficiaries until the utilization is rolled into the bundle at which point it will transition to the bundled payment amount. With regards to Parsabiv (HCPCS code J0606), this drug is not indicated for AKI and therefore no bills should be submitted for Parsabiv in the AKI population.

Note that MACs will Return to the Provider (RTP) any AKI claim billed with modifier AX on type of bill 72x (AKI) with condition code 84, CPT code G0491 and one of the following ICD-10 diagnosis codes:

1. N17.0 - Acute kidney failure with tubular necrosis
2. N17.1 - Acute kidney failure acute cortical necrosis
3. N17.2 - Acute kidney failure with medullary necrosis
4. N17.8 - Other acute kidney failure
5. N17.9 - Acute kidney failure, unspecified
6. T79.5XXA - Traumatic anuria, initial encounter
7. T79.5XXD - Traumatic anuria, subsequent encounter
8. T79.5XXS - Traumatic anuria, sequela
9. N99.0 - Post-procedural (acute)(chronic) renal failure

In addition, MACs will RTP AKI claims billed HCPCS J0604 or J0606.

ADDITIONAL INFORMATION


DOCUMENT HISTORY

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<td>October 30, 2017</td>
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ESRD PPS and Payment for Dialysis Furnished for AKI in ESRD Facilities for CY 2018

MLN Matters Number: MM10312
Related Change Request (CR) Number: 10312
Related CR Release Date: November 3, 2017
Effective Date: January 1, 2018
Related CR Transmittal Number: R237BP
Implementation Date: January 2, 2018

PROVIDER TYPES AFFECTED
This MLN Matters® Article is intended for End Stage Renal Disease (ESRD) facilities that submit claims to Medicare Administrative Contractors (MACs) for renal dialysis services provided to Medicare beneficiaries.

WHAT YOU NEED TO KNOW
Change Request (CR) 10312 implements the Calendar Year (CY) 2018 rate updates for the ESRD Prospective Payment System (PPS) and updates the payment for renal dialysis services furnished to beneficiaries with Acute Kidney Injury (AKI) in ESRD facilities. This MLN Matters® (MM) Article summarizes these changes. Make sure that your billing staffs are aware of these changes.

BACKGROUND
Effective January 1, 2011, the Centers for Medicare & Medicaid Services (CMS) implemented the ESRD PPS based on the requirements of Section1881(b)(14) of the Social Security Act (the Act) as added by Section 153(b) of the Medicare Improvements for Patients and Providers Act (MIPPA). Section 1881(b)(14)(F) of the Act, as added by Section 153(b) of MIPPA and amended by Section 3401(h) of the Affordable Care Act. As a result, beginning with CY 2012, and each subsequent year, the Secretary shall annually increase payment amounts by an ESRD market basket increase factor, reduced by the productivity adjustment described in Section 1886(b)(3)(B)(ix)(II) of the Act. The ESRD bundled market basket increase factor minus the productivity adjustment will update the ESRD PPS base rate. Section 217(b)(2) of the Protecting Access to Medicare Act of 2014 (PAMA) included a provision that dictated how the market basket should be reduced for CY 2018.

In accordance with Section 808(b) of the Trade Preferences Extension Act of 2015 (TPEA), CMS pays ESRD facilities for furnishing renal dialysis services to Medicare beneficiaries with AKI. CR 9598 implemented the payment for renal dialysis services and provides detailed information regarding payment policies. You can view the corresponding MLN Matters Article at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9598.pdf.

The ESRD PPS includes Consolidated Billing (CB) requirements for limited Part B services included in the ESRD facility’s bundled payment. CMS periodically updates the lists of items and services that are subject to Part B consolidated billing and are therefore no longer separately payable when provided to ESRD beneficiaries by providers other than ESRD facilities.

CY 2018 ESRD PPS updates are as follows:

ESRD PPS base rate:
• A 0.3 percent update to the CY 2017 payment rate. ($231.55 x 1.003 =$232.24).
• A wage index budget-neutrality adjustment factor of 1.000531. ($232.24 x 1.000531 = $232.37)

Wage index:
• The wage index adjustment will be updated to reflect the latest available wage data.
• The wage index floor will remain at 0.4000.

Labor-related share:
• The labor-related share will remain at 50.673.
Outlier Policy:
CMS made the following updates to the adjusted average outlier service Medicare Allowable Payment (MAP) amount per treatment:

- For adult patients, the adjusted average outlier service MAP amount per treatment is $42.41.
- For pediatric patients, the adjusted average outlier service MAP amount per treatment is $37.31.

CMS made the following updates to the fixed dollar loss amount that is added to the predicted MAP to determine the outlier threshold:

- The fixed dollar loss amount is $77.54 for adult patients.
- The fixed dollar loss amount is $47.79 for pediatric patients.

CMS made the following changes to the list of outlier services:

- Renal dialysis drugs that are oral equivalents to injectable drugs are based on the most recent prices retrieved from the Medicare Prescription Drug Plan Finder, are updated to reflect the most recent mean unit cost. In addition, CMS will add or remove any renal dialysis items and services that are eligible for outlier payment. See Attachment A of CR10312 for a list of CY2018 outlier services.
- The mean dispensing fee of the National Drug Codes (NDCs) qualifying for outlier consideration is revised to $0.76 per NDC per month for claims with dates of service on or after January 1, 2018. See Attachment A of CR10312.

Consolidated Billing Requirements:
The CB requirements for drugs and biologicals included in the ESRD PPS is updated by:

1. Adding the following Healthcare Common Procedure Coding System (HCPCS) codes to the bone and mineral metabolism category:
   - J0604 - Cinacalcet, oral, 1 mg, (for ESRD on dialysis)
   - J0606 - Injection, etelcalcetide, 0.1 mg

2. These drugs are payable under the Transitional Drug Add-on Payment Amount (TDAPA) policy for ESRD beneficiaries and are not separately payable for AKI beneficiaries. The TDAPA was implemented with CR 10065. (See the related MLN Matters article at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm10065.pdf. New drugs and biologicals that are eligible for TDAPA do not qualify as an outlier service.

3. Adding the following HCPCS to the composite rate drugs and biologicals category since these drugs meet the definition of a composite rate drug in the Medicare Benefit Policy Manual, Pub. 100-02, chapter 11, section 20.3.F and are renal dialysis services:
   - J7030 Infusion, normal saline solution, 1000 cc
   - J7050 Infusion, normal saline solution, 250 cc
   - J7040 Infusion, normal saline solution, sterile
   - J7060 5% dextrose/water (500 ml = 1 unit)
   - J7042 5% dextrose/normal saline (500 ml = 1 unit)
   - J7070 Infusion, d5w, 1000 cc
   - J7120 Ringers lactate infusion, up to 1000 cc
   - J2360 Injection, orphenadrine citrate, up to 60 mg

4. HCPCS J7030, J7050, J7040, J7060, J7042, J7070, J7120, and J2360 do not meet the definition of an outlier service and therefore do not qualify for an outlier payment. In accordance with CR 8978, ESRD facilities should report J7030, J7050, J7040, J7060, J7042, J7070, J7120, and J2360 along with any other composite rate drugs listed in Attachment B of CR10312.
**CY 2018 AKI Dialysis Payment Rate for Renal Dialysis Services:**

- Beginning January 1, 2018, CMS will pay ESRD facilities $232.37 per treatment.
- The labor-related share is 50.673.
- The AKI dialysis payment rate will be adjusted for wages using the same wage index that is used under the ESRD PPS.
- The AKI dialysis payment rate is not reduced for the ESRD Quality Incentive Program (QIP).
- The TDAPA does not apply to AKI claims.

MACs will not allow a separate payment when the AY modifier is present on Type of Bill 72x (ESRD) with the HCPCS codes J0604 and J0606.

**ADDITIONAL INFORMATION**


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FQHC PPS Recurring File Update – CY 2018

MLN Matters Number: MM10334
Related Change Request (CR) Number: 10334
Related CR Release Date: November 16, 2017
Effective Date: January 1, 2018
Related CR Transmittal Number: R3922CP
Implementation Date: January 2, 2018

PROVIDER TYPES AFFECTED
This MLN Matters Article is intended for Federally Qualified Health Centers (FQHCs) billing Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

WHAT YOU NEED TO KNOW
Change Request (CR) 10334 informs MACs that, effective January 1, 2018, the following items apply to FQHC claims:

• Beginning in 2017, the FQHC Prospective Payment System (PPS) rate is updated annually by the FQHC market basket. Based on historical data through second quarter 2017, the FQHC market basket for Calendar Year (CY) 2018 is 1.9 percent. From January 1, 2018, through December 31, 2018, the FQHC PPS base payment rate is $166.60. The 2018 base payment rate reflects a 1.9 percent increase above the 2016 base payment rate of $163.49.

• The Pricer update, effective for January 1, 2018, also corrects the Geographic Adjustment Factor (GAF) for carrier/locality 0118272 (San Diego-Carlsbad, Ca) to be 1.054 for CY 2017.

• MACs will mass adjust all FQHC claims with dates of service on or after January 1, 2017, through December 31, 2017 for carrier locality 0118272 within 90 days of the implementation of CR10334.

BACKGROUND
Under the FQHC PPS, Medicare pays FQHCs based on the lesser of their actual charges or the PPS rate for all FQHC services furnished to a beneficiary on the same day when a medically necessary face-to-face FQHC visit is furnished to a Medicare beneficiary. Section 1834(o)(2)(B)(ii) of the Social Security Act (the Act) requires that the payment for the first year after the implementation year be increased by the percentage increase in the Medicare Economic Index (MEI). In subsequent years, the FQHC PPS base payment rate will be increased by the percentage increase in a market basket of FQHC goods and services, or if such an index is not available, by the percentage increase in the MEI.

In accordance with Section 1834(o)(1)(A) of the Act, the FQHC PPS base rate is adjusted for each FQHC by the FQHC GAF, based on the Geographic Practice Cost Indices (GPCIs) used to adjust payment under the Physician Fee Schedule (PFS). The FQHC GAF is adapted from the work and practice expense GPCIs, and are updated when the work and practice expense GPCIs are updated for the PFS. For CY 2018, the FQHC PPS GAFs have been updated in order to be consistent with the statutory requirements.

ADDITIONAL INFORMATION

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IRF Medical Review Changes
MLN Matters Number: SE17036
Article Release Date: December 11, 2017

PROVIDER TYPE AFFECTED
This MLN Matters Article is intended for Inpatient Rehabilitation Facilities (IRFs), physicians, and other practitioners with patients in IRFs who are receiving Part A inpatient services.

PROVIDER ACTION NEEDED
Special Edition article SE17036 reiterates policy related to claims submitted with regard to services provided to Medicare beneficiaries IRFs. Please make sure your billing and coding staffs review these policies associated with the Medicare IRF benefit.

BACKGROUND
The Medicare IRF benefit provides intensive rehabilitation therapy in a resource intensive inpatient hospital environment, including Inpatient Rehabilitation Hospitals and Inpatient Rehabilitation Units. The IRF benefit is for a beneficiary who, due to the complexity of their nursing, medical management, and rehabilitation needs, requires and can reasonably be expected to benefit from an inpatient stay and an interdisciplinary team approach to rehabilitation care.

In order for IRF services to be covered under the Medicare IRF benefit, submitted documentation must sufficiently demonstrate that a beneficiary’s admission to an IRF was reasonable and necessary, according to Medicare guidelines. Key elements of IRF coverage criteria include a reasonable expectation that at the time of the beneficiary’s admission to the IRF the beneficiary:

• Requires the active and ongoing therapeutic intervention of multiple therapy disciplines (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics) one of which must be physical or occupational therapy

• Generally requires an intensive rehabilitation therapy program. Under current industry standards, this intensive rehabilitation therapy program generally consists of at least 3 hours of therapy per day at least 5 days per week. In certain well-documented cases, this intensive rehabilitation therapy program might instead consist of at least 15 hours of intensive rehabilitation therapy within a 7-consecutive day period, beginning with the date of admission to the IRF

• Is sufficiently stable and can reasonably be expected to be able to actively participate in, and benefit significantly from, an intensive rehabilitation therapy program. The patient can only be expected to benefit significantly from the intensive rehabilitation therapy program if the patient’s condition and functional status are such that the patient can reasonably be expected to make measurable improvement (that will be of practical value to improve the patient’s functional capacity or adaptation to impairments) as a result of the rehabilitation treatment, and if such improvement can be expected to be made within a prescribed period of time

• Requires physician supervision by a rehabilitation physician, defined as a licensed physician with specialized training and experience in inpatient rehabilitation. The requirement for medical supervision means that the rehabilitation physician must conduct face-to-face visits with the patient at least 3 days per week throughout the patient’s stay in the IRF to assess the patient both medically and functionally, as well as to modify the course of treatment as needed to maximize the patient’s capacity to benefit from the rehabilitation process. (See 42 CFR 412.622, which is available at https://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol2/pdf/CFR-2011-title42-vol2-sec412-622.pdf.)

• Requires an intensive and coordinated interdisciplinary approach to providing rehabilitation

Required documentation elements for an IRF claim include, but are not limited to:

• A comprehensive preadmission screening that is:
  • Conducted by a licensed or certified clinician(s) designated by a rehabilitation physician
  • Completed within the 48 hours immediately preceding the IRF admission
  • Provides a detailed and comprehensive review of each patient’s condition and medical history
A post-admission physician evaluation that:

- Is conducted by a rehabilitation physician
- Is completed within 24 hours of the patient’s admission to the IRF
- Provides documentation of the patient’s status on admission to the IRF, including a comparison with the information noted in the preadmission screening documentation
- Support the medical necessity of the IRF admission

An individualized plan of care that:

- Is developed by a rehabilitation physician with input from the interdisciplinary team
- Is based on the findings of the post-admission physician evaluation
- Is completed within the first 4 days of the IRF admission
- Supports the determination that the IRF admission is reasonable and necessary
- Admission Orders
- An Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI)

Particular attention should be paid to documenting the patient’s need for intensive rehabilitation therapy services requiring care in an IRF. Documentation in the patient’s medical record must be accurate and avoid vague or subjective descriptions of the patient’s care needs that would not be sufficient to indicate the need for intensive rehabilitation services.

Recently, the Centers for Medicare & Medicaid Services (CMS) advised its medical review contractors that when the current industry standard of providing in general at least 3 hours of therapy (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics) per day at least 5 days per week or at least 15 hours of intensive rehabilitation therapy within a 7-consecutive day period is not met, the claim should undergo further review. This further review will require the use of clinical review judgment to determine medical necessity of the intensive rehabilitation therapy program based on the individual facts and circumstances of the case, and not on the basis of any threshold of therapy time.

Also, CMS advised its medical review contractors that the standard of care for IRF patients is individualized (i.e., one-on-one) therapy. Group and concurrent therapy can be used on a limited basis within the current industry standard of generally 3 hours of therapy per day at least 5 days per week or at least 15 hours of intensive rehabilitation therapy within a 7-consecutive day period. In those instances in which group therapy better meets the patient’s needs on a limited basis, the situation/rationale that justifies group therapy should be specified in the patient’s medical record at the IRF.

For more information on billing and payment criteria related to IRFs, please refer to the following documentation:


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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

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)(ii) 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
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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>
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<th>Date of Change</th>
<th>Description</th>
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<tr>
<td>December 15, 2017</td>
<td>Initial article released.</td>
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IPPS and LTCH PPS FY 2018 Changes – Revised

MLN Matters Number: MM10273
Related Change Request (CR) Number: 10273
Related CR Release Date: October 17, 2017
Effective Date: October 1, 2017
Related CR Transmittal Number: R3885CP
Implementation Date: October 2, 2017

This article was revised on October 18, 2017, to reflect a revised CR10273 issued on October 17. The CR was revised to update the factor 3 denominator for hospitals treated as new, the fixed-loss amount for LTCH standard Federal payment rate cases, reference to the Grouper software version, applicable tables and files available on the CMS website, and to clarify the list of ICD-10 codes eligible for the GORE IBE device system new technology add-on payment. In addition, updating the assignment of the wage index for Indian Health Service or Tribal Hospitals of the Pricer in the attachment to the CR. The article was updated accordingly. All other information remains the same.

PROVIDER TYPES AFFECTED

This MLN Matters® Article is intended for hospitals that submit claims to Medicare Administrative Contractors (MACs) for inpatient hospital services provided to Medicare beneficiaries by short term acute care and long-term care hospitals (LTCHs).

PROVIDER ACTION NEEDED

Change Request (CR) 10273 implements policy changes for the Fiscal Year (FY) 2018 Inpatient Prospective Payment System (IPPS) and LTCH Prospective Payment System (PPS). Failure to adhere to these new policies could affect payment of Medicare claims.

BACKGROUND

The Social Security Amendments of 1983 (P.L. 98-21) provided for establishment of a PPS for Medicare payment of inpatient hospital services. In addition, the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA), as amended by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), required that a budget neutral, per discharge PPS for LTCHs based on diagnosis-related groups (DRGs) be implemented for cost reporting periods beginning on or after October 1, 2002.

IPPS FY 2018 Update

The following policy changes for FY 2018 were displayed in the Federal Register on August 2, 2017, with a publication date of August 14, 2017. All items covered in CR10273 are effective for hospital discharges occurring on or after October 1, 2017, through September 30, 2018, unless otherwise noted.

New IPPS and LTCH PPS Pricer software packages will be released prior to October 1, 2017, that will include updated rates that are effective for claims with discharges occurring on or after October 1, 2017, through September 30, 2018.

Files for download listed throughout the CR are available on the Centers for Medicare & Medicaid Services (CMS) website. The key links are:

Alternatively, the files on the webpages listed above are also available at [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html). Click on the link on the left side of the screen titled, “FY 2018 IPPS Final Rule Home Page” or the link titled “Acute InpatientFiles for Download” (and select ‘Files for FY 2018 Final Rule and Correction Notice’).

**IPPS FY 2018 Update**

**A. FY 2018 IPPS Rates and Factors**

For the Operating Rates/Standardized Amounts and the Federal Capital Rate, refer to Tables 1A-C and Table 1D, respectively, of the FY 2018 IPPS/LTCH PPS Final Rule, available on the FY 2018 Final Rule Tables webpage. For other IPPS factors, including applicable percentage increase, budget neutrality factors, high cost outlier (HCO) threshold, and cost-of-living adjustment (COLA) factors, refer to the MAC Implementation Files 1 available on the FY 2018 MAC Implementation Files webpage.

**B. Medicare Severity - Diagnosis Release Group (MS-DRG) Grouper and Medicare Code Editor (MCE) Changes**

The Grouper Contractor, 3M Health Information Systems (3M-HIS), developed the new International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10) MS-DRG Grouper, Version 35.0, software package effective for discharges on or after October 1, 2017. The GROUPER assigns each case into a MS-DRG on the basis of the reported diagnosis and procedure codes and demographic information (that is age, sex, and discharge status). The ICD-10 MCE Version 35.0 which is also developed by 3M-HIS, uses edits for the ICD-10 codes reported to validate correct coding on claims for discharges on or after October 1, 2017.

For discharges occurring on or after October 1, 2017, the Fiscal Intermediary Shared System (FISS) calls the appropriate GROUPER based on discharge date. For discharges occurring on or after October 1, 2017, the MCE selects the proper internal code edit tables based on discharge date.

For the October update, CMS has:

- Reduced the number of MS-DRGs from 757 to 754 for FY 2018. CMS is not implementing any new MS-DRGs for FY 2018. In addition, CMS is deleting MS-DRGs 984, 985 and 986.
- Revised the title to MS-DRG 023 to Craniotomy with Major Device Implant or Acute Complex Central Nervous System (CNS) Principal Diagnosis (PDX) with MCC or Chemotherapy Implant or Epilepsy with Neurostimulator.
- Modified the titles for MS-DRGs 061, 062, and 063 to Ischemic Stroke, Precerebral Occlusion or Transient Ischemia with Thrombolytic Agent w MCC, CC and without CC/MCC, respectively, and retitled MS-DRG 069 to Transient Ischemia without Thrombolytic.
- Revised the titles for MS-DRGs 246 and 248 to state “arteries” instead of “vessels” to better reflect the I-10 terminology in the classification. The revised titles for MS-DRGs 246 and 248 are Percutaneous cardiovascular procedures with drug-eluting stent with MCC or 4+ arteries or stents and Percutaneous cardiovascular procedures with non-drug-eluting stent with MCC or 4+ arteries or stents, respectively.
- Modified the title for MS-DRGs 469 and 470 to Major Hip and Knee Joint Replacement or Reattachment of Lower Extremity with MCC or Total Ankle Replacement and Major Hip and Knee Joint Replacement or Reattachment of Lower Extremity without MCC, respectively.
- Revised the titles for MS-DRGs 823, 824 and 825 to Lymphoma and Non-Acute Leukemia with Other Procedure with CC/MCC and without CC/MCC, respectively.
- Revised the titles for MS-DRGs 829 and 830 to Myeloproliferative Disorders or Poorly Differentiated Neoplasms with Other Procedure with CC/MCC and without CC/MCC, respectively.

**C. Post-acute Transfer and Special Payment Policy**

The changes to MS-DRGs for FY 2018 have been evaluated against the general post-acute care transfer policy criteria using the FY 2016 MedPAR data according to the regulations under Sec. 412.4 (c). As a result of this review, no new MS-DRGs will be added to the list of MS-DRGs subject to the post-acute care transfer policy; however MS-DRGs 987, 988 and 989 (Non-Extensive O.R. Procedure Unrelated To Principal Diagnosis with major complication or comorbidity (MCC), with complication or comorbidity (CC), without CC/MCC, respectively) were added to the special payment policy list. See Table 5 of the FY 2018 IPPS/
LTCH PPS Final Rule for a listing of all Post-acute and Special Post-acute MS-DRGs available on the FY 2018 Final Rule Tables webpage.

D. New Technology Add-On

The following items will continue to be eligible for new-technology add-on payments in FY 2018:

1. Name of Approved New Technology: Defitelio®
   - Maximum Add-on Payment: $75,900
   - Identify and make new technology add-on payments with ICD-10-PCS procedure codes: XW03392 or XW04392

2. Name of Approved New Technology: GORE IBE device system
   - Maximum Add-on Payment: $5,250
   - Identify and make new technology add-on payments with ICD-10-PCS procedure codes: 04VC0EZ; 04VC3EZ; 04VC4EZ; 04VD0EZ; 04VD3EZ or 04VD4EZ (CMS notes ICD-10-PCS procedure codes 04VC0FZ; 04VC3FZ; 04VC4FZ; 04VD0FZ; 04VD3FZ; and 04VD4FZ are no longer valid effective October 1, 2017)

3. Name of Approved New Technology: Idarucizumab
   - Maximum Add-on Payment: $1,750
   - Identify and make new technology add-on payments with ICD-10-PCS procedure codes: XW03331 or XW04331

4. Name of Approved New Technology: Vistogard™
   - Maximum Add-on Payment: $40,130 (Note: The maximum payment has changed from FY 2018)
   - Identify and make new technology add-on payments with any of the following ICD-10 clinical modification (ICD-10-CM) diagnosis codes T45.1x1A, T45.1x1D, T45.1x1S, 1x5A, T45.1x5D, or T45.1x5S in combination with ICD-10-PCS procedure code W0DX82

The following items are eligible for new-technology add-on payments in FY 2018:

5. Name of Approved New Technology: ZINPLAVA™
   - Maximum Add-on Payment: $1,900
   - Identify and make new technology add-on payments with ICD-10-PCS procedure codes XW033A3 or XW043A3.

6. Name of Approved New Technology: Stelara®
   - Maximum Add-on Payment: $2,400
   - Identify and make new technology add-on payments with ICD-10-PCS procedure code XW033F3.

   - Maximum Add-on Payment: $6,110.23
   - Identify and make new technology add-on payments with ICD-10-PCS code X2RF032.

E. Cost of Living Adjustment (COLA) Update for IPPS PPS

The IPPS incorporates a COLA for hospitals located in Alaska and Hawaii. CMS has updated the COLAs for FY 2018, and the COLAs for the qualifying counties in all of Alaska and in Hawaii is 1.25, except for the county of Hawaii which is 1.21. For reference, a table showing the applicable COLAs that are effective for discharges occurring on or after October 1, 2017, are available in the FY 2018 IPPS/LTCH PPS final rule and in MAC Implementation File 1 available on the FY 2018 MAC Implementation Files webpage.
F. FY 2017 Wage Index Changes and Issues

1. Transitional Wage Indexes

Effective October 1, 2014, CMS revised the labor market areas used for the wage index based on the most recent labor market area delineations issued by the Office of Management and Budget (OMB) using 2010 Census data.

For hospitals that were located in an urban county prior to October 1, 2014, that became rural effective October 1, 2014, CMS assigned a hold-harmless urban wage index value of the labor market area in which they are physically located for FY 2014 for 3 years for FY 2015, 2016 and 2017. These hold harmless wage indexes have expired for FY 2018. MACs will ensure hospitals that were eligible for transitional wage indexes in FY 2017 no longer receive a transitional wage index for FY 2018.

2. Adoption of Federal Information Processing Standard (FIPS) County Codes

Core Based Statistical Areas (CBSAs) are made up of one or more constituent counties. Each CBSA and constituent county has its own unique identifying codes. There are two different lists of codes associated with counties: Social Security Administration (SSA) codes and FIPS codes. Historically, CMS has listed and used SSA and FIPS county codes to identify and crosswalk counties to CBSA codes for purposes of the hospital wage index. CMS has learned that SSA county codes are no longer being maintained and updated. However, the FIPS codes continue to be maintained by the U.S. Census Bureau. The Census Bureau’s most current statistical area information is derived from ongoing census data received since 2010; the most recent data are from 2015. For the purposes of crosswalking counties to CBSAs, in the FY 2018 IPPS/LTCH PPS final rule, CMS finalized that it would discontinue the use of SSA county codes and begin using only the FIPS county codes beginning in FY 2018.

Based on information included in the Census Bureau’s website, since 2010, the Census Bureau has made the following updates to the FIPS codes for counties or county equivalent entities:

- Petersburg Borough, AK (FIPS State County Code 02-195), CBSA 02, was created from part of former Petersburg Census Area (02-195) and part of Hoonah-Angoon Census Area (02-105). The CBSA code remains 02.
- The name of La Salle Parish, LA (FIPS State County Code 22-059), CBSA 14, is now LaSalle Parish, LA (FIPS State County Code 22-059). The CBSA code remains as 14.
- The name of Shannon County, SD (FIPS State County Code 46-113), CBSA 43, is now Oglala Lakota County, SD (FIPS State County Code 46-102). The CBSA code remains as 43.

CMS adopted the implementation of these FIPS code updates, effective October 1, 2017, beginning with the FY 2018 wage indexes. A County to CBSA Crosswalk File is available on the FY 2018 Final Rule Data Files webpage.

Note: The county update changes listed above changed the county names. However, the CBSAs to which these counties map did not change from the prior counties. Therefore, there is no payment impact or change to hospitals in these counties; they continue to be considered rural for the hospital wage index under these changes.

3. Treatment of Certain Providers Redesignated Under Section 1886(d)(8)(B) of the Act

42 CFR 412.64(b)(3)(ii) implements section 1886(d)(8)(B) of the Act, which redesignates certain rural counties adjacent to one or more urban areas as urban for the purposes of payment under the IPPS. (These counties are commonly referred to as “Lugar counties”.) Accordingly, hospitals located in Lugar counties are deemed to be located in an urban area and their IPPS payments are determined based upon the urban area to which they are redesignated. A hospital that waives its Lugar status in order to receive the out-migration adjustment has effectively waived its deemed urban status, and is considered rural for all IPPS purposes. The following is a list of hospitals that have waived LUGAR status for FY 2018: 010164, 070004, 070011, 140167, 250117, 390008, 390031, 390150 and 520102.

4. Section 505 Hospital (Out-Commuting Adjustment)

Section 505 of the Medicare Modernization Act of 2003 (MMA), also known as the “outmigration adjustment, is an adjustment that is based primarily on commuting patterns and is available to hospitals that are not reclassified by the Medicare Geographic Classification Review Board (MGCRB), reclassified as a rural hospital under § 412.103, or redesignated under section 1886(d)(8)(B) of the Act.
G. Treatment of Certain Urban Hospitals Reclassified as Rural Hospitals Under § 412.103 and Hospitals reclassified under the MGCRB

An urban hospital that reclassifies as a rural hospital under § 412.103 is considered rural for all IPPS purposes. Note, hospitals reclassified as rural under § 412.103 are not eligible for the capital Disproportionate Share Hospital (DSH) adjustment since these hospitals are considered rural under the capital PPS (see § 412.320(a)(1)).

Prior to April 21, 2016, the regulations at § 412.230(a)(5)(ii) and § 412.230(a)(5)(iii) prohibited hospitals from simultaneously receiving an urban to rural reclassification under § 412.103 and a reclassification under the MGCRB. Also, the regulations did not allow a Lugar hospital to keep its Lugar status if it was approved for an urban to rural reclassification under § 412.103. Effective April 21, 2016, hospitals nationwide that have an MGCRB reclassification or Lugar status during FY 2016 and subsequent years can simultaneously seek urban to rural reclassification under § 412.103 for IPPS payment and other purposes, and keep their existing MGCRB reclassification or Lugar status.

H. Multicampus Hospitals with Inpatient Campuses in Different CBSAs

Beginning with the FY 2008 wage index, CMS instituted a policy that allocates the wages and hours to the CBSA in which a hospital campus is located when a multicampus hospital has campuses located in different CBSAs. Medicare payment to a hospital is based on the geographic location of the hospital facility at which the discharge occurred. Therefore, if a hospital has a campus or campuses in different CBSAs, the MAC adds a suffix to the CMS Certification Number (CCN) of the hospital in the Provider Specific File (PSF), to identify and denote a subcampus in a different CBSA, so that the appropriate wage index associated with each campus’s geographic location can be assigned and used for payment for Medicare discharges from each respective campus. Also note that, under certain circumstances, it is permissible for individual campuses to have reclassifications to another CBSA, in which case, the appropriate reclassified CBSA and wage index needs to be noted in the PSF.

I. Updating the PSF for Wage Index, Reclassifications and Redesignations

MACs will update the PSF by following the steps, in order, in Attachment 1 of CR10273 to determine the appropriate wage index based on policies mentioned above.

J. Expiration of Medicare-Dependent, Small Rural Hospital (MDH) Program

The MDH program is currently effective through September 30, 2017, as provided by section 205 of the Medicare Access and CHIP Reauthorization Act of 2015. Under current law, beginning in October 1, 2017, all previously qualifying hospitals will no longer have MDH status and will be paid solely on the Federal rate. (Note that, the SCH policy at § 412.92(b) allows MDHs to apply for SCH status and be paid as such under certain conditions, following the expiration of the MDH program.) Provider Types 14 and 15 will no longer be valid beginning October 1, 2017.

K. Hospital Specific (HSP) Rate Factors for Sole Community Hospitals (SCHs)

For FY 2018, the HSP amount in the PSF for SCHs (and MDHs as applicable) will continue to be entered in FY 2012 dollars. PRICER will apply the cumulative documentation and coding adjustment factor for FYs 2011 through 2014 of 0.9480 and apply all of the updates and DRG budget neutrality factors to the HSP amount for FY 2013 and beyond.

Note: The FY 2017 2 midnight rule one time prospective increase of 1.006 (as well as the removal of 0.998 2 midnight rule adjustment applied in 2014) are not applied to the HSP update for FY 2018.

L. Low-Volume Hospitals – Criteria and Payment Adjustments for FY2018

The temporary changes to the low-volume hospital payment adjustment originally provided by the Affordable Care Act, and extended by subsequent legislation, which expanded the definition of a low-volume hospital and modified the methodology for determining the payment adjustment for hospitals meeting that definition, is currently effective through September 30, 2017, as provided by section 204 of the Medicare Access and CHIP Reauthorization Act of 2015. Under current law, beginning in October 1, 2017, the low-volume hospital qualifying criteria and payment adjustment methodology will revert to that which was in effect prior to the amendments made by the Affordable Care Act and subsequent legislation (that is, the low-volume hospital payment adjustment policy in effect for FYs 2005 through 2010). The regulations implementing the hospital payment adjustment policy are at § 412.101.
In addition, CMS is implementing an adjustment parallel to the low-volume hospital payment adjustment so that, for discharges occurring in FY 2018 and subsequent years, only the distance between Indian Health Service (IHS) or Tribal hospitals will be considered when assessing whether an IHS or Tribal hospital meets the mileage criterion under § 412.101(b)(2). Similarly, only the distance between non-IHS hospitals would be considered when assessing whether a non-IHS hospital meets the mileage criterion under § 412.101(b)(2). This parallel adjustment is implemented in 42 CFR 412.101(e).

For FY 2018, a hospital must make a written request for low-volume hospital status that is received by its MAC no later than September 1, 2017, in order for the 25-percent, low-volume, add-on payment adjustment to be applied to payments for its discharges beginning on or after October 1, 2017 (through September 30, 2018). Under this procedure, a hospital that qualified for the low-volume hospital payment adjustment for FY 2017 may continue to receive a low-volume hospital payment adjustment for FY 2018 without reapplying if it meets both the discharge criterion and the mileage criterion applicable for FY 2018. As in previous years, such a hospital must send written verification that is received by its MAC no later than September 1, 2017, stating that it meets the mileage criterion applicable for FY 2018. For FY 2018, this written verification must also state, based upon the most recently submitted cost report, that the hospital meets the discharge criterion applicable for FY 2018 (that is, less than 200 discharges total, including both Medicare and non-Medicare discharges). If a hospital’s request for low-volume hospital status for FY 2018 is received after September 1, 2017, and if the MAC determines the hospital meets the criteria to qualify as a low-volume hospital, the MAC will apply the 25-percent, low-volume hospital payment adjustment to determine the payment for the hospital’s FY 2018 discharges, effective prospectively within 30 days of the date of the MAC’s low-volume hospital status determination. CMS notes that this process mirrors its established application process but is updated to ensure that providers currently receiving the low-volume hospital payment adjustment verify that they meet both the mileage criterion and the discharge criterion applicable for FY 2018 to continue receiving the adjustment for FY 2018.

The low-volume hospital payment is based on and in addition to all other IPPS per discharge payments, including capital, DSH (including the uncompensated care payment), Indirect Medical Education (IME) and outliers. For SCHs (and MDHs, when applicable), the low-volume hospital payment is based on and in addition to either payment based on the Federal rate or the hospital-specific rate, whichever results in a greater operating IPPS payment.

M. Hospital Quality Initiative

The hospitals that will receive the quality initiative bonus are listed at www.qualitynet.org. Should a provider later be determined to have met the criteria after publication of this list, they will be added to the list.

N. Hospital Acquired Condition Reduction Program (HAC)

Under the HAC Reduction Program, a 1-percent payment reduction applies to a hospital whose ranking is in the top quartile (25 percent) of all applicable hospitals, relative to the national average, of HACs acquired during the applicable period, and applies to all of the hospital’s discharges for the specified fiscal year.

A list of providers subject to the HAC Reduction Program for FY 2018 was not publicly available in the final rule because the review and correction process was not yet completed. MACs will receive a preliminary list of hospitals subject to the HAC Reduction Program. Updated hospital level data for the HAC Reduction Program will be made publicly available following the review and corrections process.

O. Hospital Value Based Purchasing (VBP)

For FY 2018, CMS will implement the base operating DRG payment amount reduction and the value-based incentive payment adjustments, as a single value-based incentive payment adjustment factor applied to claims for discharges occurring in FY 2018. CMS expects to post the value-based incentive payment adjustment factors for FY 2018 in the near future in Table 16B of the FY 2018 IPPS/LTCH PPS final rule (which will be available through the Internet on the FY 2018 IPPS Final Rule Tables webpage).

P. Hospital Readmissions Reduction Program

The readmissions payment adjustment factors for FY 2018 are in Table 15 of the FY 2018 IPPS/LTCH PPS final rule (which are available through the Internet on the FY 2018 IPPS Final Rule Tables webpage). Hospitals that are not subject to a reduction under the Hospital Readmissions Reduction Program in FY 2018 (such as Maryland hospitals), have a readmission adjustment factor of 1.0000. For FY 2018, hospitals should only have a readmission adjustment factor between 1.0000 and 0.9700.
NOTE: Hospitals located in Maryland (for FY 2018) and in Puerto Rico are not subject to the Hospital Readmissions Reduction Program, and therefore, are not listed in Table 15. Therefore, MACs shall follow the instructions in the second bullet above for the PSF for these hospitals.

Q. Medicare Disproportionate Share Hospitals (DSH) Program

Section 3133 of the Affordable Care Act modified the Medicare DSH program beginning in FY 2014. Under current law, hospitals received 25 percent of the amount they previously would have received under the current statutory formula for Medicare DSH. The remainder, equal to 75 percent of what otherwise would have been paid as Medicare DSH, will become an uncompensated care payment after the amount is reduced for changes in the percentage of individuals that are uninsured. Each Medicare DSH hospital will receive a portion of the aggregate amount available for uncompensated care payments based on its share of total uncompensated care reported by Medicare DSH hospitals. A Medicare DSH hospital’s share of uncompensated care for FY 2018 is based on the average of three individual Factor 3s calculated using three sets of data. The first two sets of data consist of Medicaid days and Medicare SSI days, while the third consists of hospital uncompensated care costs from Worksheet S-10.

The Medicare DSH payment is reduced to 25 percent of the amount they previously would have received under the current statutory formula in PRICER. The calculation of the Medicare DSH payment adjustment will remain unchanged and the 75 percent reduction to the DSH payment is applied in PRICER.

The total uncompensated care payment amount to be paid to Medicare DSH hospitals was finalized in the FY 2018 IPPS Final Rule, and the uncompensated care payment will continue to be paid on the claim as an estimated per discharge amount to the hospitals that have been projected to receive Medicare DSH for FY 2018. The estimated per discharge uncompensated care payment amount will be included in the outlier payment determinations. In addition the estimated per discharge uncompensated care payment amount will be included as a Federal payment for SCHs to determine if a claim is paid under the hospital-specific rate or Federal rate (and for MDHs to determine if the claim is paid 75 percent of the difference between payment under the hospital-specific rate and payment under the Federal rate, when applicable). The total uncompensated care payment amount displayed in the Medicare DSH Supplemental Data File on the CMS website will be reconciled at cost report settlement with the interim estimated uncompensated care payments that are paid on a per discharge basis.

For FY 2018, new hospitals with a CCN established after October 1, 2014 that are eligible for Medicare DSH will have their Factor 3 calculated at cost report settlement using uncompensated care costs reported on Line 30 of Worksheet S-10 as the numerator and a denominator of $25,199,302,174. Factor 3 is then applied to the total uncompensated care payment amount finalized in the FY 2018 IPPS Final Rule to determine the total amount to be paid to the hospital. MACs can refer to the Medicare DSH Supplemental Data File on the CMS website to confirm whether a hospital should be treated as new.

R. Recalled Devices

A hospital’s IPPS payment is reduced, for specified MS-DRGs when the implantation of a device is replaced without cost or with a credit equal to 50 percent or more of the cost of the replacement device. New MS-DRGs are added to the list subject to the policy for payment under the IPPS for replaced devices offered without cost or with a credit when they are formed from procedures previously assigned to MS-DRGs that were already on the list. There are no new MS-DRGs for FY 2018 subject to the policy for replaced devices offered without cost or with a credit.

CMS is revising the titles to MS-DRGs 023 (Craniotomy with Major Device Implant or Acute Complex Central Nervous System (CNS) Principal Diagnosis (PDX) with MCC or Chemotherapy Implant or Epilepsy with Neurostimulator), 469 (Major Hip and Knee Joint Replacement or Reattachment of Lower Extremity with MCC or Total Ankle Replacement), and 470 (Major Hip and Knee Joint Replacement or Reattachment of Lower Extremity without MCC). These MS-DRGs continue to be subject to the replaced devices offered without cost or with a credit policy, effective October 1, 2017.

LTCH PPS FY 2018 Update

2018 LTCH PPS Rates and Factors

The FY 2018 LTCH PPS Standard Federal Rates are located in Table 1E available on the FY 2018 Final Rule Tables webpage. Other FY 2018 LTCH PPS Factors are in MAC Implementation File 2 available on the FY 2018 MAC Implementation File webpage.
The LTCH PPS Pricer has been updated with the Version 35.0 MS-LTC-DRG table, weights and factors, effective for discharges occurring on or after October 1, 2017, and on or before September 30, 2018.

A. Application of the Site Neutral Payment Rate

Section 1206(a) of Public Law 113–67 amended section 1886(m) of the Act to establish patient-level criteria for payments under the LTCH PPS for implementation beginning for cost reporting periods beginning on or after October 1, 2015.


The provisions of section 1206(a) of Public Law 113-67 establishes a transitional blended payment rate for site neutral payment rate LTCH discharges occurring in cost reporting periods beginning during FY 2016 or FY 2017, which is implemented in the regulations at § 412.522(c)(1). The blended payment rate is comprised of 50 percent of the site neutral payment rate for the discharge and 50 percent of the LTCH PPS standard Federal payment rate that would have applied to the discharge if the provisions of Public Law 113-67 had not been enacted. This transitional blended payment rate for site neutral payment rate LTCH discharges is included in the Pricer logic.

Effective with discharges occurring in LTCHs’ cost reporting periods beginning on or after October 1, 2017 (FY 2018), the transitional blended payment rate for site neutral payment rate cases is no longer applicable, and such cases will be paid based on 100 percent of the site neutral payment rate for the discharge.

B. Changes to the Short-Stay Outlier (SSO) Payment Adjustment

CMS is revising the payment formula used to determine payments for SSO cases beginning in FY 2018. This change is reflected in the LTCH PPS Pricer logic.

Effective for LTCH PPS discharges occurring on or after October 1, 2017, the adjusted payment for a SSO case is equal to the “blended payment amount option” under the previous SSO policy. That is, the adjusted payment for a SSO case is equal a blend of an amount comparable to what would otherwise be paid under the IPPS, computed as a per diem, and capped at the full IPPS DRG comparable amount, and the 120 percent LTC-DRG per diem amount. Note there has been no change in the definition of a SSO case (and it continues to be for discharges where the covered length of stay that is less than or equal to five sixths of the geometric average length of stay for each MS–LTC–DRG).

C. Changes to High-Cost Outlier (HCO) Payments for LTCH PPS Standard Federal Payment Rate Cases

When CMS implemented the LTCH PPS, it established a policy allowing for HCO payments to cases where the estimated cost of the case exceeds the outlier threshold. In general, the outlier threshold is the LTCH PPS payment plus a fixed-loss amount that is determined annually. Historically, CMS set this threshold so that aggregate estimated HCO payments accounted for 8 percent of the estimated total aggregate payments to LTCH PPS Standard Federal payment rate cases. In addition, to ensure these estimated HCO payments did not increase or decrease its estimated payments to LTCH PPS Standard Federal Payment Rates, CMS reduced the LTCH PPS Standard Federal payment rate by 8 percent.

Section 15004(b) of the 21st Century Cures Act (Pub. L. 114-255) requires that beginning in FY 2018, CMS continue to reduce the LTCH PPS standard Federal payment rate by 8 percent, but establish the HCO fixed-loss amount so that aggregate HCO payments are estimated to be 7.975 percent of estimated aggregate payments for standard Federal payment rate cases. Accordingly, the FY 2018 fixed-loss amount of $27,381 for LTCH PPS Standard Federal Payment Rate cases reflects this statutory requirement.

D. LTCH Quality Reporting (LTCHQR) Program

Section 3004(a) of the Affordable Care Act requires the establishment of the Long-Term Care Hospital Quality Reporting (LTCHQR) Program. For FY 2018, the annual update to a standard Federal rate will
continue to be reduced by 2.0 percentage points if a LTCH does not submit quality reporting data in accordance with the LTCHQR Program for that year.

E. Provider Specific File (PSF)

The PSF required fields for all provider types which require a PSF is available in the Medicare Claims Processing Manual, Chapter 3, §20.2.3.1 at https://www.cms.gov/Regulations-and-Guidance/Guidance-Manuals/Downloads/clm104c03.pdf.

As noted above in section A.1., effective with discharges occurring in LTCHs’ cost reporting periods beginning on or after October 1, 2017 (FY 2018), the transitional blended payment rate for site neutral payment rate cases is no longer applicable, and such cases will be paid based 100 percent of the site neutral payment rate for the discharge. MACs shall ensure that the Fiscal Year Beginning Date field in the PSF (Data Element 4, Position 25) is updated as applicable with the correct date.

Table 8C contains the FY 2018 Statewide average LTCH total cost-to-charge ratios (CCRs) for urban and rural LTCHs. Table 8C is available on the FY 2018 Final Rule Tables webpage. Per the regulations in 42 CFR sections 412.525(a)(4)(iv)(C) and 412.529(f)(4)(iii), for FY 2018, Statewide average CCRs are used in the following instances:

New hospitals that have not yet submitted their first Medicare cost report. (For this purpose, a new hospital is defined as an entity that has not accepted assignment of an existing hospital’ s provider agreement in accordance with 42 CFR 489.18).

LTCHs with a total CCR is in excess of 1.280 (referred to as the total CCR ceiling).

Any hospital for which data to calculate a CCR is not available.

NOTE: Hospitals and/or MACs can request an alternative CCR to the statewide average CCR per the instructions in section 150.24 of chapter 3 of the Medicare Claims Processing Manual.

F. Cost of Living Adjustment (COLA) under the LTCH PPS

The LTCH PPS incorporates a COLA for hospitals located in Alaska and Hawaii. The COLAs, which have been updated for FY 2018, and effective for discharges occurring on or after October 1, 2017, can be found in the FY 2018 IPPS/LTCH PPS final rule and are also located in MAC Implementation File 2 available on the FY 2018 MAC Implementation Files webpage. (Note that the same COLA factors are used under the IPPS and the LTCH PPS for FY 2018.)

G. 25-percent Threshold Policy

Section 15006 of the 21st Century Cures Act established a moratorium on the implementation of the 25-percent threshold policy until October 1, 2017. CMS also established an additional regulatory moratorium on the implementation of the 25-percent threshold policy effective until October 1, 2018. CMS codified changes to the regulations at § 412.538 in the FY 2018 final rule.

H. Average Length of Stay Calculation

Section 15007 of the 21st Century Cures Act excluded Medicare Advantage and site neutral discharges from the calculation of the average length of stay for all LTCHs. CMS codified changes to the regulations at § 412.23(e)(3) in the FY 2018 final rule.

I. Discharge Payment Percentage

Beginning with LTCHs’ FY 2016 cost reporting periods, the statute requires LTCHs to be notified of their “discharge payment percentage” (DPP), which is the ratio (expressed as a percentage) of the LTCHs’ FFS discharges which received LTCH PPS standard Federal rate payment to the LTCHs’ total number of LTCH PPS discharges. MACs shall continue to provide notification to the LTCH of its DPP upon final settlement of the cost report.

J. Extended Neoplastic Disease Care Hospitals

Section 15008 of the 21st Century Cures Act removed certain hospitals, previously referred to as “subclause (II) LTCHs,” from the IPPS-exclude hospital designation of an LTCH and created a new category of IPPS-excluded hospital for these entities, now referred to as “extended neoplastic disease care hospitals.” As such, these hospitals are no longer subject to the LTCH PPS effective for cost reporting periods beginning on or after January 1, 2015.
Section 15008 of the 21st Century Cures Act further specifies that, for cost reporting periods beginning on or after January 1, 2015, payment for inpatient operating costs for such hospitals is to be made as described in 42 CFR 412.526(c)(3), and payment for capital costs is to be made as described in 42 CFR 412.526(c)(4). (Note that any prior instructions issued by CMS for the payment of such hospitals redesignated by Section 15008 of the 21st Century Cures Act for cost reporting periods beginning on or after January 1, 2015 (for example, CR 9912), any references to “subclause (II) LTCHs” shall be read as “extended neoplastic disease care hospitals”.)

Hospitals Excluded from the IPPS

The update to extended neoplastic disease care hospital’s target amount is the applicable annual rate-of-increase percentage specified in § 413.40(c)(3), which is equal to the percentage increase projected by the hospital market basket index. In the FY 2018 final rule, CMS established an update to an extended neoplastic disease care hospital’s target amount for FY 2018 of 2.7 percent.

ADDITIONAL INFORMATION


DOCUMENT HISTORY

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 18, 2017</td>
<td>This article was revised to reflect a revised CR10273 issued on October 17. The CR was revised to update the factor 3 denominator for hospitals treated as new, the fixed-loss amount for LTCH standard Federal payment rate cases, reference to the Grouper software version, applicable tables and files available on the CMS website, and to clarify the list of ICD-10 codes eligible for the GORE IBE device system new technology add-on payment. In addition, updating the assignment of the wage index for Indian Health Service or Tribal Hospitals of the Pricer in the attachment to the CR. The article was updated accordingly. All other information remains the same.</td>
</tr>
<tr>
<td>September 11, 2017</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>
Chemotherapy Administration Redetermination Requests

Noridian has received a significant volume of redetermination requests on the denied HCPCS code 96413. Noridian has created a Chemotherapy Administration Article to determine what drug codes support chemotherapy administration versus therapeutic administration.

- Go to Noridian Chemotherapy Administration Article for the current article
- If Dates of Service are prior to 7/1/2016
  - View the “Public Versions” history under “Associated Documents”
  - Choose the applicable date span for the desired date of service.

To register for the Chemotherapy Administration: A Noridian Redetermination’s Finding webinar on October 31, 2017, visit the Noridian Schedule of Events.

Chest X-Ray LCD - R8

The following JF Local Coverage Determination (LCD) has been revised under contractor numbers 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT), 03601 (WY).

Medicare Coverage Database (MCD) Number: L34097

LCD Title: Chest X-Ray Policy

Effective Date: January 1, 2018

Summary of Changes: This LCD has been updated to include and/or remove 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/jfa/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
Immune Globulin Intravenous (IVIg) LCD – R6

The following JF Local Coverage Determination (LCD) has been revised under contractor numbers 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT), 03601 (WY).

Medicare Coverage Database (MCD) Number: L34074

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/jfa/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 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601 (WY).

Medicare Coverage Database (MCD) Number/Contractor Determination Number: L37358

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/jfa/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 JF Local Coverage Determination (LCD) has been revised under contractor numbers 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT), 03601 (WY).

Medicare Coverage Database (MCD) Number: L36386
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/jfa/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 - CDD: ProMark Risk Score LCD – R1
The following JF Local Coverage Determination (LCD) has been revised under contractor numbers 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT), 03601 (WY).

Medicare Coverage Database (MCD) Number: L36706
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/jfa/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 JF Local Coverage Determination (LCD) has been revised under contractor numbers 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT), 03601 (WY).

Medicare Coverage Database (MCD) Number: L34066
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.

- Go to https://med.noridianmedicare.com/web/jfa/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: 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 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601 (WY).

**Medicare Coverage Database (MCD) Number/Contractor Determination Number:** L37311

**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/jfa/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 JF Local Coverage Determination (LCD) has been revised under contractor numbers 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT), 03601 (WY).

**Medicare Coverage Database (MCD) Number:** L36186

**LCD Title:** MolDX: Genetic Testing for BCR-ABL Negative Myeloproliferative Disease

**Effective Date:** October 1, 2017

**Summary of Changes:** Added ICD-10 code D47.02, effective 10/1/2017. Added 21st Century Act required fields. Added ICD-10 codes C92.11 and C92.12 effective 10/13/2016.

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

- Go to https://med.noridianmedicare.com/web/jfa/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 – R3**

The following JF Local Coverage Determination (LCD) has been revised under contractor numbers 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT), 03601 (WY).

**Medicare Coverage Database (MCD) Number:** L36256

**LCD Title:** MolDX: Molecular Diagnostic Tests (MDT)

**Effective Date:** January 1, 2018

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

New CPT/HCPCS codes

- 81175, 81176, 81230, 81232, 81238, 81247, 81248, 81249, 81258, 81259, 81269, 81283, 81284, 81334, 81335, 81346, 81347, 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/jfa/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 JF Local Coverage Determination (LCD) has been revised under contractor numbers 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT), 03601 (WY).

**Medicare Coverage Database (MCD) Number:** L36171

**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/jfa/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 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601 (WY).

**Medicare Coverage Database (MCD) Number/Contractor Determination Number:** L37313

**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/jfa/policies/lcd/future](https://med.noridianmedicare.com/web/jfa/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 JF Local Coverage Determination (LCD) has been revised under contractor numbers 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT), 03601 (WY).

**Medicare Coverage Database (MCD) Number:** L36526

**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/jfa/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 - R22
The following JF Local Coverage Determination (LCD) has been revised under contractor numbers 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT), 03601 (WY).

Medicare Coverage Database (MCD) Number: L35008

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 esophagogastric 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/jfa/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.
Special Histochemical Stains and Immunohistochemical Stains LCD – R3
The following JF Local Coverage Determination (LCD) has been revised under contractor numbers 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT), 03601 (WY).

Medicare Coverage Database (MCD) Number: L36353

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 A55803 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/jfa/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 – R11
The following JF Local Coverage Determination (LCD) has been revised under contractor numbers 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT), 03601 (WY).

Medicare Coverage Database (MCD) Number: L34010

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/jfa/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 5, 2017
MLN Connects® for Thursday, October 5, 2017
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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
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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

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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

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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
MLN CONNECTS

- 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 biologics 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
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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
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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
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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

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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

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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
MLN Connects® for Thursday, December 21, 2017

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

**Smoking Cessation Benefit Information**

Next Eligible Date:
Base Sessions: 8
Sessions Remaining: 8

**Pulmonary Rehabilitation Services**

Professional Sessions Remaining: 0
Technical Sessions Remaining: 0

**Cardiac Rehabilitation Services**

Professional Sessions Used: 0
Technical Sessions Used: 0

**Intensive Cardiac Rehabilitation Services**

Professional Sessions Used: 0
Technical Sessions Used: 0
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.
Remittance Advice Messaging for the 20 Hour Weekly Minimum for Partial Hospitalization Program Services – Reissued

MLN Matters® Number: MM9880 Re-Issued
Related Change Request (CR) #: CR 9880
Related CR Release Date: April 28, 2017
Effective Date: October 1, 2017
Related CR Transmittal #: R1833OTN
Implementation Date: October 2, 2017

This article was re-issued on October 3, 2017, to confirm that its content remains valid even though Special Edition Article SE1607 was rescinded.

Provider Types Affected
This MLN Matters® Article is intended for Outpatient Prospective Payment System (OPPS) providers submitting Partial Hospitalization Program (PHP) claims to Medicare Administrative Contractors (MACs) for PHP services provided to Medicare beneficiaries.

What You Need to Know
Change Request (CR) 9880 implements informational messaging, effective October 1, 2017, that conveys supplemental and educational information to the provider submitting claims for PHP services where the patient did not receive the minimum 20 hours per week of therapeutic services his plan of care indicates is required, on claims with line item date of service (LIDOS) on or after October 1, 2017. When the minimum 20 hours per week care is not provided, MACs will return Remittance Advice Remarks Code N787 - “Alert: An eligible PHP beneficiary requires a minimum of 20 hours of PHP services per week, as evidenced in the plan of care. PHP services must be furnished in accordance with the plan of care.”

Background
Partial hospitalization services are intensive outpatient services provided in lieu of inpatient hospitalization for mental health conditions. The regulation at 42 CFR 410.43(c)(1) states that PHPs are intended for patients who require a minimum of 20 hours per week of therapeutic services as evidenced in their plan of care. Additionally, the regulation at 42 CFR 410.43(a)(3) requires that PHP services are services that are furnished in accordance with a physician certification and plan of care as specified under 42 CFR 424.24(e).

Additional Information

Document History

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 3, 2017</td>
<td>Article re-issued to confirm that its content remains valid even though Special Edition Article SE1607 was rescinded.</td>
</tr>
<tr>
<td>April 28, 2017</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>
January 2018 Update of the Hospital Outpatient Prospective Payment System (OPPS)

MLN Matters Number: MM10417  
Related CR Release Date: December 22, 2017  
Related CR Transmittal Number: R3941CP  
Related Change Request (CR) Number: 10417  
Effective Date: January 1, 2018  
Implementation Date: January 2, 2018

PROVIDER TYPE AFFECTED

This MLN Matters Article is intended for providers and suppliers submitting claims to Medicare Administrative Contractors (MACs), including Home Health and Hospice (HH&H) MACs, for services provided to Medicare beneficiaries and paid under the Outpatient Prospective Payment System (OPPS).

PROVIDER ACTION NEEDED

Change Request (CR) 10417 describes changes to the OPPS to be implemented in the January 2018 update. Make sure your billing staffs are aware of these changes.

BACKGROUND

CR10417 describes changes to and billing instructions for various payment policies implemented in the January 2018 OPPS update. The January 2018 Integrated Outpatient Code Editor (I/OCE) will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in this Change Request (CR).

The January 2018 revisions to I/OCE data files, instructions, and specifications are provided in the forthcoming January 2018 I/OCE CR10385. Once the I/OCE CR is issued, a related MLN Matters article will be available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10385.pdf.

Key changes to and billing instructions for various payment policies implemented in the January 2018 OPPS update are as follows:

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New Device Pass-Through Categories

Section 1833(t)(6)(B) of the Social Security Act (the Act) requires that, under the OPPS, categories of devices be eligible for transitional pass-through payments for at least two (2), but not more than three (3), years. Section 1833(t)(6)(B)(ii)(IV) of the Act requires that the Centers for Medicare & Medicaid Services (CMS) create additional categories for transitional pass-through payment of new medical devices not described by existing or previously existing categories of devices.

Effective January 1, 2018, there are no device categories eligible for pass-through payment. However, an existing device described by HCPCS code C2623 (Catheter, transluminal angioplasty, drug coated, non-laser) was approved on August 25, 2017, by the Food and Drug Administration (FDA) for a new indication, specifically the treatment of patients with dysfunctional Arteriovenous (AV) fistulae.

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

Refer to [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html) for the most current device pass-through information.

### Transitional Pass-Through Payments for Designated Devices

Certain designated new devices are assigned to Ambulatory Payment Classifications (APCs) and identified by the OCE as eligible for payment based on the reasonable cost of the new device reduced by the amount included in the APC for the procedure that reflects the packaged payment for device(s) used in the procedure. OCE will determine the proper payment amount for these APCs as well as the coinsurance and any applicable deductible. All related payment calculations will be returned on the same APC line and identified as a designated new device. Refer to [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Annual-Policy-Files-Items/2018-Annual-Policy-Files.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Annual-Policy-Files-Items/2018-Annual-Policy-Files.html) for the most current OPPS HCPCS Offset File.

### Device Offset from Payment for Device Category

Section 1833(t)(6)(D)(ii) of the Act requires CMS to deduct from pass-through payments for devices an amount that reflects the portion of the APC payment amount. With respect to device code C2623, CMS has previously determined that the costs associated with C2623 are not reflected in the APC payment amount. Therefore, CMS is not applying a device offset to the retroactive pass-through payments for C2623. Retroactive pass-through payments for August 25, 2017, through December 31, 2017, will only apply when HCPCS code C2623 is billed with CPT code 36902 or CPT code 36903. The device/procedure offset pair requirements for HCPCS code C2623 listed in Change Request 9553, Transmittal 3483 are no longer applicable effective January 1, 2018.

### New Separately Payable Procedure Code

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

#### Table 1. – New Separately Payable Procedure Code Effective January 1, 2018

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>January 2018 OPPS STATUS INDICATOR (SI)</th>
<th>January 2018 OPPS APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9748</td>
<td>Prostatic rf water vapor tx</td>
<td>Transurethral destruction of prostate tissue; by radiofrequency water vapor (steam) thermal therapy</td>
<td>J1</td>
<td>5373</td>
</tr>
</tbody>
</table>

**Argus Retinal Prosthesis Add-on Code (C1842)**

Effective January 1, 2017, CMS created HCPCS code C1842 (Retinal prosthesis, includes all internal and external components; add-on to C1841) and assigned it the Status Indicator (SI) of “N.” HCPCS code C1842 was created to resolve a claims processing issue for Ambulatory Surgical Centers (ASCs) and should not be reported on institutional claims by hospital outpatient department providers. HCPCS code C1842 is included in the Calendar Year (CY) 2018 Annual HCPCS file.

### Changes to New Technology APCs 1901 –1908

Effective January 1, 2018, two additional New Technology APCs (1907 and 1908) are created. In addition, the payment ranges for APCs 1901 –1906 have been changed. All changes are documented in Table 2.
## Table 2. – CY 2018 Additional New Technology APC Groups

<table>
<thead>
<tr>
<th>CY 2018 APC</th>
<th>CY 2018 APC Title</th>
<th>CY 2018 SI</th>
<th>Updated or New APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>1901</td>
<td>New Technology - Level 49 ($100,001-$115,000)</td>
<td>S</td>
<td>Updated</td>
</tr>
<tr>
<td>1902</td>
<td>New Technology - Level 49 ($100,001-$115,000)</td>
<td>T</td>
<td>Updated</td>
</tr>
<tr>
<td>1903</td>
<td>New Technology - Level 50 ($115,001-$130,000)</td>
<td>S</td>
<td>Updated</td>
</tr>
<tr>
<td>1904</td>
<td>New Technology - Level 50 ($115,001-$130,000)</td>
<td>T</td>
<td>Updated</td>
</tr>
<tr>
<td>1905</td>
<td>New Technology - Level 51 ($130,001-$145,000)</td>
<td>S</td>
<td>Updated</td>
</tr>
<tr>
<td>1906</td>
<td>New Technology - Level 51 ($130,001-$145,000)</td>
<td>T</td>
<td>Updated</td>
</tr>
<tr>
<td>1907</td>
<td>New Technology - Level 52 ($145,001-$160,000)</td>
<td>S</td>
<td>New</td>
</tr>
<tr>
<td>1908</td>
<td>New Technology - Level 52 ($145,001-$160,000)</td>
<td>T</td>
<td>New</td>
</tr>
</tbody>
</table>

### Services Eligible for New Technology APC Assignment and Payments

Under OPPS, services eligible for payment through New Technology APCs are those codes that are assigned to the series of New Technology APCs published in Addendum A of the latest OPPS update. OPPS considers any HCPCS code assigned to the APCs below to be a “new technology procedure or service.” As of January 1, 2018, the range of New Technology APCs include:

- APCs 1491 through 1500
- APCs 1502 through 1537
- APCs 1539 through 1585,
- APCs 1589 through 1599
- APCs 1901 through 1908

The application for consideration as a New Technology procedure or service is available at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/passthrough_payment.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/passthrough_payment.html). At that website, under the “Downloads” section, refer to the document, entitled “For a New Technology Ambulatory Payment Classification (APC) Designation Under the Hospital Outpatient Prospective Payment System (OPPS)” for information on the requirements for submitting an application. The list of HCPCS codes and payment rates assigned to New Technology APCs are in Addendum B of the latest OPPS update regulation each year at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html).

### Payment Changes for X-rays Taken Using Film and Computed Radiography Technology

On December 18, 2015, the Consolidated Appropriations Act of 2016 was signed into law (Public Law 114-113). Section 502 of the Consolidated Appropriations Act requires that Medicare implement the following provisions under the hospital OPPS for the technical component of imaging services:

- Reduce payment by 20 percent for an X-ray taken using film, beginning January 1, 2017, and
- Reduce payment by 7 percent from January 1, 2018 through December 31, 2022, and
- Thereafter to 10 percent, beginning January 1, 2023,

For an imaging service that is an X-ray taken using computed radiography technology. In response to these provisions, CMS established modifiers “FX,” effective January 1, 2017, and “FY,” effective January 1, 2018. Below is additional information related to these modifiers. CMS notes that
Section 502(b) of Division O, Title V of the Consolidated Appropriations Act of 2016 amended Section 1833(t)(16) of the Act by adding new subparagraph (F).

**Payment Modifier for X-ray Taken Using Film, Effective January 1, 2017**

Consistent with the requirements set forth in Section 1833(t)(16)(F)(i) and in accordance with provisions allowed under Section 1833(t)(16)(F)(iv) of the Act, CMS established modifier “FX” (X-ray taken using film) to identify imaging services that are X-rays taken using film. As stated in the CY 2017 OPPS/ASC final rule with comment period (81 FR 79729 through 79730) and in the January 2017 Update of the OPPS (Change Request 9930, Transmittal 3685, dated December 22, 2016), hospitals are required to use this modifier to report imaging services that are x-rays taken using film, effective January 1, 2017.

The use of the FX modifier is applicable to all imaging services that are X-rays taken using film and results in a payment reduction of 20 percent, beginning January 1, 2017. All imaging services are listed in the OPPS Addendum B.

**Payment Modifier for X-ray Taken Using Computed Radiography Technology, Effective January 1, 2018**

Consistent with the requirements set forth in Section 1833(t)(16)(F)(ii) and in accordance with provisions allowed under Section 1833(t)(16)(F)(iv) of the Act, CMS established modifier “FY” (X-ray taken using computed radiography technology/cassette-based imaging) to identify an imaging service that is an X-ray taken using computed radiography technology. Effective January 1, 2018, hospitals are required to use this modifier to report imaging services that are X-rays taken using computed radiography technology.

The use of this modifier results in a payment reduction of 7 percent from January 1, 2018, through December 31, 2022, and thereafter to 10 percent beginning January 1, 2023, for imaging services that are X-rays taken using computed radiography technology/cassette-based imaging. All imaging services are listed in the OPPS Addendum B.

**Deletion of Modifier “CP”**

Modifier “CP” became effective in CY 2016 and was used to identify adjunctive services on a claim related to a procedure assigned to a Comprehensive Ambulatory Payment Classification (C-APC) procedure. The use of the modifier was required for CYs 2016 and 2017 and the data collection period for this modifier was set to conclude on December 31, 2017. Accordingly, for CY 2018, CMS is deleting modifier “CP” and discontinuing its required use. Also, for CY 2018, for the C-APC for Stereotactic Radio Surgery (SRS), specifically, C-APC 5627 (Level 7 Radiation Therapy), CMS will continue to make separate payments for the 10 planning and preparation services adjunctive to the delivery of the SRS treatment using either the Cobalt-60-based or LINAC-based technology when furnished to a beneficiary within 30 days of the SRS treatment. The 10 planning and preparation codes listed in Table 3 will be paid according to their assigned SI when furnished within 30 days of SRS treatment delivery.

**Table 3. – Excluded Planning and Preparation CPT Codes**

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>CY 2018 Short Descriptor</th>
<th>CY 2018 SI</th>
</tr>
</thead>
<tbody>
<tr>
<td>70551</td>
<td>MRI brain stem w/o dye</td>
<td>Q3</td>
</tr>
<tr>
<td>70552</td>
<td>MRI brain stem w/dye</td>
<td>Q3</td>
</tr>
<tr>
<td>70553</td>
<td>MRI brain stem w/o &amp; w/dye</td>
<td>Q3</td>
</tr>
<tr>
<td>77011</td>
<td>Ct scan for localization</td>
<td>N</td>
</tr>
<tr>
<td>77014</td>
<td>Ct scan for therapy guide</td>
<td>N</td>
</tr>
<tr>
<td>77280</td>
<td>Set radiation therapy field</td>
<td>S</td>
</tr>
<tr>
<td>77285</td>
<td>Set radiation therapy field</td>
<td>S</td>
</tr>
<tr>
<td>77290</td>
<td>Set radiation therapy field</td>
<td>S</td>
</tr>
<tr>
<td>77295</td>
<td>3-d radiotherapy plan</td>
<td>S</td>
</tr>
<tr>
<td>77336</td>
<td>Radiation physics consult</td>
<td>S</td>
</tr>
</tbody>
</table>

**Changes to the Inpatient-Only (IPO List)**

The Medicare Inpatient-Only (IPO) list includes procedures that are typically only provided in the inpatient
setting and therefore are not paid under the OPPS. For CY 2018, CMS is removing Total Knee Arthroplasty (TKA) from the IPO list as well as five other procedures. CMS is also adding one procedure to the IPO list. The changes to the IPO list for CY 2018 are included in Table 4.

Table 4. – Changes to the Inpatient Only List for CY 2018

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>27447</td>
<td>Arthroplasty, knee, condyle and plateau; medical and lateral compartments with or without patella resurfacing (total knee arthroplasty)</td>
<td>Removed</td>
<td>5115</td>
<td>J1</td>
</tr>
<tr>
<td>43282</td>
<td>Laparoscopy, surgical, repair of para-esophageal hernia, includes fundoplasty, when performed; with implantation of mesh</td>
<td>Removed</td>
<td>5362</td>
<td>J1</td>
</tr>
<tr>
<td>43772</td>
<td>Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device component only</td>
<td>Removed</td>
<td>5303</td>
<td>J1</td>
</tr>
<tr>
<td>43773</td>
<td>Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric restrictive device component only</td>
<td>Removed</td>
<td>5361</td>
<td>J1</td>
</tr>
<tr>
<td>43774</td>
<td>Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device and subcutaneous port components</td>
<td>Removed</td>
<td>5303</td>
<td>J1</td>
</tr>
<tr>
<td>55866</td>
<td>Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing; includes robotic assistance, when performed</td>
<td>Removed</td>
<td>5362</td>
<td>J1</td>
</tr>
<tr>
<td>92941</td>
<td>Percutaneous transluminal evascularization of acute total/subtotal occlusion during acute myocardial infarction, coronary artery or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty, including aspiration thrombectomy when performed, single vessel</td>
<td>Added</td>
<td>N/A</td>
<td>C</td>
</tr>
</tbody>
</table>

Revisions to the Laboratory Date of Service (DOS) Policy

a. Laboratory Test/Service Performed by an Independent Laboratory

In the CY 2018 OPPS/ASC final rule (82 FR 52533-52540), CMS discussed an additional exception to current laboratory DOS regulations at 42 Code of Federal Regulations (CFR) 414.510. This new exception to the laboratory DOS policy permits independent laboratories to bill Medicare directly for molecular pathology tests and Advanced Diagnostic Laboratory Tests (ADLTs), which are excluded from the OPPS packaging policy, if the specimen was collected from a hospital outpatient during a hospital outpatient encounter and the test was performed following the patient’s discharge from the hospital outpatient department. Consequently, Hospital Outpatient Departments (HOPDs) should no longer bill Medicare for molecular pathology tests and ADLTs performed by independent laboratories following the patient’s discharge from the HOPD, and independent laboratories will no longer have to seek payment from the HOPD for these tests, if all of the conditions are met.

Note there are no current codes designated as ADLTs; however, molecular pathology codes are currently assigned to OPPS SI “A” to indicate that they are not paid under the OPPS, but may be paid under a different Medicare payment system.
b. Laboratory Test/Service Performed by a Hospital Laboratory

For a molecular pathology test or ADLT test performed by a hospital laboratory, refer to the "Medicare Claims Processing Manual", Chapter 16, Laboratory Services, Section 50.3, Hospitals.

**OPPS Status Indicator Updates for Clinical Laboratory Fee Schedule (CLFS) Molecular Pathology Tests and Advanced Diagnostic Laboratory Tests (ADLTs)**

Under the OPPS, Medicare conditionally packages laboratory tests and only pays separately for certain types of laboratory tests. Molecular pathology tests and ADLTs are paid separately at the CLFS rate rather than the OPPS. The current list of molecular pathology tests is available in the OPPS Addendum B (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html) and are identified with status indicator “A.”

However, for the January 2018 OPPS update, there are no laboratory tests currently designated by CMS as ADLTs under the CLFS. As stated in the CY 2017 OPPS/ASC final rule with comment period (81 FR 79594), CMS will assign SI “A” (Not paid under OPPS. Paid by Medicare Administrative Contractors (MACs) under a fee schedule or payment system other than OPPS) to ADLTs once a laboratory test has been granted ADLT status under the CLFS.

Prior to ADLT designation, applicants must submit an application to CMS requesting ADLT status for a laboratory test. Once a test is designated by CMS as an ADLT under paragraph (1) of the definition of advanced diagnostic laboratory test in 42 CFR 414.502, CMS will update the OPPS Addendum B on a quarterly basis to reflect the appropriate SI assignment.

**Billing Instructions for 340B-Acquired Drugs**

As finalized in the CY 2018 OPPS/ASC final rule with comment period, separately payable Part B drugs (assigned SI “K”), other than vaccines (assigned SI “L” or “M”) and drugs on pass-through payment status (assigned SI “G”) that are acquired through the 340B Program or through the 340B prime vendor program, will be paid at the Average Sales Price (ASP) minus 22.5 percent, when billed by a hospital paid under the OPPS that is not excepted from the payment adjustment.

Hospital types that are excepted from the 340B payment policy in CY 2018 include rural Sole Community Hospitals (SCHs), children's hospitals, and Prospective Payment System (PPS)-exempt cancer hospitals. These excepted hospitals will continue to receive ASP + 6 percent payment for separately payable drugs. Medicare will continue to pay separately payable drugs that were not acquired under the 340B Program at ASP + 6 percent.

In addition, effective January 1, 2018, hospitals paid under the OPPS that are not excepted from the 340B drug payment policy for CY 2018 are required to report modifier “JG” on the same claim line as the drug HCPCS code to identify a 340B-acquired drug. Since rural SCHs, children’s hospitals and PPS-exempt cancer hospitals are excepted from the 340B payment adjustment in CY 2018, these hospitals will report informational modifier “TB” for 340B-acquired drugs, and will continue to be paid at the ASP + 6 percent.

The 340B modifiers and their descriptors are listed in Table 5.

**Table 5 – Modifiers for 340B-Acquired Drugs**

<table>
<thead>
<tr>
<th>2-Digit HCPCS Modifier</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>JG</td>
<td>340B acquired drug</td>
<td>Drug or biological acquired with 340B drug pricing program discount</td>
<td>01/01/2018</td>
</tr>
<tr>
<td>TB</td>
<td>Tracking 340B acquired drug</td>
<td>Drug or biological acquired with 340B drug pricing program discount, reported for informational purposes</td>
<td>01/01/2018</td>
</tr>
</tbody>
</table>
Drugs, Biologicals, and Radiopharmaceuticals

a. New CY 2018 HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Radiopharmaceuticals

For CY 2018, several new HCPCS codes have been created for reporting drugs and biologicals in the hospital outpatient setting, where there have not previously been specific codes available. These new codes are listed in Table 6.

Table 6 – New CY 2018 HCPCS Codes Effective for Certain Drugs, Biologicals, and Radiopharmaceuticals

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>C9014</td>
<td>Injection, cerliponase alfa, 1 mg</td>
<td>G</td>
<td>9014</td>
</tr>
<tr>
<td>C9015</td>
<td>Injection, c-1 esterase inhibitor (human), Haegarda, 10 units</td>
<td>G</td>
<td>9015</td>
</tr>
<tr>
<td>C9016</td>
<td>Injection, triptorelin extended release, 3.75 mg</td>
<td>G</td>
<td>9016</td>
</tr>
<tr>
<td>C9024</td>
<td>Injection, liposomal, 1 mg daunorubicin and 2.27 mg cytarabine</td>
<td>G</td>
<td>9302</td>
</tr>
<tr>
<td>C9028</td>
<td>Injection, inotuzumab ozogamicin, 0.1 mg</td>
<td>G</td>
<td>9028</td>
</tr>
<tr>
<td>C9029</td>
<td>Injection, gusekumab, 1 mg</td>
<td>G</td>
<td>9029</td>
</tr>
<tr>
<td>J0604</td>
<td>Cinacalcet, oral, 1 mg, (for ESRD on dialysis)</td>
<td>B</td>
<td>N/A</td>
</tr>
<tr>
<td>J0606</td>
<td>Injection, etelcalcetide, 0.1 mg</td>
<td>K</td>
<td>9031</td>
</tr>
<tr>
<td>J1555</td>
<td>Injection, immune globulin (cuvitru), 100 mg</td>
<td>K</td>
<td>9034</td>
</tr>
<tr>
<td>J7211</td>
<td>Injection, factor viii, (antihemophilic factor, recombinant, (kovaltry), 1 i.u.</td>
<td>K</td>
<td>9075</td>
</tr>
<tr>
<td>J7345</td>
<td>Aminolevulinic acid hcl for topical administration, 10% gel, 10 mg</td>
<td>G</td>
<td>9301</td>
</tr>
<tr>
<td>J9203</td>
<td>Injection, gemtuzumab ozogamicin, 0.1 mg</td>
<td>G</td>
<td>9495</td>
</tr>
<tr>
<td>Q2040</td>
<td>Tisagenlecleucel, up to 250 million car-positive viable t cells, including leukapheresis and dose preparation procedures, per infusion</td>
<td>K</td>
<td>9081</td>
</tr>
<tr>
<td>Q4176</td>
<td>Neopatch, per square centimeter</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>Q4177</td>
<td>Floweramnioflo, 0.1 cc</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>Q4178</td>
<td>Floweramniopatch, per square centimeter</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>Q4179</td>
<td>Flowerderm, per square centimeter</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>Q4180</td>
<td>Revita, per square centimeter</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>Q4181</td>
<td>Amnio wound, per square centimeter</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>Q4182</td>
<td>Transcyte, per square centimeter</td>
<td>N</td>
<td>N/A</td>
</tr>
</tbody>
</table>

b. Other Changes to CY 2018 HCPCS and CPT Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals

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

Table 7 notes those drugs, biologicals, and radiopharmaceuticals that have undergone changes in their HCPCS/CPT code, their long descriptor, or both. Each product’s CY 2017 HCPCS/CPT code and long descriptor are noted in the two left-hand columns and the CY 2018 HCPCS/CPT code and long descriptor are noted in the adjacent right-hand columns.
### Table 7 – Other CY 2018 HCPCS and CPT Code Changes for Certain Drugs, Biologicals, and Radiopharmaceuticals

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>C9490</td>
<td>Injection, bezlotoxumab, 10mg</td>
<td>J0565</td>
<td>Injection, bezlotoxumab, 10mg</td>
</tr>
<tr>
<td>C9484</td>
<td>Injection, eteplirsen, 10 mg</td>
<td>J1428</td>
<td>Injection, eteplirsen, 10 mg</td>
</tr>
<tr>
<td>C9486</td>
<td>Injection, granisetron extended release, 0.1 mg</td>
<td>J1627</td>
<td>Injection, granisetron extended release, 0.1 mg</td>
</tr>
<tr>
<td>Q9986</td>
<td>Injection, hydroxyprogesterone caproate (Makena), 10 mg</td>
<td>J1726</td>
<td>Injection, hydroxyprogesterone caproate (Makena), 10 mg</td>
</tr>
<tr>
<td>Q9985</td>
<td>Injection, hydroxyprogesterone caproate, not otherwise specified, 10 mg</td>
<td>J1729</td>
<td>Injection, hydroxyprogesterone caproate, not otherwise specified, 10 mg</td>
</tr>
<tr>
<td>C9489</td>
<td>Injection, nusinersen, 0.1 mg</td>
<td>J2326</td>
<td>Injection, nusinersen, 0.1 mg</td>
</tr>
<tr>
<td>C9494</td>
<td>Injection, ocrelizumab, 1 mg</td>
<td>J2350</td>
<td>Injection, ocrelizumab, 1 mg</td>
</tr>
<tr>
<td>Q9989</td>
<td>Ustekinumab, for Intravenous Injection, 1 mg</td>
<td>J3358</td>
<td>Ustekinumab, for Intravenous Injection, 1 mg</td>
</tr>
<tr>
<td>C9140</td>
<td>Injection, Factor VIII (antihemophilic factor, recombinant) (Afstyla), 1 I.U.</td>
<td>J7210</td>
<td>Injection, factor viii, (antihemophilic factor, recombinant), (Afstyla), 1 i.u.</td>
</tr>
<tr>
<td>Q9984</td>
<td>Levonorgestrel-releasing intrauterine contraceptive system (Kyleena), 19.5 mg</td>
<td>J7296</td>
<td>Levonorgestrel-releasing intrauterine contraceptive system (Kyleena), 19.5 mg</td>
</tr>
<tr>
<td>C9483</td>
<td>Injection, atezolizumab, 10 mg</td>
<td>J9022</td>
<td>Injection, atezolizumab, 10 mg</td>
</tr>
<tr>
<td>C9491</td>
<td>Injection, avelumab, 10 mg</td>
<td>J9023</td>
<td>Injection, avelumab, 10 mg</td>
</tr>
<tr>
<td>C9485</td>
<td>Injection, olaratumab, 10 mg</td>
<td>J9285</td>
<td>Injection, olaratumab, 10 mg</td>
</tr>
</tbody>
</table>

c. Drugs and Biologicals with Payments Based on Average Sales Price (ASP), Effective January 1, 2018

For CY 2018, payment for non-pass-through drugs, biologicals and therapeutic radiopharmaceuticals that were not acquired through the 340B Program is made at a single rate of ASP + 6 percent (or ASP minus 22.5 percent if acquired under the 340B Program), which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical.

In CY 2018, a single payment of ASP + 6 percent for pass-through drugs, biologicals and radiopharmaceuticals is made to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items. Payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available.

Effective January 1, 2018, payment rates for many drugs and biologicals have changed from the values published in the CY 2018 OPPS/ASC final rule with comment period as a result of the new ASP calculations based on sales price submissions from the third quarter of CY 2017. In cases where adjustments to payment rates are necessary, changes to the payment rates will be incorporated in the January 2018 Fiscal Intermediary Shared System (FISS) release.

CMS is not publishing the updated payment rates in CR10417 implementing the January 2018 update of the OPPS. However, the updated payment rates effective January 1, 2018, are in the January 2018 update of the OPPS Addendum A and Addendum B at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html.
d. Drugs and Biologicals Based on ASP Methodology with Restated Payment Rates

Some drugs and biologicals based on ASP methodology will have payment rates that are corrected retroactively. These retroactive corrections typically occur on a quarterly basis. The list of drugs and biologicals with corrected payments rates will be accessible on the CMS website on the first date of the quarter at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/OPPS-Restated-Payment-Rates.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/OPPS-Restated-Payment-Rates.html).

Providers may resubmit claims that were impacted by adjustments to the previous quarter’s payment files.

e. Biosimilar Payment Policy

Effective January 1, 2018, the payment rate for biosimilars in the OPPS will generally continue to be the same as the payment rate in the physician office setting, calculated as the ASP of the biosimilar described by the HCPCS code + 6 percent of the ASP of the reference product. Biosimilars will also be eligible for transitional pass-through payment for which payment will be made at the ASP of the biosimilar described by the HCPCS code + 6 percent of the ASP of the reference product. A biosimilar that does not have pass-through status, but instead has SI of “K,” will be paid the ASP of the biosimilar minus 22.5 percent of the ASP of the reference product, effective January 1, 2018.

In addition, effective January 1, 2018, newly approved biosimilar biological products with a common reference product will no longer be grouped into the same billing code with other biosimilars. CMS will issue guidance on coding, including instructions for new codes for biosimilars that are currently grouped into a common payment code and the use of modifiers separate from CR10417. However, until such guidance is released, providers should continue to use applicable existing HCPCS codes and report a biosimilar modifier that identifies the manufacturer of the specific product. The modifier does not affect payment determination, but is used to distinguish between biosimilar products that appear in the same HCPCS code, but are made by different manufacturers. A list of the biosimilar biological product HCPCS codes and modifiers is available on the CMS website at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/Part-B-Biosimilar-Biological-Product-Payment.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/Part-B-Biosimilar-Biological-Product-Payment.html).

Skin Substitute Procedure Edits

The payment for skin substitute products that do not qualify for pass-through status will be packaged into the payment for the associated skin substitute application procedure. The skin substitute products are divided into two groups:

1) high cost skin substitute products, and
2) low cost skin substitute products for packaging purposes.

Table 8 lists the skin substitute products and their assignment as either a high-cost or a low-cost skin substitute product, when applicable.

**Table 8 - Skin Substitute Assignments to High-Cost and Low-Cost Groups for CY 2018**

<table>
<thead>
<tr>
<th>CY 2018 HCPCS Code</th>
<th>CY 2018 Short Descriptor</th>
<th>CY 2018 SI</th>
<th>CY 2018 High/Low Assignment</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9363</td>
<td>Integra Meshed Bil Wound Mat</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4100</td>
<td>Skin Substitute, NOS</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4101</td>
<td>Apligra</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4102</td>
<td>Oasis Wound Matrix</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4103</td>
<td>Oasis Burn Matrix</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4104</td>
<td>Integra bmwd</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4105</td>
<td>Integra dt or omnigraft</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4106</td>
<td>Dermagraft</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4107</td>
<td>GraftJacke</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4108</td>
<td>Integra Matrix</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4110</td>
<td>Primatrix</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4111</td>
<td>Gammagraft</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4115</td>
<td>Alloskin</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4116</td>
<td>Alloderm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4117</td>
<td>Hyalomatrix</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4121</td>
<td>Theraskin</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4122</td>
<td>Dermacell</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4123</td>
<td>Alloskin</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4124</td>
<td>Oasis Tri-layer Wound Matrix</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4126</td>
<td>Memoderm/derma/tranz/integup</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4127</td>
<td>Talymed</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4128</td>
<td>Flexhd/Allopatchhd/Matrixhd</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4131</td>
<td>Epifix or epicord</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4132</td>
<td>Grafix core, grafixpl core</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4133</td>
<td>Grafix prime grafix pl prime</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4134</td>
<td>Hmatrix</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4135</td>
<td>Mediskin</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4136</td>
<td>Ezderm</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4137</td>
<td>Amnioexcel or Biodexcel, 1cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4138</td>
<td>Biodfence dryflex, 1cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4140</td>
<td>Biodfence 1cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4141</td>
<td>Alloskin ac, 1cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4143</td>
<td>Repriza, 1cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4146</td>
<td>Tensix, 1 cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4147</td>
<td>Architect ecm px fx 1 sq cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4148</td>
<td>Neox neox rt, or clarix cord</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4150</td>
<td>Allowrap ds or dry 1 sq cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4151</td>
<td>Amnioband, guardian 1 sq cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4152</td>
<td>Dermapure 1 square cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4153</td>
<td>Dermavest, plurivest sq cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4154</td>
<td>Biovance 1 square cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4156</td>
<td>Neox 100 or clarix 100</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4157</td>
<td>Revitalon 1 square cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4158</td>
<td>Kerecis omega3, per sq cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4159</td>
<td>Affinity 1 square cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4160</td>
<td>NuShield 1 square cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4161</td>
<td>BioConnekt per square cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4163</td>
<td>Woundex, bioskin, per sq cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4164</td>
<td>Helicoll, per square cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4165</td>
<td>Keramatrix, per square cm</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4166</td>
<td>Cytal, per square cm</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4167</td>
<td>Truskin, per square cm</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4169</td>
<td>Artacent wound, per square cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4170</td>
<td>Cygnus, per square cm</td>
<td>N</td>
<td>Low</td>
</tr>
</tbody>
</table>
**New HCPCS Codes for Pathogen Reduced Platelets and Pathogen Testing for Platelets**

For the January 2018 update, the HCPCS Workgroup deleted HCPCS codes Q9987 and Q9988 for Medicare reporting and replaced the codes with two new HCPCS codes effective January 1, 2018. Specifically, to report the service described by HCPCS code Q9988 based on the code descriptor in effect for July 1, 2017, through December 31, 2017, providers must instead report HCPCS code P9073 (Platelets, pathogen reduced, each unit) instead of HCPCS code Q9988 effective January 1, 2018. Providers reporting the service described by HCPCS code Q9987 based on the code descriptor in effect for July 1, 2017, through December 31, 2017 shall instead report HCPCS code P9100 (Pathogen(s) test for platelets) instead of HCPCS code Q9987 effective January 1, 2018. Note that HCPCS code P9100 should be reported to describe the test used for the detection of bacterial contamination in platelets as well as any other test that may be used to detect pathogen contamination. Table 9 describes blood platelet coding changes that are effective January 1, 2018. The coding changes associated with these codes were also published on the CMS HCPCS Quarterly Update website effective January 2018, at [https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update.html](https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update.html). The payment rates for HCPCS codes P9073 and P9100 can be found in the January 2018 OPPS Addendum B, which is available at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html).

**Table 9. –Blood Platelet Coding Changes Effective January 1, 2018**

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>January 2018 OPPS SI</th>
<th>January 2018 OPPS APCS</th>
</tr>
</thead>
<tbody>
<tr>
<td>P9073</td>
<td>Platelets, pathogen reduced</td>
<td>Platelets, pathogen reduced, each unit</td>
<td>R</td>
<td>9536</td>
</tr>
<tr>
<td>P9100</td>
<td>Pathogen test for platelets</td>
<td>Pathogen(s) test for platelets</td>
<td>S</td>
<td>1493</td>
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</table>

**Payment Adjustment for Certain Cancer Hospitals Beginning CY 2018**

For certain cancer hospitals that receive interim monthly payments associated with the cancer hospital adjustment at 42 CFR 419.43(i), Section 16002(b) of the 21st Century Cures Act which requires that, for CY 2018 and subsequent calendar years, the target Payment-to-Cost Ratio (PCR) that should be used in the calculation of the interim monthly payments and at final cost report settlement is reduced by 0.01. For CY 2018, the target PCR, after including the reduction required by Section 16002(b), is 0.88.

**Section 4011 of the 21st Century Cures Act**

Section 4011 of the 21st Century Cures Act created a new subsection (t) in Section 1834 of the Social Security Act that requires CMS to make available to the public a searchable Internet website that compares estimated payment and beneficiary liability for an appropriate number of items and services paid under the OPPS and the ASC Payment System. Consistent with this statute, CMS plans to first make this website available during CY 2018.
CMS believes that making available a comparison for all services that receive separate payment under both the OPPS and ASC payment system would be most useful to the public with regards to displaying the comparison for an “appropriate number of such items and services.” CMS believes that displaying the national unadjusted payments and copayment amounts will allow the user to make a meaningful comparison between the systems for items and services paid under both systems. CMS may consider providing payment and copayment comparisons at the locality or provider level for future years.

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

**Changes to OPPS Pricer Logic**

a. Rural SCHs and Essential Access Community Hospitals (EACHs) will continue to receive a 7.1 percent payment increase for most services in CY 2018. The rural SCH and EACH payment adjustment excludes drugs, biologicals, items and services paid at charges reduced to cost, and items paid under the pass-through payment policy in accordance with Section 1833(t)(13) (B) of the Act, as added by Section 411 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA).

b. New OPPS payment rates and copayment amounts will be effective January 1, 2018. All copayment amounts will be limited to a maximum of 40 percent of the APC payment rate. Copayment amounts for each service cannot exceed the CY 2018 inpatient deductible of $1,340. For most OPPS services, copayments are set at 20 percent of the APC payment rate.

c. For hospital outlier payments under OPPS, there will be no change in the multiple threshold of 1.75 for 2018. This threshold of 1.75 is multiplied by the total line-item APC payment to determine eligibility for outlier payments. This factor also is used to determine the outlier payment, which is 50 percent of the estimated cost less 1.75 times the APC payment amount. The payment formula is (cost-(APC payment x 1.75))/2.

d. The fixed-dollar threshold for OPPS outlier payments increases in CY 2018 relative to CY 2017. The estimated cost of a service must be greater than the APC payment amount plus $4,150 in order to qualify for outlier payments.

e. For outliers for Community Mental Health Centers (bill type 76x), there will be no change in the multiple threshold of 3.4 for 2017. This threshold of 3.4 is multiplied by the total line-item APC payment for APC 5853 to determine eligibility for outlier payments. This multiple amount is also used to determine the outlier payment, which is 50 percent of estimated costs less 3.4 times the APC payment amount. The payment formula is (cost-(APC 5853 payment x 3.4))/2.

f. Continuing Medicare’s established policy for CY 2018, the OPPS Pricer will apply a reduced update ratio of 0.980 to the payment and copayment for hospitals that fail to meet their hospital outpatient quality data reporting requirements or that fail to meet CMS validation edits. The reduced payment amount will be used to calculate outlier payments.

g. Effective January 1, 2018, CMS is adopting the FY 2018 IPPS post-recategorization wage index values with application of the CY 2018 out-commuting adjustment authorized by Section 505 of the MMA to non-IPPS hospitals as implemented through the Pricer logic.

h. Effective January 1, 2014, for claims with APCs, which require implantable devices and have significant device offsets (greater than 40%), a device offset cap will be applied based on the credit amount listed in the “FD” (Credit Received from the Manufacturer for a Replaced Medical Device) value code. The credit amount in value code “FD” which reduces the APC payment for the applicable procedure, will be capped by the device offset amount for that APC. The offset amounts for the above referenced APCs are available at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html).

**Coverage Determinations**

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

ADDITIONAL INFORMATION


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<td>December 22, 2017</td>
<td>Initial article released.</td>
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OUTPATIENT THERAPY

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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<td>November 13, 2017</td>
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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.


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<td>August 7, 2017</td>
<td>Initial article released.</td>
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**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.

**ADDITIONAL INFORMATION**


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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 Adjustmnet 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.

ADDITIONAL INFORMATION


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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.

ADDITIONAL INFORMATION


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<tbody>
<tr>
<td>September 29, 2017</td>
<td>Initial article released.</td>
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</table>
Fiscal Year (FY) 2014 and 2015 Worksheet S-10 Revisions: Further Extension for All Inpatient Prospective Payment System (IPPS) Hospitals

MLN Matters Number: MM10378
Related Change Request (CR) Number: CR 10378
Related CR Release Date: December 1, 2017
Effective Date: January 2, 2018
Related CR Transmittal Number: R1981OTN
Implementation Date: January 2, 2018

Provider Type Affected
This MLN Matters Article is intended for Inpatient Prospective Payment System (IPPS) hospitals billing Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed
Change Request (CR) 10378 clarifies deadlines for uploading revised or initial Worksheet S-10 submissions to the Health Care Provider Cost Report Information System (HCRIS) for Fiscal Year (FY) 2014 or FY 2015 cost reports that have not been final settled. Make sure your cost report staffs are aware of these changes.

Background
The Centers for Medicare & Medicaid Services (CMS) has extended the deadline to resubmit certain Worksheet S-10 data from October 31, 2017, until January 2, 2018, for all IPPS hospitals. For revisions to be considered CMS modified the deadline such that amended Fiscal Year (FY) 2014 and FY 2015 cost reports, due to revised or initial submissions of Worksheet S-10, must be received by MACs on or before January 2, 2018.

If an IPPS hospital whose FY 2014 or FY 2015 cost report has been final settled requests to revise Worksheet S-10 for that FY 2014 or FY 2015 cost report and the request was received on or before December 1, 2017, MACs will:
- Issue a Notice of Reopening (NOR) in order to reopen the cost report for revisions to Worksheet S-10
- Create and input Worksheet S-10 adjustments to the most recently final settled cost report
- Issue a Revised Notice of Program Reimbursement (RNPR)
- Upload the FY 2014 or FY 2015 revised cost report to the Health Care Provider Cost Report Information System (HCRIS) on or before December 31, 2017.

If an IPPS hospital whose FY 2014 or FY 2015 cost report has been final settled requests to revise Worksheet S-10 for that FY 2014 or FY 2015 cost report and the request is received between December 2, 2017, and January 2, 2018 (inclusive of those dates), MACs will:
- Issue an NOR in order to reopen the cost report for revisions to Worksheet S-10
- Create and input Worksheet S-10 adjustments to the most recently final settled cost report
- Issue an RNPR
- Upload the FY 2014 or FY 2015 revised cost report to HCRIS on or before January 31, 2018.

If an IPPS hospital whose FY 2014 or FY 2015 cost report has not been final settled requests to revise Worksheet S-10 for that FY 2014 or FY 2015 cost report, providers shall submit an amended cost report with Worksheet S-10 revisions only. MACs will review, accept, and upload the amended cost reports in accordance with the deadlines outlined in CR10378.

Cost reports amended to revise only Worksheet S-10 will not require a tentative settlement.

Change Request (CR) 10378 supersedes the previous deadline in CR10026 (issued June 30, 2017), with respect to the dates by which MACs will issue an NOR in order to accept a revised or newly submitted Worksheet S-10, issue an RNPR, and upload the FY 2014 or FY 2015 revised cost report to HCRIS. (A
related MLN Matters article is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10026.pdf.)

MACs will continue to use the information contained in CR10026 or other previous instructions with respect to FY 2014 and FY 2015 Worksheet S-10 revisions for any matters not addressed in CR10378.

Additional Information


Document History

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<td>December 4, 2017</td>
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Care Coordination Services and Payment for RHCs and FQHCs – Revised

MLN Matters Number: MM10175 Revised  
Related Change Request (CR) Number: 10175  
Related CR Release Date: August 11, 2017  
Effective Date: January 1, 2018  
Related CR Transmittal Number: R1899OTN  
Implementation Date: January 2, 2018

This article was revised on November 13, 2017, to correct statements on page 2 (in bold). All other information is unchanged.

**PROVIDER TYPES AFFECTED**

This MLN Matters Article is intended for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

**PROVIDER ACTION NEEDED**

Change Request (CR) 10175 provides instructions for payment to Rural Health Clinics (RHCs) billing under the all-inclusive rate (AIR), and Federally Qualified Health Centers (FQHCs) billing under the prospective payment system (PPS), for care coordination services for dates of service on or after January 1, 2018.

**BACKGROUND**

As authorized by §1861(aa) of the Social Security Act, RHCs and FQHCs are paid for physician services and supplies incident to physician services. Care coordination services are RHC and FQHC services, but payment for the additional costs associated with certain care coordination services are not included in the RHC AIR or the FQHC PPS rate. In the CY 2016 Medicare Physician Fee Schedule (PFS) final rule (80 FR 71080), Centers for Medicare & Medicaid Services (CMS) finalized requirements and a payment methodology for Chronic Care Management (CCM) services furnished by RHCs and FQHCs. Effective January 1, 2016, CCM payment to RHCs and FQHCs is based on the Medicare PFS national non-facility payment rate when CPT code 99490 is billed alone or with other payable services on a RHC or FQHC claim. The rate is updated annually and there is no geographic adjustment. Revisions to the CCM RHCs and FQHCs were in the CY 2017 PFS final rule (81 FR 80256) for services furnished on or after January 1, 2017.

In the CY 2017 PFS final rule (81 FR 80225), CMS established separate payment, beginning January 1, 2017, for practitioners billing under the PFS, for complex CCM services, General Behavioral Health Integration (BHI) services, and a psychiatric collaborative care model (CoCM). To allow payment to RHCs and FQHCs for these new services, CMS finalized in the CY 2018 Physician Fee Schedule Finale Rule to revise payment for care coordination services in RHCS and FQHCs by establishing 2 new G codes for use by RHCs and FQHCs, effective January 1, 2018. The first new G code will be a General Care Management code for RHCs and FQHCs with the payment amount set at the average of the 3 national non-facility PFS payment rates for the CCM and general BHI codes. The second new G code for RHCs and FQHCs will be a Psychiatric CoCM code with the payment amount set at the average of the 2 national non-facility PFS payment rates for psychiatric CoCM services. RHC or FQHC claims submitted using CPT 99490 for dates of service on or after January 1, 2018, will be denied.

Effective for dates of service on or after January 1, 2018, RHCs and FQHCs will be paid for General Care Management services when G0511 is billed alone or with other payable services on a RHC or FQHC claim. Payment for G0511 is set at the average of the 3 national non-facility PFS payment rates for the CCM (CPT code 99490 and CPT code 99487) and general BHI (CPT code 99484). The rate is updated annually based on the PFS amounts and coinsurance applies. This code could only be billed once per month per beneficiary, and could not be billed if other care management services are billed for the same time period.

Effective for dates of service on or after January 1, 2018, RHCs and FQHCs will be paid for Psychiatric CoCM services when G0512 is billed alone or with other payable services on an RHC or FQHC claim. Payment for G0512 is set at the average of the 2 national non-facility PFS payment rates for CoCM (CPT code 99492 and CPT code 99493). The rate is updated annually based on the PFS amounts and...
coinsurance applies. This code could only be billed once per month per beneficiary, and could not be billed if other care management services are billed for the same time period.

**General Care Management (G0511) Requirements: RHCs and FQHCs can bill the new General Care Management G code when the following requirements are met:**

1. **Initiating Visit:** An Evaluation Management (E/M), Annual Wellness Visit (AWV), or Initial Preventive Physical Examination (IPPE) visit furnished by a physician, Nurse Practitioner (NP), Physician Assistants (PA), or Certified Nurse-Midwives (CNM) has occurred no more than one-year prior to commencing care coordination services. This would be billed as an RHC or FQHC visit.

2. **Beneficiary Consent:** Has been obtained during or after the initiating visit and before provision of care coordination services by RHC or FQHC practitioner or clinical staff; can be written or verbal, must be documented in the medical record and includes information:
   - On the availability of care coordination services and applicable cost-sharing
   - That only one practitioner can furnish and be paid for care coordination services during a calendar month
   - On the right to stop care coordination services at any time (effective at the end of the calendar month)
   - Permission to consult with relevant specialists.

3. **Billing Requirements:** At least 20 minutes of care coordination services has been furnished in the calendar month furnished a) under the direction of the RHC or FQHC physician, NP, PA, or CNM, and b) by an RHC or FQHC practitioner, or by clinical personnel under general supervision.

4. **Patient Eligibility:** Patient must have:
   - **Option A:** Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, and place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, OR
   - **Option B:** Any behavioral health or psychiatric condition being treated by the RHC or FQHC practitioner, including substance use disorders, that, in the clinical judgment of the RHC or FQHC practitioner, warrants BHI services.

5. **Requirement Service Elements**

   For patients meeting the eligibility requirements of Option A, the RHC or FQHC must meet all of the following requirements:
   - Structured recording of patient health information using Certified EHR Technology and includes demographics, problems, medications, and medication allergies that inform the care plan, care coordination, and ongoing clinical care
   - 24/7 access to physicians or other qualified health care professionals or clinical staff including providing patients/caregivers with a means to make contact with health care professionals in the practice to address urgent needs regardless of the time of day or day of week, and continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments
   - Comprehensive care management including systematic assessment of the patient’s medical, functional, and psychosocial needs; system-based approaches to ensure timely receipt of all recommended preventive care services; medication reconciliation with review of adherence and
   - Comprehensive care plan including the creation, revision, and/or monitoring of an electronic care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment and an inventory of resources and supports; a comprehensive care plan for all health issues with particular focus on the chronic conditions being managed
   - Care plan information made available electronically (including fax) in a timely manner within and outside the RHC or FQHC as appropriate and a copy of the plan of care given to the patient and/or caregiver
   - Management of care transitions between and among health care providers and settings, including referrals to other clinicians; follow-up after an emergency department visit; and follow-up after discharges from hospitals, skilled nursing facilities, or other health care facilities; timely creation and exchange/transmit continuity of care document(s) with other practitioners and providers;
• Coordination with home- and community-based clinical service providers, and documentation of communication to and from home- and community-based providers regarding the patient’s psychosocial needs and functional deficits in the patient’s medical record

• Enhanced opportunities for the patient and any caregiver to communicate with the practitioner regarding the patient’s care through not only telephone access, but also through the use of secure messaging, Internet, or other asynchronous non-face-to-face consultation methods.

For patients meeting the eligibility requirements of Option B, the RHC or FQHC must meet all of the following requirements:

• Initial assessment or follow-up monitoring, including the use of applicable validated rating scales

• Behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes

• Facilitating and coordinating treatment (such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation)

• Continuity of care with a designated member of the care team.

Psychiatric CoCM (G0512) Requirements: RHCs and FQHCs can bill the Psychiatric CoCM G code when the following requirements are met:

1. Initiating Visit: An E/M, AWV, or IPPE visit furnished by a physician, NP, PA, or CNM has occurred no more than one-year prior to commencing psychiatric CoCM services. This would be billed as an RHC or FQHC visit.

2. Beneficiary Consent: Has been obtained during or after the initiating visit and before provision of care coordination services by RHC or FQHC practitioner or clinical staff; can be written or verbal, must be documented in the medical record and include:
   • Information on the availability of care coordination services and applicable cost-sharing
   • That only one practitioner can furnish and be paid for care coordination services during calendar month
   • That the patient has the right to stop care coordination services at any time (effective at the end of the calendar month)
   • The patient is giving permission to consult with relevant specialists

3. Billing Requirements: At least 70 minutes in the first calendar month, and at least 60 minutes in subsequent calendar months of psychiatric CoCM services, furnished a) under the direction of the RHC or FQHC practitioner, and b) by an RHC or FQHC practitioner or Behavioral Health Care Manager under general supervision.

4. Patient Eligibility: Patient must have a behavioral health or psychiatric condition that is being treated by the RHC or FQHC practitioner, including substance use disorders, that, in the clinical judgment of the RHC or FQHC practitioner, warrants psychiatric CoCM services.

5. Requirement Service Elements: Psychiatric CoCM requires a team that includes the following:

RHC or FQHC Practitioner (physician, NP, PA, or CNM) who:

• Directs the behavioral health care manager or clinical staff

• Oversees; the beneficiary’s care, including prescribing medications, providing treatments for medical conditions, and making referrals to specialty care when needed

• Remains involved through ongoing oversight, management, collaboration and reassessment

Behavioral Health Care Manager who:

• Provides assessment and care management services, including the administration of validated rating scales; behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes; provision of brief psychosocial interventions; ongoing collaboration with the RHC or FQHC practitioner; maintenance of the registry; acting in consultation with the psychiatric consultant
• Is available to provide services face-to-face with the beneficiary; has a continuous relationship with the patient and a collaborative, integrated relationship with the rest of the care team
• Is available to contact the patient outside of regular RHC or FQHC hours as necessary to conduct the behavioral health care manager’s duties

Psychiatric Consultant who:
• Participates in regular reviews of the clinical status of patients receiving CoCM services;
• Advises the RHC or FQHC practitioner regarding diagnosis, options for resolving issues with beneficiary adherence and tolerance of behavioral health treatment; making adjustments to behavioral health treatment for beneficiaries who are not progressing; managing any negative interactions between beneficiaries’ behavioral health and medical treatments
• Facilitate referral for direct provision of psychiatric care when clinically indicated

MACs will apply coinsurance and deductible to HCPCS codes G0511 and G0512 on FQHC claims.

ADDITIONAL INFORMATION

DOCUMENT HISTORY

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<th>Date of Change</th>
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<tbody>
<tr>
<td>November 13, 2017</td>
<td>The article was revised to correct statements on page 2 (in bold).</td>
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<tr>
<td>November 8, 2017</td>
<td>Initial article released</td>
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RHC AIR Payment Limit Update for CY 2018

MLN Matters Number: MM10333
Related Change Request (CR) Number: 10333
Related CR Release Date: November 9, 2017
Effective Date: January 1, 2018
Related CR Transmittal Number: R3919CP
Implementation Date: January 2, 2018

PROVIDER TYPE AFFECTED
This MLN Matters Article is intended for Rural Health Clinics (RHCs) billing Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

WHAT YOU NEED TO KNOW
The RHC payment limit per visit for Calendar Year (CY) 2018 is $83.45 effective January 1, 2018, through December 31, 2018. The CY 2018 RHC payment limit reflects a 1.4 percent increase above the CY 2017 payment limit of $82.30.

BACKGROUND
Medicare Part B payment to RHCs is 80 percent of the All-Inclusive Rate (AIR), subject to a payment limit for medically necessary medical, and qualified preventive face-to-face visits with a practitioner and a Medicare beneficiary for RHC services. As authorized by Section 1833(f) of the Social Security Act (the Act), the payment limits for a subsequent year shall be increased in accordance with the rate of increase in the Medicare Economic Index (MEI). Based on historical data through second quarter 2017, the CY 2018 MEI is 1.4 percent. The RHC payment limit per visit for CY 2018 is $83.45 effective January 1, 2018, through December 31, 2018. The CY 2018 RHC payment limit reflects a 1.4 percent increase above the CY 2017 payment limit of $82.30.

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**RHC and FQHC Medicare Benefit Policy Manual Chapter 13 Update**

**MLN Matters Number:** MM10350  
**Related Change Request (CR) Number:** 10350  
**Related CR Release Date:** November 17, 2017  
**Effective Date:** February 15, 2018  
**Related CR Transmittal Number:** R238BP  
**Implementation Date:** February 15, 2018

**PROVIDER TYPES AFFECTED**

This MLN Matters Article is intended for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) billing Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

**PROVIDER ACTION NEEDED**

Change Request (CR) 10350 notifies RHCs and FQHCs of updates to Chapter 13 of the Medicare Benefit Policy Manual (Pub. 100-02). These updates clarify payment and other policy information. Make sure your billing staffs are aware of these updates.

**BACKGROUND**

The 2018 update of Chapter 13 of the Medicare Benefit Policy Manual – Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services – provides information on requirements and payment policies for RHCs and FQHCs, as authorized by Section 1861(aa) of the Social Security Act. This chapter now includes payment policy for Care Management in RHCs and FQHCs as finalized in the Calendar Year (CY) 2018 Physician Fee Schedule Final Rule. All other revisions serve to clarify existing policy.

New Manual sections relevant to Care Management Services in RHCs and FQHCs include:

- Section 230 – Care Management Services
- Section 230.1 – Transitional Care Management Services
- Section 230.2 – General Care Management Services – Chronic Care Management and General Behavioral Health Integration Services
- Section 230.3 – Psychiatric Collaborative Care Model (CoCM) Services

The revised chapter is attached to CR 10350.

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SNF PPS Fiscal Year (FY) 2018 Pricer Off-Cycle Update

MLN Matters Number: MM10377
Related Change Request (CR) Number: 10377
Related CR Release Date: November 22, 2017
Effective Date: October 1, 2017
Related CR Transmittal Number: R3928CP
Implementation Date: January 2, 2018

PROVIDER TYPES AFFECTED
This MLN Matters® Article is intended for freestanding Skilled Nursing Facilities (SNFs), SNFs affiliated with acute care facilities, and all non-Critical Access Hospital (CAH) swing-bed rural hospitals submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED
Change Request (CR) 10377 adds logic into the Skilled Nursing Facility (SNF) Prospective Payment System (PPS) Pricer to apply the Quality Reporting Program (QRP) payment reduction for Fiscal Year (FY) 2018 for those facilities that do submit require quality data. Please make sure your billing staffs are aware of this update.

BACKGROUND
Section 1888(e)(6)(B)(i)(II) of the Social Security Act (the Act) requires that each SNF submit, for FYs beginning on or after the specified application date (as defined in Section 1899B(a)(2)(E) of the Act), data on quality measures specified under Section 1899B(c)(1) of the Act and data on resource use and other measures specified under Section 1899B(d)(1) of the Act in a manner and within the time frames specified by the Secretary.

The SNF QRP applies to freestanding SNFs, SNFs affiliated with acute care facilities, and all non-Critical Access Hospital (CAH) swing-bed rural hospitals.

Beginning with FY 2018 and in each subsequent year, if an SNF does not submit required quality data; their payment rates for the year are reduced by 2 (two) percentage points for that FY. Application of the 2-percent reduction may result in an update that is less than 0.0 for an FY and in payment rates for an FY being less than such payment rates for the preceding FY. In addition, reporting-based reductions to the market basket increase factor will not be cumulative; rather they will only apply for the FY involved.

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