Medicare A News

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Contact Noridian

- Interactive Voice Response (IVR) 877-908-8431
- Provider Contact Center (PCC)
- Provider Enrollment
- EDISS
- User Security (including Endeavor) Claim-specific inquiries
  Monday – Friday 8 a.m. – 4 p.m. (in respective time zones)

Text Teletype Calls (TTY) 877-261-4163
Monday – Friday 8 a.m. – 4 p.m. (in respective time zones)

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. 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

**Sources:** Transmittal 50, CR 3247 dated July 30, 2004; Internet Only Manual (IOM) Medicare Financial Management Manual, Publication 100-06, Chapter 5, Section 410
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.

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.

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340B Drug Program Webpage

Noridian has created a webpage, dedicated to information on the 340B Drug Program. View 340B Drug Program page for background, billing guidance, resources and more.

ACT Questions & Answers – January 17, 2018

The following questions and answers (Q&As) are cumulative from the Ask the Contractor Teleconference. Some questions have been edited for clarity and answers may have been expanded to provide further details. Similar questions were combined to eliminate redundancies.

Q1. Are Critical Access Hospitals (CAHs) exempt from using the FY modifier, per the Medicare Learning Network (MLN) Matters (MM) 10188?

A1. At this time, CAHs are exempt, as they are not reimbursed under Medicare Physician Fee Schedule (MPFS) or Outpatient Prospective Payment System (OPPS).
Q2. Would Noridian deny claims for medically necessary services if a patient was participating in a non-qualifying clinical trial? When Noridian states “if the services are medical necessary and not done as part of the clinical trial,” is Noridian making reference to the reporting of the Q1 modifier?

A2. Refer to Publication 100-02, Chapter 16, Section 180, titled: Services Related to and Required as a Result of Services Which Are Not Covered Under Medicare.

The Q1 modifier is to be used in an approved clinical trial for routine services. If there is a claim-specific example, please reach out to the Provider Contact Center (PCC).

Q3. In regards to the newly initiated mechanical ventilation exclusion, does Noridian also recognize newly initiated bilevel positive airway pressure devices? If initiated in the Emergency Department (ED) and the patient improves and transfers to the floor on oxygen, would the exclusion still apply?

A3. Bilevel positive airway pressure devices (a type of Respiratory Assist Device [RAD]) are not to be confused with “mechanical ventilators.” Further questions or clarification should be sought from the Quality Improvement Organization (QIO).

Q4. When a hospital system with multiple levels of care has a patient transition to a new setting, a new account is opened and the patient is evaluated to establish goals and a treatment plan for that level of care. If the orthosis/prosthesis is still being actively managed, do providers bill 97760 or 97761 for the first encounter addressing the device, although it was billed on a previous account at a different level of care?

A4. CPT resolved this in their 2018 manual with the addition of 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).

Q5. Does the therapy cap apply to services billed on type of bill (TOB) 13x? The Therapy Cap page on the CMS website states it does; however, Publication 100-04, Chapter 5, Section 10.3 seems to state the therapy cap does not:

- “Limits apply to outpatient Part B therapy services furnished in all settings except outpatient hospitals, including hospital emergency departments. These excluded hospital services are reported on bill types 12x or 13x, or 85x.”

A5. Yes; the therapy cap does apply to services billed on TOB 13x. The manual passage cited is fragmented. The manual goes on to say, “Effective for dates of service on or after October 1, 2012, the limits also apply to outpatient Part B therapy services furnished in outpatient hospitals other than CAHs and hospitals in Maryland. During this period, only type of bill 12x claims with a CMS certification number in the CAH range, type of bill 12x and 13x claims with a CMS certification number beginning with the State code for Maryland, and type of bill 85x claims are excluded. Effective for dates of service on or after January 1, 2014, the limits also apply to CAHs. Effective for dates of service on or after January 1, 2016, the limits also apply to hospitals in Maryland.”

Q6. With the implementation of modifier “JG” drugs could now be billed with several payment modifiers; for example: J1566 may be billed with the modifiers JW, JG and PO. When a code requires more than one payment modifier, is there any specific sequencing that needs to take place to ensure the claim processes and pays accurately? In the example provided, does it matter whether the JW or JG modifier is in the first position?

A6. Refer to the Medicare-FFS Program Billing 340B Modifiers under the Hospital Outpatient Prospective Payment System (OPPS) Frequently Asked Questions (December 13, 2017), question and answer number 13:

- “How are providers to bill for the discarded drug amount on 340B-acquired drugs? How does this affect modifiers that are already required for off-campus departments of a hospital?

- The discarded drug amount should be billed on a separate claim line with the JW modifier and the appropriate 340B modifier. Modifier “PO” or “PN” is also required if the 340B-acquired drug is furnished in an off-campus outpatient provider-based department of a hospital, in which case three modifiers will be reported on the drug HCPCS line. For example, a 340B-acquired drug (assigned status indicator “K”) furnished in an excepted off-campus department of a hospital, would bill one claim line with the drug HCPCS code and modifiers “JG” and “PO”, and another claim line with the drug HCPCS.
code and modifiers “JG”, “JW”, and “PO”. As a reminder, when multiple modifiers are reported, providers should report pricing modifiers first followed by descriptive modifiers.

Please refer to the JW modifier FAQ document for more information available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/JW-Modifier-FAQs.pdf.”

Q7. The next several questions are related. Different scenarios have been provided to determine when it would be appropriate to use the KX or SC modifier in a single or dual chamber pacemaker or generator.

- Q7(a). Is SC only to be used when a patient does not have a covered diagnosis code for Cardiac Resynchronization Therapy (CRT), replacement, etc.? For instance, in the example of a patient with a diagnosis from Group I or II, and CRT, do providers bill with modifiers SC and KX? Also, in the example of a patient without a diagnosis from Group I or II and CRT, do providers bill with modifier SC only?

- A7(a). Providers should not bill with both the SC and KX modifiers; the claim will reject. The SC modifier is not to be billed with any Group I or Group II diagnoses codes. The KX modifier should be used as an attestation (documentation is on file verifying the patient has a symptomatic arrhythmia or a high potential for progression of the rhythm disturbance requiring a permanent pacemaker for Groups I and II) with an approved diagnosis code from either Group I or Group II.

- If the patient initially had the pacemaker placed with a payable diagnosis code, providers should bill that diagnosis code and the KX modifier when billing for replacement of the pacemaker or generator.

- Q7(b). In the example of chronic atrial fibrillation (AF), single lead, do providers bill with modifiers KX and SC? Denials for diagnosis code I48.2 have been seen, but a single lead is appropriate for chronic AF.

A7(b). Providers should not bill with both the SC and KX modifiers; the claim will reject. I48.2 is not a covered diagnosis code according to Noridian’s JF coverage requirements article, Single Chamber and Dual Chamber Permanent Cardiac Pacemakers – Coding and Billing (A54931). If the patient is symptomatic, a more appropriate diagnosis code may be I48.1 or I48.91. If the medical record does not support the use of a covered diagnosis from Group I or Group II, providers may append the SC modifier.

- Q7(c). In the example of a pacemaker implant prior to Atrioventricular (AV) node ablation to create complete heart block with no Group I or II code, do providers bill with modifier SC?

A7(c). Ensuring that there is no covered diagnosis code available in either the Group I or Group II, append the SC modifier.

- Q7(d). In the example of either the Medtronic Leadless Pacemaker Coverage with Evidence Development (CED) or the St. Jude Leadless Pacemaker Clinical Trial, do providers bill modifiers KX and SC?

A7(d). Because these are clinical trials, providers should follow clinical trial coverage and billing requirements.

- Q7(e). Is there published guidance on revenue code usage as it pertains to the KX and SC modifiers?

A7(e). Noridian’s claim editing does not reject or deny claims based on the revenue code. The claims processing system will edit based on diagnosis code and modifier.

Q8. Do Disproportionate Share Hospitals (DSHs) report both JG and TB modifiers for the 340B Drug Program? Also, it appears Noridian is not ready to accept claims with these modifier as of the effective date of 1/1/18. Are providers going to need to go back and correct all claims up to the readiness of Noridian to accept our claims, or back to 1/1/18 when this was to go into effect?

A8. Assuming that the provider has enrolled, been approved and received a 340B number, and that the drugs being billed were purchased through the 340B Drug Program, the DSH would report modifiers as follows:

- Pass-through drugs with status indicator “G,” bill with modifier “TB”
- Separately payable drugs with status indicator “K,” bill with modifier “JG”
- Packed drugs with status indicator “N,” billing with modifiers “TB” or “JG” is optional.
Noridian has added the TB and JG modifiers into the claims processing system. If claims are not processing, please check that the dates of service submitted are on or after January 1, 2018; Noridian is not aware of any claims processing issues.

Q9. Can an acute hospital, participating in the claims-based reporting requirements for post-operative visits, perform the post-op visit via telehealth, once the patient has received surgical services?

A9. Per the [Claims-Based Reporting Requirements for Post-Operative Visits Frequently Asked Questions](June 2017), Question and Answer 14:

- “How should post-operative visits furnished via telehealth be reported?

[Current Procedural Terminology] CPT code 99024 should only be reported for post-operative visits that would not reported otherwise because it is delivered during the global period even though it meets all the other the requirements for [Evaluation and Management] E/M visits. Therefore, CPT code 99024 should only be reported with the place of service (POS) code 02 for a post-operative visit that meets all of the telehealth billing rules, including the geographic and setting requirements for the location of the patient. For more information, please see: [https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/telehealthsrvcsfctsht.pdf](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/telehealthsrvcsfctsht.pdf).”

Q10. Does CMS require that Managed Medicare plans collect and report functional limitation reporting codes (“G” codes) for outpatient rehabilitation therapy?

A10. “Medicare does not require Functional Reporting for Medicare Advantage Plans. However, providers should check with their plan to determine if the plan imposes requirements.” – [Functional Reporting: PT, OT, and SLP Services Frequently Asked Questions (FAQs)].

Q11. Why does Noridian state that CPT 88377 requires a Dex Z-code? CPT 88377 describes many tests other than what is found on the Noridian website and is not on the Palmetto website or Dex Registry as a CPT requiring a Z-code.

A11. The MolDX program works to provide the exact same clinical coverage and billing and coding criteria throughout the participating A/B Medicare Administrative Contractors (MACs). As it currently stands, both Noridian and Palmetto GBA will retire this article on February 27, 2018.

Q12. Skilled Nursing Facility (SNF) claims being denied because of worker’s compensation; however, their cases have been closed, or they don’t even recognize these patients as a worker’s compensation claim. Why would these claims be denied?

A12. The diagnosis code on the claim being submitted may be matching the diagnosis code in the worker’s compensation file; that would cause the claim to deny. There are specific comments to add into the claim remarks, which can be found on the Noridian website.

From the [https://med.noridianmedicare.com](https://med.noridianmedicare.com) website, select:

Browse by Topic
Claims
Claim Submission Billing, Errors and Solutions
Diagnosis Driven MSP Claim Rejections

Q13. With respect to the remittance advice (RA) not showing the qualified Medicare beneficiary (QMB) amount, will there be another RA sent out to providers?

A13. RAs will not be automatically corrected by Noridian; however, providers may adjust their claims with the D9 condition code and remarks stating, “adjusting to receive duplicate remittance advice.”

Q14. Will the KX modifier be valid for 2018, with respect to the therapy caps?

A14. Congress has not set forth a provision extending the therapy caps as of now. Noridian, along with the provider community, is awaiting further instruction from CMS.
NMP and/or IVR Use Required for Eligibility Inquiries – Effective February 5, 2018

Effective February 5, 2018, Noridian will require providers to use the Noridian Medicare Portal (NMP) and/or the Interactive Voice Response (IVR) for all eligibility inquiries. Until then, Customer Service Representatives (CSRs) will educate callers on these tools.

To access specifics about each, select the webpage links below.

**NMP:** Provides Part A and B effective and termination dates, deductible remaining, ineligible period (due to classified as unlawfully present, deported or incarcerated), beneficiary address, occupational, physical, and speech therapy, blood deductible, Managed Care Organization (MCO) and Health Maintenance Organization (HMO), Medicare Secondary Payer (MSP), Home Health Episode History (HHEH), hospice, hospital periods, Skilled Nursing Facility (SNF) periods, End Stage Renal Disease (ESRD) effective dates and benefit type, and preventive information.

View the Eligibility Education-on-Demand Tutorial to describe eligibility inquiries and response features.

**IVR:** Provides effective and termination dates, deductible information, latest billing dates, lifetime reserve days, Managed Care (HMO), MSP, home health, hospice, SNF periods, pneumococcal vaccines, physical and occupational therapy limits, and date of death.

**Direct Data Entry (DDE):** Eligibility for providers who use DDE are not impacted by this change.

The CMS Internet Only Manual (IOM), Publication 100-09, Chapter 6, Section 50.1 mandates that all providers first access inquiries through self-service technology, “…Providers shall be required to use the IVR system to access claim status and beneficiary eligibility information. CSRs shall refer providers back to the IVR system if they have questions about claims status or eligibility that can be handled by the IVR system…. Each MAC has the discretion to also require that providers use the Internet-based provider portal for claim status and eligibility inquiries if the portal has these functionalities.”

This process change will allow Noridian to meet CMS requirements and our CSRs to assist callers with more complex inquiries which cannot be answered through these self-service tools.

Noridian is Now on Facebook!

Noridian is excited to announce that our provider and supplier community can now find us on Facebook. The Noridian Facebook page will pass along updates from Noridian and Medicare through articles and links previously published to our website. Upcoming educational events and self-paced tutorials will also be available here for you to stay connected.

Inquiries may be submitted and answered during regular business hours, however, some inquiries may require further research from another department. Keep in mind that PHI or PII is not accepted.

Give us a ‘Like’ and ‘Follow’ us to stay connected. We hope to see you there!
Noridian is on YouTube!
Noridian is now on YouTube! Our channel provides education and tutorials on several topics including Enrollment, General Medicare Coding and Billing, Preventive Services, Evaluation and Management, MSP, Appeals, Modifiers and more. Subscribe to our YouTube channel to be notified when new videos are added!

Webinar Event Materials Downloadable – Effective April 1, 2018
Noridian is working towards a more effective educational approach. As of April 1, 2018, the Part A and Part B Provider Outreach and Education (POE) team will no longer email presentation material(s) and/or CEUs to webinar attendees; however, attendees will be able to download the presentation material(s) and Continuing Education Unit(s) (CEUs), when applicable, during the webinar.

To support this change, presentation pdfs and question and answers will be no longer be published to our website on/after June 1, 2018. The content will instead be incorporated into the applicable Browse by Topic and/or Browse by Specialty/Provider Type webpages ensuring that our webpages are as comprehensive as possible. Once all applicable pages have been updated, the Event Materials webpage will be removed from our website.

We encourage you to learn more about Webinars and CEUs.

Mammography HCPCS Codes, Waiver of Coinsurance and Deductible for Preventive and Other Services, and Addition of Anesthesia and Prolonged Preventive Services – Revised
MLN Matters Number: MM10181 Revised
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
This article was revised on February 9, 2018, to reposition text under different headers on page 2. All other information is unchanged.

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”
FYI

- 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**

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**

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.

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, endoscope 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**

NGACO Year Three Benefit Enhancements – Revised

MLN Matters Number: MM10044 Revised
Related Change Request (CR) Number: 10044
Related CR Release Date: November 22, 2017
Effective Date: January 1, 2018
Related CR Transmittal Number: R187DEMO
Implementation Date: January 2, 2018

This article was revised on January 23, 2018, to reflect the revised CR10044 issued on November 22, 2017. 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 TYPES AFFECTED

This MLN Matters® Article is intended for providers who are participating in Next Generation Accountable Care Organizations (NGACOs) and submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

Change Request (CR) 10044 provides instruction to MACs to implement two new benefit enhancements for performance year three (calendar year 2018) of the NGACO Model. MACs will process and pay claims for Asynchronous Telehealth and Post-Discharge Home Visit Waiver services when those services meet the appropriate payment requirements as outlined in CR10044. Make sure your billing staff is aware of these changes.

BACKGROUND

The aim of the NGACO Model is to improve the quality of care, population health outcomes, and patient experience for the beneficiaries who choose traditional Medicare Fee-for-Service (FFS) through greater alignment of financial incentives and greater access to tools that may aid beneficiaries and providers in achieving better health at lower costs.

In order to emphasize high-value services and support the ability of ACOs to manage the care of beneficiaries, the Centers for Medicare & Medicaid Services (CMS) is issuing the authority under Section 1115A of the Social Security Act (the Act) (Section 3021 of the Affordable Care Act) to conditionally waive certain Medicare payment requirements as part of the NGACO Model.

Asynchronous Telehealth

CMS is expanding the current telehealth waiver to include asynchronous (also known as “store-and-forward”) telehealth in the specialties of teledermatology and teleophthalmology. Asynchronous telehealth includes the transmission of recorded health history (for example, retinal scanning and digital images) through a secure electronic communications system to a practitioner, usually a specialist, who uses the information to evaluate the case or render a service outside of a real-time interaction. Asynchronous telecommunications system in single media format does not include telephone calls, images transmitted via facsimile machines, and text messages without visualization of the patient (electronic mail). Photographs must be specific to the patients’ condition and adequate for rendering or confirming a diagnosis or treatment plan.

Payment will be permitted for telemedicine when asynchronous telehealth in single or multimedia formats, is used as a substitute for an interactive telecommunications system for dermatology and ophthalmology.
services. Distant site practitioners will bill for these new services using new codes, and the distant site practitioner must be an NGACO Participant or Preferred Provider.

**Asynchronous Telehealth Based on Intra-Service + 5 Minutes Post-Service Time**

- Code 1: G9868 - Receipt and analysis of remote, asynchronous images for dermatologic and/or ophthalmologic evaluation, for use under the Next Generation ACO model, less than 10 minutes.
- Code 2: G9869 - Receipt and analysis of remote, asynchronous images for dermatologic and/or ophthalmologic evaluation, for use under the Next Generation ACO model, 10-20 minutes.
- Code 3: G9870 - Receipt and analysis of remote, asynchronous images for dermatologic and/or ophthalmologic evaluation, for use under the Next Generation ACO model, 20 or more minutes.

**ADDITIONAL INFORMATION**


**DOCUMENT HISTORY**

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<tr>
<td>August 4, 2017</td>
<td>Initial article issued.</td>
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<tr>
<td>January 23, 2018</td>
<td>The article was revised to reflect the revised CR10044 issued on November 22, 2017. In the article, the CR release date, transmittal number, and the Web address of the CR are revised. All other information is the same.</td>
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**Supervised Exercise Therapy for Symptomatic Peripheral Artery Disease – Revised**

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

The article was revised on March 5, 2018, to reflect a revised CR. The MAC implementation date, CR release date, transmittal numbers and the Web addresses of the transmittals were revised. All other information remains the same.

**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.

**PROVIDER ACTION NEEDED**

Change Request (CR) 10295 informs MACs that effective May 25, 2017, the Centers for Medicare & Medicaid Services (CMS) issued a National Coverage Determination (NCD) to cover Supervised Exercise Therapy (SET) for beneficiaries with Intermittent Claudication (IC) for the treatment of symptomatic Peripheral Artery Disease (PAD). Make sure your billing staffs are aware of these changes.

**BACKGROUND**

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

Despite years of high-quality research illustrating the effectiveness of SET, more invasive treatment options (such as, endovascular revascularization) have continued to increase. This has been partly attributed to patients having limited access to SET programs. There is currently no NCD in effect.
CMS issued the NCD to cover SET for beneficiaries with IC for the treatment of symptomatic PAD. Up to 36 sessions over a 12-week period are covered if all of the following components of a SET program are met:

The SET program must:

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

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

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

**Coding Requirements for SET**

Providers should use Current Procedural Terminology (CPT) 93668 (Under Peripheral Arterial Disease Rehabilitation) to bill for these services with appropriate International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10) Code as follows:

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

Medicare will deny claim line items for SET services when they do not contain one of the above ICD-10 codes using the following messages:
• Claim Adjustment Reason Code (CARC) 167 – This (these) diagnosis (es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

• Remittance Advice Remark Code (RARC) N386: This decision was based on a National Coverage Determination 20.35 (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.

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

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

• CARC 58: Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. NOTE: Refer to the 832 Healthcare Policy Identification Segment (loop 2110 Service payment Information REF), if present.

• RARC N386: This decision was based on a National Coverage Determination 20.35 (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.

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

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

• CARC 58: “Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. NOTE: Refer to the 832 Healthcare Policy Identification Segment (loop 2110 Service payment Information REF), if present.

• RARC N386: “This decision was based on a National Coverage Determination 20.35 (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.

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

Medicare will pay claims for SET services containing CPT code 93668 on Types of Bill (TOBs) 13X under OPPS and 85X on reasonable cost, except it will pay claims for SET services containing CPT 93668 with revenue codes 096X, 097X, or 098X when billed on TOB 85X Method II Critical Access Hospitals (CAHs) based on 115% of the lesser of the fee schedule amount or the submitted charge.

Medicare will reject claims with CPT93668 which exceed 36 sessions within 84 days from the date of the first session when the KX modifier is not included on the claim line OR any SET session provided after 84 days from the date of the first session and the KX modifier is not included on the claim and use the following messages:

• CARC 96: Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

• RARC N640: Exceeds number/frequency approved/allowed within time period.

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

• Group Code PR (Patient Responsibility) assigning financial liability to the beneficiary if a claim is received with a GA modifier indicating a signed ABN is on file.
MACs will deny/reject claim lines for SET exceeding 73 sessions using the following codes:

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

Medicare’s Common Working File (CWF) will display remaining SET sessions on all CWF provider query screens (HIQA, HIQH, ELGH, ELGA, and HUQA). The Multi-Carrier System Desktop Tool will also display remaining SET sessions in a format equivalent to the CWF HIMR screen(s).

**ADDITIONAL INFORMATION**


**DOCUMENT HISTORY**

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<td>March 5, 2018</td>
<td>The article was revised to reflect a revised CR. The MAC implementation date, CR release date, transmittal numbers and the Web addresses of the transmittals were revised. All other information remains the same.</td>
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<td>February 6, 2018</td>
<td>Initial article released.</td>
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**DMEPOS Fee Schedule CY 2018 Update**

**MLN Matters Number**: MM10395  
**Related Change Request (CR) Number**: 10395  
**Related CR Release Date**: December 1, 2017  
**Effective Date**: January 1, 2018  
**Related CR Transmittal Number**: R3931CP  
**Implementation Date**: January 2, 2018

**PROVIDER TYPES AFFECTED**

This MLN Matters Article is intended for providers and suppliers submitting claims to Medicare Administrative Contractors (MACs) for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) items provided to Medicare beneficiaries and paid under the DMEPOS fee schedule.

**PROVIDER ACTION NEEDED**

Change Request (CR) 10395 provides the Calendar Year (CY) 2018 annual update for the Medicare DMEPOS fee schedule. The instructions include information on the data files, update factors and other information related to the update of the fee schedule. Make sure your billing staffs are aware of these updates.

**BACKGROUND**

Section 1834(a), (h), and (i) of the Social Security Act (the Act) requires payment on a fee schedule for certain DMEPOS. Also, payment on a fee-schedule basis is a regulatory requirement at 42 CFR Section
414.102 for Parenteral and Enteral Nutrition (PEN), splints, casts, and Intraocular Lenses (IOLs) inserted in a physician’s office.

Section 1834(a)(1)(F)(ii) of the Act mandates adjustments to the fee schedule amounts for certain items furnished on or after January 1, 2016, in areas that are not competitive bid areas, based on information from Competitive Bidding Programs (CBPs) for DME. Section 1842(s)(3)(B) of the Act provides authority for making adjustments to the fee schedule amounts for enteral nutrients, equipment, and supplies (enteral nutrition) based on information from CBPs. Regulations at 42 CFR Section 414.210(g) established the methodologies for adjusting DMEPOS fee schedule amounts using information from CBPs. Recent program instructions on these changes are available in Transmittal 3551, CR9642, dated June 23, 2016 (MM9642 is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM9642.pdf), and Transmittal 3416, CR9431, dated November 23, 2015 (MM9431 is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM9431.pdf).

The DMEPOS and Parenteral and Enteral Nutrition (PEN) fee schedule files contain HCPCS codes that are subject to the adjusted fee schedule amounts as well as codes that are not subject to the fee schedule CBP adjustments. Fee schedule amounts that are adjusted using information from CBPs will not be subject to the annual DMEPOS covered item update, but will be updated pursuant to 42 CFR Section 414.210(g)(8) when information from the CBPs is updated.

Pursuant to 42 CFR Section 414.210(g)(4), for items where the Single Payment Amounts (SPAs) from CBPs no longer in effect are used to adjust fee schedule amounts, the SPAs are increased by the percentage changes in the Consumer Price Index for all Urban Consumers (CPI-U) from the last year of the applicable CBP to the current year. Information on the update factor for CY 2018 is included below.

The ZIP code associated with the address used for pricing a DMEPOS claim determines the rural fee schedule payment applicability for codes with rural and non-rural adjusted fee schedule amounts. ZIP codes for non-continental Metropolitan Statistical Areas (MSAs) are not included in the DMEPOS Rural ZIP code file. The DMEPOS Rural ZIP code file is updated on a quarterly basis, as necessary. Regulations at 42 CFR 414.202 define a rural area to be a geographical area represented by a postal ZIP code where at least 50 percent of the total geographical area of the ZIP code is estimated to be outside any MSA. A rural area also included any ZIP code within an MSA that is excluded from a competitive bidding area established for that MSA.

The DMEPOS fee schedule file contains fee schedule amounts for non-rural and rural areas. Also, the PEN fee schedule file includes state fee schedule amounts for enteral nutrition items and national fee schedule amounts for parenteral nutrition items.

The DMEPOS and PEN fee schedules and the rural zip code Public Use Files (PUFs) will be available for State Medicaid Agencies, managed care organizations, and other interested parties at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched.

New Codes Added

New DMEPOS codes added to the HCPCS file, effective January 1, 2018, where applicable, are:

- E0953 and E0954 in the Inexpensive/Routinely Purchased (IN) payment category
- L3761, L7700, L8625, L8694, and Q0477, which are all in the Prosthetics and Orthotics (PO) payment category.

For gap-filling pricing purposes, deflation factors are applied before updating to the current year. The deflation factors for 2017 by the payment category are:

- 0.447 for Oxygen
- 0.450 for Capped Rental
- 0.451 for Prosthetics and Orthotics
- 0.572 for Surgical Dressings
- 0.623 for Parental and Enteral Nutrition
- 0.953 for Splints and Casts
- 0.937 for Intraocular Lenses
Codes Deleted

No HCPCS codes will be deleted from the DMEPOS fee schedule files effective January 1, 2018.

Specific Coding and Pricing Issues

Effective January 1, 2018, new Off-The-Shelf orthotic (OTS) code L3761 - Elbow Orthosis (EO), with adjustable position locking joint(s) prefabricated off-the-shelf - is included in the fee schedule file. Code L3760 was split into two codes. The existing code revised, effective January 1, 2018, to only describe devices customized to fit a specific patient by an individual with expertise, and a new code describing OTS items (L3761).

The fee schedule amount for existing code L3760 will be applied to new code L3761 effective January 1, 2018. The cross-walking of fee schedule amounts for a single code that is split into two codes for distinct complete items is in accordance with the instructions stated in Chapter 3, Section 60.3.1 of the “Medicare Claims Processing Manual.” An update will be made to the list of orthotic codes that are designated as OTS at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/OTS_Orthotics.html to reflect added code L3761.

As part of this update, a corrected calculation is applied to the adjusted fee schedule amounts for codes A4619, E0147, and E0580. The fee schedule adjustment methodology at 42 CFR 414.210(g) was incorrectly applied to these codes, and therefore corrections to the adjusted fee schedule amounts for these codes have been made.

Effective January 1, 2018, the replacement external sound processor (HCPCS code L8691) is split into two codes in order to appropriately identify devices where the actuator is a separate component from the sound processor, microphones, and battery. The two codes are a revised L8691 and a new L8694 transducer/actuator code.

Effective January 1, 2018, the existing fee schedules for L8691 are revised to remove payment for the separate transducer/actuator component. Suppliers billing for replacement sound processors that do not separate the sound processor and the actuator should use both L8691 and L8694 to describe the replaced items. Suppliers billing for replacement sound processors that separate the sound processor and the actuator components should use either or both L8691 and L8694 as appropriate to describe the sound processor component(s).

The replacement Ventricular Assist Device (VAD) power module code Q0479 is split in order to separately identify the patient cable. Effective January 1, 2018, HCPCS code Q0477 identifies a replacement patient cable. Thus, the fees for Q0479 are revised to reflect the establishment of the new patient cable code.

The Centers for Medicare & Medicaid Services (CMS) is also adjusting the fee schedule amounts for shoe modification codes A5503 through A5507 in order to reflect more current allowed service data. Section 1833(o)(2)(C) of the Act required that the payment amounts for shoe modification codes A5503 through A5507 be established in a manner that prevented a net increase in expenditures when substituting these items for therapeutic shoe insert codes (A5512 or A5513). To establish the fee schedule amounts for the shoe modification codes, the base fees for codes A5512 and A5513 were weighted based on the approximated total allowed services for each code for items furnished during the second quarter of calendar year 2004.

For 2018, CMS is updating the weighted average insert fees used to establish the fee schedule amounts for the shoe modification codes with more current allowed service data for each insert code. The base fees for A5512 and A5513 will be weighted based on the approximated total allowed services for each code for items furnished during the calendar year 2016. The fee schedule amounts for shoe modification codes A5503 through A5507 are being revised to reflect this change, effective January 1, 2018.

As part of this file update, the jurisdiction for HCPCS code E0781 is revised from ‘J’ to ‘D’.

HCPCS code Q0477 (Power Module Patient Cable for Use with Electric or Electric/Pneumatic Ventricular Assist Device, Replacement Only) is being added to the HCPCS file, effective January 1, 2018, to describe a replacement accessory for Ventricular Assist Devices (VADs). Similar to the other VAD supplies and accessories coded at Q0478 thru Q0495, Q0497-Q0502, and Q0504 thru Q0509, CMS has determined the reasonable useful lifetime for code Q0477 to be one year. Therefore, CMS will deny claims for Q0477 before the lifetime of these items has expired. Suppliers and providers will need to add modifier RA to claims for code Q0477 in cases where the battery is being replaced because it was lost, stolen, or irreparably damaged.
Fees for the ‘KU’ modifier when billed with wheelchair codes E0953 and E0954 are included in the January 2018 file for billing when these items are furnished in connection with Group 3 complex rehabilitative power wheelchairs.

**Diabetic Testing Supplies**

The fee schedule amounts for non-mail order Diabetic Testing Supplies (DTS) (without KL modifier) for codes A4233, A4234, A4235, A4236, A4253, A4256, A4258, and A4259 are not updated by the annual covered item update. In accordance with Section 636(a) of the American Taxpayer Relief Act of 2012, the fee schedule amounts for these codes were adjusted in CY 2013 so that they are equal to the Single Payment Amounts (SPAs) for mail order DTS established in implementing the national mail order CBP under Section 1847 of the Act. The National Mail-Order Recompete DTS SPAs are available at [https://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home](https://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home).

The non-mail order DTS amounts on the fee schedule file will be updated each time the SPAs are updated. This can happen no less often than every time the mail order CBP contracts are recompeted. The CBP for mail order diabetic supplies is effective July 1, 2016, to December 31, 2018. The program instructions reviewing these changes are included in Transmittal 2709, Change Request (CR) 8325, dated May 17, 2013, and Transmittal 2661, CR8204, dated February 22, 2013. You can review related article MM8325 at [https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8325.pdf](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8325.pdf) and MM8204 at [https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8204.pdf](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8204.pdf).

### 2018 Fee Schedule Update Factor of 1.1 Percent

For CY 2018, an update factor of 1.1 percent is applied to certain DMEPOS fee schedule amounts. In accordance with the statutory Sections 1834(a)(14) of the Act, certain DMEPOS fee schedule amounts are updated for 2018 by the percentage increase in the CPI- U for the 12-month period ending June 30, 2017, adjusted by the change in the economy-wide productivity equal to the 10-year moving average of changes in annual economy-wide private non-farm business Multi-Factor Productivity (MFP). The MFP adjustment is 0.5 percent and the CPI-U percentage increase is 1.6 percent. Thus, the 1.6 percentage increase in the CPI-U is reduced by the 0.5 percentage increase in the MFP resulting in a net increase of 1.1 percent for the update factor.

### 2018 Update to the Labor Payment Rates

The CY 2018 allowed payment amounts for HCPCS labor payment codes K0739, L4205, and L7520 are in the table below. Since the percentage increase in the CPI- U for the 12-month period ending with June 30, 2017, is 1.6 percent, this change is applied to the 2017 labor payment amounts to update the rates for CY 2018.

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<th>L4205</th>
<th>L7520</th>
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2018 National Monthly Fee Schedule Amounts for Stationary Oxygen Equipment

CMS is implementing the 2017 monthly fee schedule payment amounts for stationary oxygen equipment (HCPCS codes E0424, E0439, E1390, and E1391), effective for claims with dates of service from January 1, 2018, through December 31, 2018. As required by statute, the addition of the separate payment classes for Oxygen Generating Portable Equipment (OGPE) and stationary and portable oxygen contents must be annually budget neutral. Medicare expenditures must account for these separate oxygen payment classes.

Therefore, the fee schedule amounts for stationary oxygen equipment are reduced by a certain percentage each year to balance the increase in payments made for the additional separate oxygen payment classes. For dates of service January 1, 2018, through December 31, 2018, the monthly fee schedule payment amounts for stationary oxygen equipment range from approximately $66 to $76 incorporating the budget neutrality adjustment factor.

When updating the stationary oxygen equipment amounts, corresponding updates are made to the fee schedule amounts for HCPCS codes E1405 and E1406 for oxygen and water vapor enriching systems. Since 1989, the payment amounts for codes E1405 and E1406 have been established based on a combination of the Medicare payment amounts for stationary oxygen equipment and nebulizer codes E0585 and E0570, respectively.

2018 Maintenance and Servicing Payment Amount for Certain Oxygen Equipment

CMS is also updating for 2018 the payment amount for maintenance and servicing for certain oxygen equipment. Payment for claims for maintenance and servicing of oxygen equipment was instructed in Transmittal 635, CR6792, dated February 5, 2010, and Transmittal 717, CR6990, dated June 8, 2010. (You can review related articles MM6792 at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLN MattersArticledownloads/MM6792.pdf and MM6990 at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6990.pdf.) To summarize, payment for maintenance and servicing of certain oxygen equipment can occur every 6 months beginning 6 months after the end of the 36th month of continuous use or end of the supplier’s or manufacturer’s warranty, whichever is later for either HCPCS code E1390, E1391, E0433, or K0738, billed with the “MS” modifier. Payment cannot occur more than once per beneficiary, regardless of the combination of oxygen concentrator equipment and/or transfilling equipment used by the beneficiary, for any 6-month period.

Per 42 CFR 414.210(e)(5)(iii), the 2010 maintenance and servicing fee for certain oxygen equipment was based on 10 percent of the average price of an oxygen concentrator. For CY 2011 and subsequent years, the maintenance and servicing fee is adjusted by the covered item update for DME as set forth in §1834(a) (14) of the Act. Thus, the 2017 maintenance and servicing fee is adjusted by the 1.1 percent MFP-adjusted covered item update factor to yield a CY 2018 maintenance and servicing fee of $70.74 for oxygen concentrators and transfilling equipment.
ADDITIONAL INFORMATION


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PWK Segment of the esMD System Implementation Modifications

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

PROVIDER TYPE AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 10397 updates the business requirements to enable MACs to receive unsolicited documentation (also known as paperwork (PWK)) via the Electronic Submission of Medical Documentation (esMD) system. CR10397 is for esMD purposes only. Please make sure your billing staffs are aware of these updates.

BACKGROUND

CR10397 also contains attachments that include cover sheets that must be used for electronic, fax, or mail submissions of documentation. There are three cover sheets, one each for Part A and Part B providers, as well as one for durable medical equipment (DME) suppliers. In addition, there are two companion guides attached to CR10397, one for institutional claims and one for professional claims. A link to CR10397 is available in the Additional Information section of this article.

With CR10397, MACs will modify PWK, also known as unsolicited documentation procedures to include electronic submission(s) via esMD. Also, Medicare systems will accept PWK 02 values “EL” and “FT” for those MACs in a CMS-approved esMD system. This mechanism will suppress initial auto letter generation, if applicable, when PWK 02 is “EL” or “FT,” and is present at any level of the claim or line.

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

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

MACs will allow 7 calendar “waiting days” (from the date of receipt) for additional information to be submitted when the PWK 02 value is “EL” or “FT.”

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

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

Once again, examples of the cover sheet are included as an attachment to CR10397.

**ADDITIONAL INFORMATION**


**DOCUMENT HISTORY**

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**HPTCS April 2018 Code Set Update**

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

**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) 10402 directs MACs to obtain the most recent Healthcare Provider Taxonomy Codes (HPTCs) code set and use it to update their internal HPTC tables and/or reference files. Make sure your billing staffs are aware of these changes.

**BACKGROUND**

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

You should note that:

• Valid HPTCs are those codes approved by the National Uniform Claim Committee (NUCC) for current use.
• Terminated codes are not approved for use after a specific date.
Newly approved codes are not approved for use prior to the effective date of the code set update in which each new code first appears.

Specialty and/or provider type codes issued by any entity other than the NUCC are not valid.

Medicare would be guilty of non-compliance with HIPAA if MACs accepted claims that contain invalid HPTCs.

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

Although the NUCC generally posts their updates on the WPC webpage 3 months prior to the effective date, changes are not effective until April 1 or October 1, as indicated in each update. The changes to the code set include the addition of a new code and addition of definitions to existing codes. When reviewing the HCPT code set online, revisions made since the last release are identifiable by these color codes:

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

ADDITIONAL INFORMATION


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E/M Service Documentation Provided By Students (Manual Update)

MLN Matters Number: MM10412
Related Change Request (CR) Number: 10412
Related CR Release Date: February 2, 2018
Effective Date: January 1, 2018
Related CR Transmittal Number: R3971CP
Implementation Date: March 5, 2018

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 10412 revises the Medicare Claims Processing Manual to allow the teaching physician to verify in the medical record any student documentation of components of E/M services, rather than re-documenting the work. Make sure your billing staffs are aware of the changes.

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) is revising the Medicare Claims Processing Manual, Chapter 12, Section 100.1.1, to update policy on Evaluation and Management (E/M) documentation to allow the teaching physician to verify in the medical record any student documentation of components of E/M services, rather than re-documenting the work. Students may document services in the medical record. However, the teaching physician must verify in the medical record all student documentation or findings, including history, physical exam and/or medical decision making. The teaching physician must personally perform (or re-perform) the physical exam and medical decision making activities of the E/M service being
billed, but may verify any student documentation of them in the medical record, rather than re-documenting this work.

ADDITIONAL INFORMATION


DOCUMENT HISTORY

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<tr>
<td>February 5, 2018</td>
<td>Initial article released</td>
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QMB Indicator Reinstated in Medicare FFS Claims Processing System from CR9911 – Second Revision

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

This article was revised on March 13, 2018, to reflect an updated Change Request (CR). That CR added CARCs 66, 247, and 248 (page 3 below). DME MACs were added to the “Providers Affected” section and the QMB enrollment numbers were also updated on page 2 to reflect 2016 statistics. Pharmacies were also included in the “Background” section. The CR date, transmittal number and link to the transmittal also changed. All other information is unchanged.

PROVIDER TYPES AFFECTED

This MLN Matters® Article is intended for providers and suppliers who submit claims to Part A/B and DME Medicare Administrative Contractors (MACs).

WHAT YOU NEED TO KNOW

Effective with CR 10433, the Centers for Medicare & Medicaid Services (CMS) will reintroduce Qualified Medicare Beneficiary (QMB) information in the Medicare Remittance Advice (RA) and Medicare Summary Notice (MSN). CR 9911 modified the Fee-For-Service (FFS) systems to indicate the QMB status and zero cost-sharing liability of beneficiaries on RAs and MSNs for claims processed on or after October 2, 2017. On December 8, 2017, CMS suspended CR 9911 to address unforeseen issues preventing the processing of QMB cost-sharing claims by States and other secondary payers outside of the Coordination of Benefits Agreement (COBA) process. CR 10433 remediates these issues by including revised “Alert” Remittance Advice Remark Codes (RARC) in RAs for QMB claims without adopting other RA changes that impeded claims processing by secondary payers. CR 10433 reinstates all changes to the MSNs under CR 9911. Please make sure your billing staff is aware of these changes.

BACKGROUND

Federal law bars Medicare providers and suppliers, including pharmacies, from billing an individual enrolled in the QMB program for Medicare Part A and Part B cost-sharing under any circumstances. (See Sections 1902(n)(3)(B), 1902(n)(3)(C), 1905(p)(3), 1866(a)(1)(A), and 1848(g)(3)(A) of the Social Security Act.) The QMB program is a State Medicaid benefit that assists low-income Medicare beneficiaries with Medicare Part A and Part B premiums and cost-sharing, including deductibles, coinsurance, and copays. In 2016, 7.5 million individuals (more than one out of 8 beneficiaries) were enrolled in the QMB program.

Providers and suppliers, including pharmacies, may bill State Medicaid agencies for Medicare cost-sharing amounts. However, as permitted by Federal law, States may limit Medicare cost-sharing payments, under certain circumstances. Be aware, persons enrolled in the QMB program have no legal liability to pay Medicare providers for Medicare Part A or Part B cost-sharing.
System Changes to Assist Providers under CR 9911

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

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

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

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

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

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

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

All Medicare’s FFS systems will discontinue the practice of outputting Claim Adjustment Group Code OA with CARC 209 in place of CARCs 1 and 2, as well as CARCs 66, 247, and 248, on the ERAs and on SPRs, as applicable.

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

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

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

ADDITIONAL INFORMATION

ASP Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files for April 2018

MLN Matters Number: MM10447  
Related Change Request (CR) Number: 10447  
Related CR Release Date: January 5, 2018  
Effective Date: April 1, 2018  
Related CR Transmittal Number: R3947CP  
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 Medicare Part B drugs provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED  
Change Request (CR) 10447 instructs MACs to download and implement the April 2018 and, if released, the revised January 2018, October 2017, July 2017, and April 2017 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 April 2, 2018, with dates of service April 1, 2018, through June 30, 2018. Make sure that your billing staffs are aware of these changes.

BACKGROUND  
The Average Sales Price (ASP) methodology is based on quarterly data submitted by manufacturers to CMS. CMS supplies 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 available in Chapter 4, Section 50 of the Medicare Claims Processing Manual at https://www.cms.gov/Regulations-and-Guidance/Guidance-Manuals/Downloads/clm104c04.pdf.

- File: April 2018 ASP and ASP NOC -- Effective for Dates of Service of April 1, 2018, through June 30, 2018
- File: January 2018 ASP and ASP NOC -- Effective for Dates of Service of January 1, 2018, through March 31, 2018
- File: October 2017 ASP and ASP NOC -- Effective for Dates of Service of October 1, 2017, through December 31, 2017
- File: July 2017 ASP and ASP NOC -- Effective for Dates of Service of July 1, 2017, through September 30, 2017
• File: April 2017 ASP and ASP NOC -- Effective for Dates of Service of April 1, 2017, through June 30, 2017

For any drug or biological not listed in the ASP or NOC drug pricing files, your 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 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 on or after January 1, 2017, associated with the passage of the 21st Century Cures Act which is available at https://www.gpo.gov/fdsys/pkg/PLAW-114publ255/pdf/PLAW-114publ255.pdf.

ADDITIONAL INFORMATION


DOCUMENT HISTORY

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HCPCS Drug/Biological Code Changes - April 2018 Update – Revised

MLN Matters Number: MM10454 Revised
Related Change Request (CR) Number: 10454
Related CR Release Date: March 7, 2018
Effective Date: April 1, 2018
Related CR Transmittal Number: R3997CP
Implementation Date: April 2, 2018

This article was revised on March 8, 2018, to reflect an updated Change Request (CR). That CR provided additional instructions for the MACs, regarding use of the long descriptors. The CR date, transmittal number and link to the transmittal also changed. All other information is unchanged.

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

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

BACKGROUND

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

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

HCPCS Code: Q5101
• Short Description: Injection, zarxio
• Long Description: Injection, filgrastim-sndz, biosimilar, (zarxio), 1 microgram
HCPCS Code: Q5103
- Short Description: Injection, inflectra
- Long Description: Injection, infliximab-dyyb, biosimilar, (inflectra), 10 mg
- Type of Service (TOS) Code: 1,P
- Medicare Physician Fee Schedule Database (MPFSDB) Status Indicator: E

HCPCS Code: Q5104
- Short Description: Injection, renflexis
- Long Description: Injection, infliximab-abda, biosimilar, (renflexis), 10 mg
- TOS Code: 1, P
- MPFSDB Status Indicator: E

HCPCS Code: Q2041
- Short Description: Axicabtagene ciloleucel car+
- Long Description: Axicabtagene Ciloleucel, up to 200 million autologous Anti-CD19 CAR T Cells, Including leukapheresis and dose preparation procedures, per infusion
- TOS Code: 1
- MPFSDB Status Indicator: E

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

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

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

**ADDITIONAL INFORMATION**


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<tr>
<td>February 2, 2018</td>
<td>Initial article released.</td>
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Diagnosis Code Update for Add-on Payments for Blood Clotting Factor Administered to Hemophilia Inpatients – Revised

MLN Matters Number: MM10474 Revised
Related Change Request (CR) Number: 10474
Related CR Release Date: March 1, 2018
Effective Date: July 1, 2018
Related CR Transmittal Number: R3990CP
Implementation Date: July 2, 2018

This article was revised on March 2, 2018, to reflect the revised CR10474 issued on March 1. 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 providers who submit claims to Medicare Administration Contractors (MACs) for inpatient services to Medicare beneficiaries with hemophilia.

WHAT YOU NEED TO KNOW

Change Request (CR) 10474 provides updates to diagnosis codes required in order to allow add-on payments under the Inpatient Prospective Payment System (IPPS) for blood clotting factor administered to hemophilia inpatients. The add-on payment criteria for blood clotting factors administered to hemophilia inpatients will be updated July 1, 2018, by terminating International Classification of Diseases, Clinical Modification (ICD-CM) code D68.32, effective with that date. The list of ICD-CM codes that will continue to receive the add-on payment can be found in Section 20.7.3, of Chapter 3 of the “Medicare Claims Processing Manual”. Make sure your billing staffs are aware of this update.

BACKGROUND

The September 1, 1993, IPPS final rule (58 FR 46304) states that payment will be made for the blood clotting factor only if an ICD-CM diagnosis code for hemophilia is included on the bill.

Effective July 1, 2018, code D68.32 (Antiphospholipid antibody with hemorrhagic disorder) is TERMINATED. Therefore, providers that include diagnosis code D68.32 on inpatient claims with discharge dates after July 1, 2018, will not receive the add-on payment.

ADDITIONAL INFORMATION


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<td>This article was revised to reflect the revised CR10474 issued on March 1. 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.</td>
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<tr>
<td>February 9, 2018</td>
<td>Initial article released.</td>
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Appropriate Use Criteria for Advanced Diagnostic Imaging – Voluntary Participation and Reporting Period – Claims Processing Requirements – HCPCS Modifier QQ

MLN Matters Number: MM10481
Related Change Request (CR) Number: 10481
Related CR Release Date: March 2, 2018
Effective Date: July 1, 2018
Related CR Transmittal Number: R20400TN
Implementation Date: July 2, 2018

PROVIDER TYPE AFFECTED
This MLN Matters Article is intended for physicians, facilities and other practitioners billing Part B services to Medicare Administrative Contractors (MACs) for advanced diagnostic imaging provided to Medicare beneficiaries.

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

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

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

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

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

1. The ordering professional having a significant hardship,
2. Situations in which the patient has an emergency medical condition, or,
3. An applicable imaging service ordered for an inpatient, and for which payment is made under Part A.
Ultimately, this program will result in identified outlier ordering professionals being subject to prior authorization.

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

Effective July 1, 2018, HCPCS modifier QQ (Ordering Professional Consulted A Qualified Clinical Decision Support Mechanism For This Service And The Related Data Was Provided To The Furnishing Professional) is available for this reporting. The modifier may be:

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

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

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

**Magnetic Resonance Imaging**

70336, 70540, 70542, 70543, 70544, 70545, 70546, 70547, 70548, 70549, 70551, 70552, 70553, 70554, 70555, 71550, 71551, 71552, 71556, 72141, 72142, 72146, 72147, 72148, 72149, 72156, 72157, 72158, 72159, 72195, 72196, 72197, 72198, 73218, 73219, 73220, 73221, 73222, 73223, 73225, 73718, 73719, 73720, 73721, 73722, 73723, 73725, 74181, 74182, 74183, 74185, 75557, 75559, 75561, 75563, 75565, 76498

**Computerized Tomography**

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

**Single-Photon Emission Computed Tomography**

76390

**Nuclear Medicine**

78012, 78013, 78014, 78015, 78016, 78018, 78020, 78070, 78071, 78072, 78075, 78099, 78102, 78103, 78104, 78110, 78111, 78120, 78121, 78122, 78130, 78135, 78140, 78185, 78191, 78195, 78199, 78201, 78202, 78205, 78206, 78215, 78216, 78226, 78227, 78230, 78231, 78232, 78258, 78261, 78262, 78264, 78265, 78266, 78267, 78268, 78270, 78271, 78272, 78278, 78282, 78290, 78291, 78299, 78300, 78305, 78306, 78315, 78320, 78350, 78351, 78399, 78414, 78428, 78445, 78451, 78452, 78453, 78454, 78456, 78457, 78458, 78459, 78466, 78468, 78469, 78472, 78473, 78481, 78483, 78491, 78492, 78494, 78496, 78499, 78579, 78580, 78582, 78597, 78598, 78599, 78600, 78601, 78605, 78606, 78607, 78608, 78609, 78610, 78630, 78635, 78645, 78647, 78650, 78660, 78699, 78700, 78701, 78707, 78708, 78709, 78710, 78725, 78730, 78740, 78761, 78799, 78800, 78801, 78802, 78803, 78804, 78805, 78806, 78807, 78811, 78812, 78813, 78814, 78816, 78999

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<td>Initial article released.</td>
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MPFSDB – April 2018 Update

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

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 10488 amends payment files issued to MACs based upon the calendar year 2018 Medicare Physician Fee Schedule (MPFS) Final Rule. Make sure your billings staffs are aware of these changes.

BACKGROUND

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

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

### CPT/HCPCS & Mod

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<th>Action</th>
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<tr>
<td>G0516</td>
<td>Change in short descriptor on 4-1-18 to “insert drug implant,&gt;=4”</td>
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<tr>
<td>45399</td>
<td>Global Days = YYY</td>
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<tr>
<td>G9976</td>
<td>Procedure Status = I</td>
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<td>G9977</td>
<td>Procedure Status = I</td>
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<td>83992</td>
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The following “Q” codes are effective for services performed on or after April 1, 2018 (see MLN Matters Article MM10454 for additional information):

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<tr>
<td>Q2041</td>
<td>Axicabtagene ciloleucel car+</td>
<td>Procedure Status = E; there are no RVUs</td>
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<td>Q5101</td>
<td>Injection, zarxio</td>
<td>Change in short descriptor</td>
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<tr>
<td>Q5102</td>
<td>Inj., infliximab biosimilar</td>
<td>Procedure Status = I (invalid); code discontinued 4-1-18 &amp; after</td>
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<tr>
<td>Q5103</td>
<td>Injection, inflectra</td>
<td>Procedure Status = E; there are no RVUs</td>
</tr>
<tr>
<td>Q5104</td>
<td>Injection, renflexis</td>
<td>Procedure Status = E; there are no RVUs</td>
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The HCPCS “G” codes listed below have been added to the MPFSDB effective for dates of service on and after April 1, 2018. All of these new codes were communicated through other instructions. Please consult
those instructions for the description and other information. In addition, the descriptions are available also at https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update.html.

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<td>Procedure Status = X; there are no RVUs; all policy indicators = concept does not apply</td>
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<td>G9874</td>
<td>Procedure Status = X; there are no RVUs; all policy indicators = concept does not apply</td>
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<td>G9875</td>
<td>Procedure Status = X; there are no RVUs; all policy indicators = concept does not apply</td>
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<td>G9876</td>
<td>Procedure Status = X; there are no RVUs; all policy indicators = concept does not apply</td>
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<td>Procedure Status = X; there are no RVUs; all policy indicators = concept does not apply</td>
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<td>G9884</td>
<td>Procedure Status = X; there are no RVUs; all policy indicators = concept does not apply</td>
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<td>G9885</td>
<td>Procedure Status = X; there are no RVUs; all policy indicators = concept does not apply</td>
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<td>G9890</td>
<td>Procedure Status = X; there are no RVUs; all policy indicators = concept does not apply</td>
</tr>
<tr>
<td>G9891</td>
<td>Procedure Status = X; there are no RVUs; all policy indicators = concept does not apply</td>
</tr>
</tbody>
</table>

Providers should be aware MACs do not need to search their files to either retract payment for claims already paid or to retroactively pay claims. However, MACs will adjust claims that you bring to their attention.

ADDITIONAL INFORMATION


DOCUMENT HISTORY

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>February 16, 2018</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>
Adjustments to QMB Claims Processed Under CR 9911

MLN Matters Number: MM10494
Related Change Request (CR) Number: CR10494
Related CR Release Date: March 16, 2018
Effective Date: December 20, 2018, for Part B MAC claims and September 20, 2018, for Part A and DME MAC claims
Related CR Transmittal Number: R2042OTN
Implementation Date: December 20, 2018, for Part B MAC claims and September 20, 2018, for Part A and DME MAC claims

PROVIDER TYPE AFFECTED
This MLN Matters® Article is intended for providers and suppliers submitting claims to Medicare Administrative Contractors (MACs), including Home Health & Hospice MACs and Durable Medical Equipment (DME) MACs, for services provided to Qualified Medicare Beneficiaries (QMB).

PROVIDER ACTION NEEDED
This article is based on Change Request (CR) 10494 which directs MACs to mass adjust QMB claims impacted by CR9911. (An article related to CR9911 is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm9911.pdf.) Make sure that your billing staff is aware of these upcoming claims adjustments.

BACKGROUND
CR9911 incorporates claims processing system modifications implemented on October 2, 2017, to generate QMB information in Remittance Advices (RAs) and Medicare Summary Notices. Providers may use RAs to bill State Medicaid Agencies and other secondary payers outside the Coordination of Benefits Agreement (COBA) crossover process, but CR9911 RAs lacked the formatting and specificity that States require to process QMB cost-sharing claims.

To address these issues, on December 8, 2017, the Centers for Medicare & Medicaid Services (CMS) temporarily suspended the CR9911 claims processing system modifications. See “QMB Remittance Advice Issue” at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination/Downloads/MM9911Update112017.pdf.

Through CR10433, CMS will reintroduce QMB information in the RA starting July 2018 and modify CR9911 to avoid disrupting claims processing by secondary payers. CR10433 will be effective for claims processed on or after July 2, 2018. A related article is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm10433.pdf.

Under CR10494, MACs will initiate non-monetary mass adjustments for claims impacted by CR 9911 QMB RA changes, which include claims that were paid after October 2, 2017 and up to December 31, 2017, and that have not been voided or replaced. MACs will issue replacement RAs without the CR 9911 changes and re-process QMB cost-sharing claims by secondary payers by December 20, 2018, for Part B/MAC claims and by September 20, 2018, for Part A/MAC and Durable Medical Equipment MAC claims.

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

Note that although mass-adjusted claims may not cross over, this solution targets affected providers who attempted to bill supplemental payers directly using CR9911 QMB RAs because their QMB cost-sharing claims either did not cross over or crossed over to supplemental payers but failed to process. The goal is to produce replacement Medicare RAs that providers can submit to supplemental payers to coordinate benefits as necessary.

Make sure your billing staff is aware of these changes.
ADDITIONAL INFORMATION

DOCUMENT HISTORY

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<tr>
<th>Date of Change</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>March 22, 2018</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>

DMEPOS Fee Schedule – April 2018 Update

MLN Matters Number: 10503
Related Change Request (CR) Number: CR10503
Related CR Release Date: March 21, 2018
Effective Date: April 1, 2018
Related CR Transmittal Number: R4004CP
Implementation Date: April 2, 2018

PROVIDER TYPE AFFECTED
This MLN Matters® Article is intended for providers and suppliers submitting claims to Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) items or services paid under the DMEPOS fee schedule.

PROVIDER ACTION NEEDED
Change Request (CR) 10503 provides the April 2018 Medicare DMEPOS fee schedule quarterly update. It provides specific instructions to your DME MAC for implementing updated Oxygen Volume Adjustments. When necessary, the DMEPOS fee schedule is updated quarterly, to implement fee schedule amounts for new codes, to correct any fee schedule amounts for existing codes (as applicable) and to apply changes in payment policies. It contains fee schedule amounts for both non-rural and rural areas. Additionally, the parenteral and enteral nutrition (PEN) fee schedule file includes state fee schedule amounts for enteral nutrition items and national fee schedule amounts for parental nutrition items.

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

BACKGROUND
Section 1834(a), (h), and (i) of the Social Security Act (the Act) require payment for Durable Medical Equipment (DME), prosthetic devices, orthotics, prosthetics and surgical dressings be completed on a fee schedule basis. Further, payment on a fee schedule basis is a regulatory requirement at 42 Code of Federal Regulations (CFR) §414.102s, for parenteral and enteral nutrition, splints, casts and Intraocular Lenses (IOLs) inserted in a physician’s office.

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

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

Additional information on adjustments to the fee schedule amounts based on information from CBPs is available in Transmittal 3551, CR 9642, dated June 23, 2016 and Transmittal 3416, CR 9431, dated November 23, 2015. You can find the MLN Matters articles associated with these Change

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

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

K0903

As part of this update, CR 10503 is adding fee schedule amounts for HCPCS code K0903 (For Diabetics Only, Multiple Density Insert, Made By Direct Carving With CAM Technology From A Rectified CAD Model Created From A Digitized Scan Of The Patient, Total Contact With Patient’s Foot, Including Arch, Base Layer Minimum Of 3/16 Inch Material Of Shore A 35 Durometer (Or Higher), Includes Arch Filler And Other Shaping Material, Custom Fabricated, Each), effective for claims with dates of service on or after April 1, 2018. The fees for code K0903 are set based on the fees for code A5513 because inserts carved from a digitized scan of the patient’s foot were determined to be comparable to inserts made over a positive model of the patient’s foot.

Oxygen Volume Adjustments

As part of the 2017 April Quarterly DMEPOS fee schedule update (Please refer to the associated MLN Matters article at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9988.pdf), the ‘QF’ modifier (Prescribed amount of oxygen is greater than 4 Liter Per Minute (LPM) and portable oxygen is prescribed) was added to the DMEPOS fee schedule for use with both stationary and portable oxygen when the oxygen flow rate exceeds 4 liters per minute (LPM) and portable oxygen is prescribed.

Section 1834(a)(5)(C) and (D) of the Act requires that when an oxygen flow rate exceeds 4 LPM, the Medicare payment amount be the higher of:

- 50 percent of the stationary payment amount (HCPCS codes E0424, E0439, E1390, or E1391); or
- The portable oxygen add-on amount (HCPCS codes E0431, E0433, E0434, E1392 or K0738); and
- Never both.

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

CR 10503 provides that effective April 1, 2018:

The ‘QF’ modifier is revised to read as follows:

QF – (PRESCRIBED AMOUNT OF STATIONARY OXYGEN WHILE AT REST EXCEEDS 4 LITERS PER MINUTE (LPM) AND PORTABLE OXYGEN IS ; and

The following new oxygen volume adjustment modifier is added to the HCPCS file:

QB – (PRESCRIBED AMOUNTS OF STATIONARY OXYGEN FOR DAYTIME USE WHILE AT REST AND NIGHTTIME USE DIFFER AND THE AVERAGE OF THE TWO AMOUNTS EXCEEDS 4 LITERS PER MINUTE (LPM) AND PORTABLE OXYGEN IS PRESCRIBED).

Specifically (effective April 1, 2018), the modifier ‘QB’ should be used in conjunction with claims submitted for stationary oxygen (codes E0424, E0439, E1390, or E1391) and portable oxygen (codes E0431, E0433, E0434, E1392, or K0738) when the prescribed amount of oxygen for daytime and nighttime differ and the average of the two amounts is greater than 4 liters per minute (LPM) and portable oxygen is prescribed.
For more information on April 1, 2018, changes to the pricing modifiers for oxygen flow rate, please refer to MLN Matters Article MM10158, titled “Revised and New Modifiers for Oxygen Flow Rate.”

Please note that the ‘QB’ modifier is used in billing to denote when: 1) The average prescribed amount of oxygen is greater than 4 LPM; 2) Portable oxygen is prescribed; and 3) There is a difference in the prescribed flow rates for nighttime and for daytime use. In these instances, regulations at 42 CFR 414.226(e)(3)(iii) require that an average of the varying nighttime and daytime flow rates is to be used in determining the volume adjustment. Therefore, the ‘QB’ modifier is used when the average of the nighttime and daytime flow rates exceed 4 LPM and portable oxygen is prescribed.

In addition, please note that Section 1834(a)(5)(C) and (D) of the Act also applies to the ‘QB’ modifier. This section of the Act requires that, when the oxygen flow rate exceeds 4 LPM, the Medicare payment amount is to be: 1) The higher of 50 percent of the stationary payment amount (codes E0424, E0439, E1390, or E1391); or 2) The portable oxygen add-on amount (E0431, E0433, E0434, E1392 or K0738); and 3) Never both.

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

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

ADDITIONAL INFORMATION


DOCUMENT HISTORY

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<tr>
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</table>

Internet Only Manual Updates to Pub. 100-01, 100-02 and 100-04 to Correct Errors and Omissions

MLN Matters Number: MM10512
Related Change Request (CR) Number: CR10512
Related CR Release Date: March 16, 2018
Effective Date: June 19, 2018
Related CR Transmittal Number: R114GI, R242BP, and R4001CP
Implementation Date: June 19, 2018

PROVIDER TYPE AFFECTED

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

PROVIDER ACTION NEEDED

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

Make sure that your billing staff are aware of these changes. See the Background and Additional Information Sections of this article for further details regarding these changes.
BACKGROUND

CR10512 updates the Medicare manuals with regard to SNF policy to clarify the existing content. These changes are being made to correct various omissions and minor technical errors. No policy, processing or system changes are anticipated.

CR10512 Changes

*Medicare General Information, Eligibility and Entitlement Manual,* Chapter 4: Physician Certification and Recertification of Services

Pub 100-01, Chapter 4, §40.1
This section is revised by adding an appropriate cross-reference.

Pub 100-01, Chapter 4, §40.2
This section is revised by clarifying the discussion of the initial certification’s required content, and by adding an appropriate cross-reference.

Chapter 5: Medicare General Information, Eligibility, and Entitlement

Pub 100-01, Chapter 5, §30.2
This section is revised by updating the existing citation to the regulations at 42 CFR 483.75(n), in order to reflect their redesignation at 42 CFR 483.70(j) in the long-term care facility requirements reform final rule (81 FR 68831, October 4, 2016).

Pub 100-01, Chapter 5, §30.3
This section is revised by updating the existing citation to the regulations at 42 CFR 482.66, in order to reflect their redesignation at 42 CFR 482.58 in a final rule that was published on May 12, 2014 (79 FR 27155), and by adding an appropriate cross-reference.

*Medicare Benefit Policy Manual*  
Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance

Pub 100-02, Chapter 8, §20.2.3
This section is revised by modifying the language that describes the starting point of the applicable 30-day period, so that it more accurately tracks that of the corresponding statutory authority in §1861(i) of the Social Security Act and the implementing regulations at 42 CFR 409.36.

Pub 100-02, Chapter 8, §30.1
This section is revised by modifying the language so that it no longer pertains to only one particular type of case-mix model, and by adding a reference to the posting of the CMS-designated case-mix classifiers on the SNF PPS web site. These changes reflect similar revisions made in the corresponding regulations at 42 CFR 409.30 and 413.345 by the FY 2018 SNF PPS final rule (82 FR 35644-45, August 4, 2017).

Pub 100-02, Chapter 8, §40.1
This section is revised by updating the existing citation to the regulations at 42 CFR 483.40(e), in order to reflect their redesignation at 42 CFR 483.30(e) in the long-term care facility requirements reform final rule (81 FR 68829, October 4, 2016).

Pub 100-02, Chapter 8, §50.3
This section is revised to correct some cross-references, and to clarify the language describing the nonparticipating portion of the same institution that also includes a participating distinct part.

Pub 100-02, Chapter 8, §50.8.2
This section is revised to correct a cross-reference.

Pub 100-02, Chapter 8, §70.4
The first paragraph of this section is revised to clarify the scope of services for which SNFs can make arrangements with outside sources, and also by adding an appropriate cross-reference.
Medicare Claims Processing Manual
Chapter 1 - General Billing Requirements

Pub 100-04, Chapter 1, §30.1.1.1

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

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

Pub 100-04, Chapter 6, §10.1

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

Pub 100-04, Chapter 6, §10.4

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

Pub 100-04, Chapter 6, §20.1.2

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

Pub 100-04, Chapter 6, §20.2.1

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

Pub 100-04, Chapter 6, §20.3

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

Pub 100-04, Chapter 6, §20.3.1

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

Pub 100-04, Chapter 6, §40.3.3

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

Pub 100-04, Chapter 6, §40.3.4

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

Pub 100-04, Chapter 6, §40.3.5

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

Pub 100-04, Chapter 6, §40.3.5.2

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

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

Pub 100-04, Chapter 20, §10.2
In column A ("Conditions"), a cross-reference in item 2 is corrected, and in column B ("Review Action"), the next-to-last paragraph in item 2 is revised to clarify the language describing the nonparticipating portion of the same institution that also includes a participating distinct part.

**Chapter 30 - Financial Liability Protections**

Pub 100-04, Chapter 30, §130.3

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

Pub 100-04, Chapter 30, §130.4

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

**ADDITIONAL INFORMATION**

The official instruction, CR10512, issued to your MAC regarding this change consists of the following three transmittals:


**DOCUMENT HISTORY**

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<tr>
<th>Date of Change</th>
<th>Description</th>
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<tbody>
<tr>
<td>March 16, 2018</td>
<td>Initial article released.</td>
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</tbody>
</table>

**I/OCE Specifications Version 19.1 - April 2018 - Revised**

MLN Matters Number: MM10514 Revised
Related Change Request (CR) Number: 10514
Related CR Release Date: March 21, 2018
Effective Date: April 1, 2018
Related CR Transmittal Number: R4006CP
Implementation Date: April 2, 2018

This article was revised on March 22, 2018, to reflect an updated Change request (CR) that updated the status indicator for the drug code J0606 from SI=G to SI=K in the CR attachments. All other information remains the same.

**PROVIDER TYPES 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**

CR 10514 provides the Integrated Outpatient Code Editor (I/OCE) instructions and specifications for the I/OCE that will be used in the Outpatient Prospective Payment System (OPPS) and non-OPPS for hospital inpatient departments, Community Mental Health Centers (CMHCs), all non-OPPS providers, and for limited services when provided in a home health agency not under the Home Health Prospective Payment System (HH PPS) or to a hospice patient for the treatment of a non-terminal illness. Make sure your billing staffs are aware of these updates.
BACKGROUND

CR10514 informs the MACs, including the Home Health and Hospice (HH&H MAC) and the Fiscal Intermediary Shared System (FISS), that the I/OCE is being updated for April 1, 2018. The I/OCE routes all institutional outpatient claims (which includes non-OPPS hospital claims) through a single integrated OCE. The I/OCE specifications are available at [http://www.cms.gov/OutpatientCodeEdit/](http://www.cms.gov/OutpatientCodeEdit/).

The following table summarizes the modifications of the I/OCE for the April 2018 V19.1 update. Readers should also read through the entire CR10514 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>Modifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/1/2018</td>
<td></td>
<td>Update the program to remove the logic that assigns HCPCS level modifier V3 to the line level output for OPPS claims submitted with drug HCPCS lines with Status Indicator (SI) = K that are reported with modifier JG.</td>
</tr>
<tr>
<td>4/1/2018</td>
<td>72</td>
<td>Implement program logic to bypass edit 72 when a HCPCS is present from a specified list for Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) claims (see quarterly data files for HCPCS subject to edit 72 bypass).</td>
</tr>
<tr>
<td>4/1/2018</td>
<td>104</td>
<td>Implement new edit 104: Service not eligible for all-inclusive rate (LIR). Edit criteria: RHC claim with bill type 71x contains a line reported with modifier CG that is not eligible for the RHC all-inclusive rate.</td>
</tr>
<tr>
<td>7/1/2017</td>
<td>105</td>
<td>Implement new edit 105: Claim reported with pass-through device prior to FDA approval for procedure (LID). Edit criteria: A procedure is reported with a pass-through device prior to the FDA approval date for the procedure paired with the device. The line item denial is returned on the device line.</td>
</tr>
<tr>
<td>4/1/2018</td>
<td>106</td>
<td>Implement new edit 106: Add-on code reported without required primary procedure code (LID). Edit criteria: A Type I add-on code is reported on a non-OPPS claim without any of its defined primary codes. The disposition is set to line item denial and is applied to the line with the add-on code.</td>
</tr>
<tr>
<td>4/1/2018</td>
<td>107</td>
<td>Implement new edit 107: Add-on code reported without required contractor-defined primary procedure code (LID). Edit criteria: A Type II add-on code is reported on a non-OPPS claim without any primary code from the contractor-defined list. The disposition is set to line item denial and is applied to the line with the add-on code.</td>
</tr>
<tr>
<td>4/1/2018</td>
<td>108</td>
<td>Implement new edit 108: Add-on code reported without required primary procedure or without required contractor-defined primary procedure code (LID). Edit criteria: A Type III add-on code is reported on a non-OPPS claim without any of its defined primary codes, or without any of the primary codes from the contractor-defined list. The disposition is set to line item denial and is applied to the line with the add-on code.</td>
</tr>
<tr>
<td>4/1/2018</td>
<td>22</td>
<td>Add the following new modifiers to the valid modifier list: VM: Mdpp virtual make-up session QA: Avg sta day/night o2 &lt; 1 lpm QB: Avg day/nite o2 &gt; 4 lpm/port QR: Avg sta day/night o2 &gt; 4 lpm</td>
</tr>
<tr>
<td>Date</td>
<td>Change Number</td>
<td>Description</td>
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<tr>
<td>4/1/2018</td>
<td>94, 103</td>
<td>Update the program logic to deactivate edits 94 and 103 associated with the reporting of biosimilar HCPCS codes with manufacturer modifier. Note: biosimilar manufacturer modifiers ZA, ZB and ZC are deleted.</td>
</tr>
<tr>
<td>4/1/2018</td>
<td></td>
<td>Update Section 6.1 of documentation (Medical Visit Processing) to include additional examples of conditions for claims containing multiple medical visits. Note: no change to logic.</td>
</tr>
<tr>
<td>4/1/2018</td>
<td></td>
<td>Update Section 6.12 of documentation (Special Processing for Drugs and Biologicals) by removing the paragraph regarding the assignment of the HCPCS level modifier, V3 for HCPCS with SI = K.</td>
</tr>
<tr>
<td>4/1/2018</td>
<td></td>
<td>Update the following lists for the release (see quarterly data files): HCPCS modifier list Biosimilar HCPCS list Complexity-adjusted comprehensive Ambulatory Payment Classification (APC) code pairs Skin substitute products (edit 87) Device offset code pairs (Mid-Quarter effective date 8/25/2017) Add on Type I (new code list for edit 106) Add on Type II (new code list for edit 107) Add on Type III (new code list for edit 108) FQHC/RHC bypass edit 72 (new code list) RHC CG modifier not payable list (new code List) Services not recognized under OPPS (edit 62) Services reportable to DMERC (edit 61) Services not billable to the MAC (edit 72)</td>
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<tr>
<td>4/1/2018</td>
<td></td>
<td>Make all HCPCS/APC/SI changes as specified by CMS (quarterly data files)</td>
</tr>
<tr>
<td>4/1/2018</td>
<td>20, 40</td>
<td>Implement version 24.1 of the National Correct Coding Initiative (NCCI) (as modified for applicable outpatient institutional providers).</td>
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</tbody>
</table>

**ADDITIONAL INFORMATION**


**DOCUMENT HISTORY**

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<th>Date of Change</th>
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<tr>
<td>March 22, 2018</td>
<td>This article was revised to reflect an updated CR that updated the status indicator for the drug code J0606 from SI=G to SI=K in the attachments. All other information remains the same.</td>
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<tr>
<td>March 2, 2018</td>
<td>Initial article released.</td>
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Claims Processing Actions to Implement Certain Provisions of the Bipartisan Budget Act of 2018

MLN Matters Number: MM10531
Related Change Request (CR) Number: 10531
Related CR Release Date: March 20, 2018
Effective Date: January 1, 2018
Related CR Transmittal Number: R2047OTN
Implementation Date: April 2, 2018 – date to begin reprocessing claims

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

WHAT YOU NEED TO KNOW
Change Request (CR) 10531 provides direction to MACs to reprocess claims related to several provisions of the Bipartisan Budget Act of 2018, referred to as Medicare Extenders. Specifically, the CR provides guidance to MACs regarding Medicare Fee For Service (FFS) claims reprocessing requirements and timeframes. Make sure your billing staffs are aware of these changes.

BACKGROUND
On February 9, 2018, Congress passed the Bipartisan Budget Act of 2018 which contains a number of provisions that extend certain Medicare FFS policies, including Ambulance add-on payment provisions, the Work Government Practice Cost Index (GPCI) Floor, and the three percent Home Health (HH) Rural Add-on Payment. In addition, the Act permanently repeals the outpatient therapy caps beginning on January 1, 2018, while retaining the requirement to submit the KX modifier for services in excess of the prior cap amounts. Due to the retroactive effective dates of these provisions, your MAC will reprocess various Medicare FFS claims impacted by this legislation.

As a result of the Work GPCI floor changes, certain Federally Qualified Health Center (FQHC) Geographic Adjustment Factors (GAFs) will change, which may result in a change to some FQHC payments. For Inpatient Prospective Payment System (IPPS) hospitals, temporary changes to the low-volume hospital payment adjustment and the Medicare-Dependent Hospital (MDH) program have been extended. In addition, for the Long-Term Care Hospital Prospective Payment (LTCH PPS), the blended payment rate for site neutral payment rate cases is extended for certain LTCH hospital discharges. Separate instructions addressing these payment updates are forthcoming.

As stipulated in Section 421(a) of the MMA, the 3 percent rural add-on is applied to the national, standardized episode rate, national per-visit payment rates, Low-Utilization Payment Adjustment (LUPA) add-on payments, and the Non-Routine Supplies (NRS) conversion factor when home health services are provided in rural (non-CBSA) areas for episodes and visits ending on or after April 1, 2010, and before January 1, 2019. Refer to Tables 1 through 4 of the attachment to CR10531 for the Calendar Year (CY)

Section 1848(e)(1)(E) of the Social Security Act stipulates that after calculating the work geographic index for purposes of MPFS payment for services furnished, the Secretary shall increase the work geographic index to 1.00 for any locality for which such work geographic index is less than 1.00. This provision expired on December 31, 2017, and the locality-specific anesthesia conversion factors for CY 2018 were calculated without this work geographic index floor of 1.00 in place.

Section 50201 of the Bipartisan Budget Act of 2018 restored the work geographic index floor of 1.00 and retroactively dated this restoration to January 1, 2018. In accordance with the law, CMS has updated the locality-specific anesthesia conversion factors for CY 2018 to include the work geographic index floor of 1.00. These updated locality-specific anesthesia conversion factors also have a retroactive effective date of January 1, 2018.

CR10531 reminds the MACs to be aware that Section 1848(b)(4) of the Social Security Act limits MPFS payment for the technical portion of most imaging procedures to the amount paid under the Outpatient Prospective Payment System (OPPS) system. This policy applies to the technical component (and technical portion of global payment) of imaging services, including X-ray, ultrasound, nuclear medicine, MRI, CT, and fluoroscopy services. The MPFS payment rates for some of these services does not reflect the most recent updates to the OPPS rates that were updated in December of 2017. CMS corrected these rates in new MPFS files and informed the MACs of the corrections on February 12, 2018. These MPFS files also contain the updates for the GPCI. This correction is unrelated to the passage of this Act, but CMS is taking the opportunity to address this issue now since new MPFS files are required as a result of the Act.

The instructions to the MACs to reprocess claims contain the following specifics:

- The MACs will reprocess therapy claims with the KX modifier containing Dates of Service in Calendar Year 2018, which were denied prior to the implementation of the updated legislative effective dates issued on January 25, 2018. NOTE: For institutional claims, these claims will include revenue codes 042x, 043x, or 044x and modifiers GN, GO, or GP.
- The MACs will reprocess therapy claims with the KX modifier which were denied due to an invalid date provided by CMS on February 12, 2018.
- The MACs will reprocess 2018 therapy claims which cannot be automatically reprocessed only if you bring such claims to the attention of your MAC.
- The MACs reprocess MPFS claims for localities and States impacted by the Work GPCI Floor fee increase for Dates of Service in CY 2018. Please refer to the chart in Attachment A - Localities and States Impacted by the Work GPCI Floor – 2018 – in CR10531.
- The MACs will reprocess 2018 MPFS claims for localities and States impacted by the Work GPCI Floor fee increase for Dates of Service in CY 2018 which cannot be automatically reprocessed only if you bring such claims to your MAC’s attention. Please refer to the chart in Attachment A - Localities and States Impacted by the Work GPCI Floor – 2018.
- The MACs will reprocess ground AFS claims using the revised 2018 AFS file for Dates of Service in Calendar Year 2018.
- The MACs will reprocess claims which cannot be automatically reprocessed only if you bring such claims to your MAC’s attention.
- MACs will reprocess home health claims with the following criteria:
  - Type of Bill 32X
  - Claim “Through” dates on or after January 1, 2018
  - Value code 61 amounts in the range 999xx
  - Receipt dates prior to the installation of the revised home health Pricer, which reflects the extension of the 3% rural add-on for CY 2018.
  - MACs will automatically reprocess claims impacted by the OPPS cap for Dates of Service in Calendar Year 2018. The MACs will reprocess claims which cannot be automatically reprocessed only if you bring such claims to your MAC’s attention.
• The MACs will automatically reprocess anesthesia claims for localities and States impacted by the Work GPCI Floor fee increase for Dates of Service in CY 2018. Please refer to the chart in Attachment A - Localities and States Impacted by the Work GPCI Floor – 2018. The MACs will reprocess claims which cannot be automatically reprocessed only if you bring such claims to your MAC’s attention.

• MACs shall ensure all reprocessing actions have been initiated within 6 months of the issuance of CR10531:
  • For therapy and MPFS adjustments
  • For ground ambulance service claims with a date of service on or after 1/1/2018
  • For OPPS adjustments
  • For anesthesia adjustments

• MACs shall ensure all reprocessing actions have been initiated within 6 months of the implementation date of the Pricer for HH rural add-on adjustments.

ADDITIONAL INFORMATION


DOCUMENT HISTORY

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<td>March 26, 2018</td>
<td>Initial article released.</td>
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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. If you have questions or need help obtaining your report, visit the Help Desk. Send us your feedback or suggestions.

Prohibition on Billing Dually Eligible Individuals Enrolled in the QMB Program – Eighth Revision

MLN Matters Number: SE1128 Revised
Related CR Release Date: March 22, 2018

This article was revised on March 22, 2018 to include updated information about the Remittance Advice (RA) and Medicare Summary Notice (MSN) for all Medicare Fee-For-Service (FFS) QMB claims. It also includes new statistics on the number of beneficiaries enrolled in QMB. All other information remains the same.

PROVIDER TYPE AFFECTED

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

PROVIDER ACTION NEEDED

This Special Edition MLN Matters® Article from the Centers for Medicare & Medicaid Services (CMS) reminds all Medicare providers and suppliers, including pharmacies, that they may not bill beneficiaries enrolled in the QMB program for Medicare cost-sharing. Medicare beneficiaries enrolled in the QMB

FYI
program have no legal obligation to pay Medicare Part A or Part B deductibles, coinsurance, or copays for any Medicare-covered items and services.

Implement key measures to ensure compliance with QMB billing requirements. Use HIPAA Eligibility Transaction System (HETS) (effective November 2017), CMS’ eligibility-verification system, and the provider RA (July 2018) to identify beneficiaries’ QMB status and exemption from cost-sharing prior to billing. Starting July 2018, look for QMB alerts messages in the Remittance Advice for FFS claims to verify QMB after claims processing. Refer to the Background and Additional Information Sections below for further details and important steps to promote compliance.

BACKGROUND

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

Billing of QMBs Is Prohibited by Federal Law

Federal law bars Medicare providers and suppliers from billing an individual enrolled in the QMB program for Medicare Part A and Part B cost-sharing under any circumstances (see Sections 1902(n)(3)(B), 1902(n)(3)(C), 1905(c)(3), 1906(a)(1)(A), and 1848(g)(3)(A) of the Social Security Act [the Act]). The QMB program is a State Medicaid benefit that assists low-income Medicare beneficiaries with Medicare Part A and Part B premiums and cost-sharing, including deductibles, coinsurance, and copays. In 2016, 7.5 million individuals (more than one out of eight beneficiaries) were enrolled in the QMB program.

Providers and suppliers may bill State Medicaid agencies for Medicare cost-sharing amounts. However, as permitted by Federal law, States can limit Medicare cost-sharing payments, under certain circumstances. Regardless, persons enrolled in the QMB program have no legal liability to pay Medicare providers for Medicare Part A or Part B cost-sharing. Medicare providers who do not follow these billing prohibitions are violating their Medicare Provider Agreement and may be subject to sanctions (see Sections 1902(n)(3)(C), 1905(c)(3), 1906(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, providers and suppliers continue to improperly bill individuals enrolled in the QMB program. Many beneficiaries are unaware of the billing restrictions (or concerned about undermining provider relationships) and simply pay the cost-sharing amounts. Others may experience undue distress when unpaid bills are referred to collection agencies. For more information, refer to Access to Care Issues Among Qualified Medicare Beneficiaries (QMB), Centers for Medicare & Medicaid Services July 2015.

Ways to Promote Compliance with QMB Billing Rules

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

1. Establish processes to routinely identify the QMB status of Medicare beneficiaries prior to billing for items and services.

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

- In July 2018, CMS will reintroduce QMB information in the Medicare RA that Original Medicare providers and suppliers can use to identify the QMB status of beneficiaries. Refer to the Additional
Information section below for educational materials on recent changes that impact RAs for Medicare FFS QMB claims.

- MA providers and suppliers should also contact the MA plan to learn the best way to identify the QMB status of plan members both before and after claims submission.

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

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

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

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

**Important Reminders Concerning QMB Billing Requirements**

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

1. All Original Medicare and MA providers and suppliers—not only those that accept Medicaid—must not charge individuals enrolled in the QMB program for Medicare cost-sharing.

2. Individuals enrolled in the QMB program keep their protection from billing when they cross State lines to receive care. Providers and suppliers cannot charge individuals enrolled in QMB even if their QMB benefit is from a different State than the State where they get care.

3. Note that individuals enrolled in QMB cannot elect to pay Medicare deductibles, coinsurance, and copays. However, a QMB who also receives full Medicaid may have a small Medicaid copay.

**ADDITIONAL INFORMATION**

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

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

- **MLN Matters Article MM9911**, discusses the claims processing system modifications implemented on October 2, 2017, to generate QMB information in the RAs and MSNs.

On December 8, 2017, the claims processing system modifications made on October 2, 2017, were temporarily suspended due to unintended issues that affected processing QMB cost-sharing claims by States and other payers secondary to Medicare. For more information, refer to **QMB Remittance Advice Issue**.

- **MLN Matters Article 10494** describes how Medicare Administrative Contractors (MACs) will issue replacement RAs for QMB claims paid on or after October 2, 2017, through December 31, 2017, that have not been voided or replaced. MACs will issue replacement RAs by December 20, 2018, for Part B claims and by September 20, 2018, for Part A/Durable Medical Equipment claims.

- **MLN Matters Article MM10433** discusses how CMS will reintroduce QMB information in the RA starting July 2018 and modify to CR 9911 to avoid disrupting claims processing by secondary payers.

## DOCUMENT HISTORY

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<tr>
<td>March 22, 2018</td>
<td>The article was revised to indicate that CMS will reintroduce QMB information in the Medicare Remittance Advice (RA) and Medicare Summary Notice (MSN) for all claims processed on or after July 2, 2018. CMS initially included QMB information in RAs and MSNs for claims processed on or after October 2, 2017, but suspended those changes on December 8, 2017, to address unforeseen issues preventing the processing of QMB cost-sharing claims by States and other secondary payers outside of the Coordination of Benefits Agreement (COBA) process. All other information remains the same.</td>
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<tr>
<td>December 4, 2017</td>
<td>The 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.</td>
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<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>
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<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>
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<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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<tr>
<td>January 12, 2017</td>
<td>This article was revised to add a reference to MLN Matters article MM9817, which instructs Medicare Administrative Contractors to issue a compliance letter instructing named providers to refund any erroneous charges and recall any existing billing to QMBs for Medicare cost sharing.</td>
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<tr>
<td>February 4, 2016</td>
<td>The article was revised on February 4, 2016, to include updated information for 2016 and a correction to the second sentence in paragraph 2 under Important Clarifications Concerning QMB Balance Billing Law on page 3.</td>
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<tr>
<td>February 1, 2016</td>
<td>The article was revised to include updated information for 2016 and a clarifying note regarding eligibility criteria in the table on page 4.</td>
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<tr>
<td>March 28, 2014</td>
<td>The article was revised on to change the name of the Coordination of Benefits Contractor (COBC) to BCRC.</td>
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Repetitive Scheduled Non-emergent Ambulance Prior Authorization Model Overview – Revised

MLN Matters® Number: SE1514 Revised

This article was revised on February 14, 2018, to provide updated information. The updates include:
1) Adding ambulance transports in Jurisdiction L: Delaware, the District of Columbia, Maryland, and Jurisdiction M: North Carolina, Virginia, or West Virginia, effective for transports on or after January 1, 2016; 2) Updating the PCS and Documentation that Facilitates an Affirmative Decision Section; 3) Updating the Medical Documentation Section; 4) Updating the Medical Documentation and adding resources in the Additional Information Section. While the updates are annotated in bold, please review the article carefully for the changes.

Provider Types Affected

This Special Edition (SE) MLN Matters® article is intended for independently enrolled Medicare ambulance suppliers who (1) provide repetitive scheduled non-emergent ambulance transports for Medicare Fee-For-Service beneficiaries, (2) are garaged in Delaware, the District of Columbia, Maryland, New Jersey, North Carolina, Pennsylvania, South Carolina, Virginia, or West Virginia and (3) submit claims to Medicare Administrative Contractors (MACs) for ambulance services provided to Medicare beneficiaries.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) began a 3-year prior authorization model for repetitive scheduled non-emergent ambulance transports in the states of New Jersey, Pennsylvania, and South Carolina on December 1, 2014, for transports on or after December 15, 2014, regardless of the origin or destination of the transport. Six additional areas were included in the model – Delaware, the District of Columbia, Maryland, North Carolina, Virginia, and West Virginia – on December 15, 2015, for transports on or after January 1, 2016.

The model was later extended in the current model states for an additional year to allow for additional evaluation of the model. The model is currently scheduled to end in all states on December 1, 2018.

CMS is issuing this Special Edition (SE) 1514 solely as an educational guide to improve compliance with documentation requirements for the repetitive scheduled non-emergent ambulance prior authorization model. SE1514 presents useful information that will help suppliers receive provisional affirmed decisions for prior authorization requests submitted for beneficiaries that meet coverage and medical necessity requirements.

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

Background

Medicare covers ambulance services, including air ambulance (fixed wing and rotary wing) services, when furnished to a beneficiary whose medical condition is such that other means of transportation are contraindicated. The Medicare ambulance benefit for non-emergent transports is very limited and designed only for beneficiaries who are clinically unable to be transported by other means. Non-emergent transportation by ambulance is appropriate if either:

• The beneficiary is bed-confined and it is documented that the beneficiary’s condition is such that other methods of transportation are contraindicated; or
• The beneficiary’s medical condition, regardless of bed confinement, is such that transportation by ambulance is medically required.

Therefore, bed confinement is not the sole criterion in determining the medical necessity of non-emergent ambulance transportation; rather, it is one factor that is considered in medical necessity determinations (See 42 CFR 410.40(d)(1)).

A repetitive ambulance service is defined as medically necessary ambulance transportation that is furnished in 3 or more round trips (or six one way trips) within a 10-day period, or at least once per week for at least 3 weeks.
Repetitive transportation services are often needed by beneficiaries receiving dialysis, covered wound care, treatment interventions or cancer treatment. For wound care, it is anticipated that wound care is managed in the home and requires only periodic clinic appointments for:

- Debridement
- Wound management or
- Infection types of services.

In any case in which some means of transportation other than an ambulance could be used without endangering the individual’s health (whether or not such other transportation is actually available), no payment may be made for ambulance services. In addition, the reason for the ambulance transport must be medically necessary. That is, the transport must be to obtain a Medicare covered service **at a covered destination**, or to return from such a service.

Medicare may cover repetitive, scheduled, non-emergent transportation by ambulance if:

- The medical necessity requirements described previously are met (that is, bed confinement or medically required); and
- The ambulance provider/supplier, before furnishing the service to the beneficiary, obtains a written order from the beneficiary’s attending physician certifying that the medical necessity requirements are met.

Note: Per 42 CFR §410.40(d)(2), the physician’s order must be dated no earlier than 60 days before the date the service is furnished (See 42 CFR 410.40(d)(2)). The written order is often referred to as a Physician Certification Statement (PCS).

In addition to the medical necessity requirements, the service must meet all other Medicare coverage and payment requirements, including requirements relating to the origin and destination of the transportation, vehicle and staff, and billing and reporting. Additional information about Medicare coverage of ambulance services and requirements for ambulance suppliers can be found in 42 CFR 410.40 and 42 CFR 410.41 and in the "Medicare Benefit Policy Manual”, Chapter 10.

Under this model, an ambulance supplier or beneficiary is encouraged to submit to their MAC a request for prior authorization along with all relevant documentation to support Medicare coverage of a repetitive scheduled non-emergent ambulance transport.

Note that prior authorization does not create new clinical documentation requirements. Instead, it requires the same information necessary to support Medicare payment, just earlier in the process.

Prior authorization allows ambulance suppliers to address issues with claims prior to rendering services and to avoid an appeal process. This will help ensure that all relevant coverage, coding, and clinical documentation requirements are met before the service is rendered to the beneficiary and before the claim is submitted for payment.

Submitting a prior authorization request is voluntary. However, if prior authorization has not been requested by the fourth round trip, the claims will be stopped for pre-payment review. After receipt of all relevant documentation, the MAC will make every effort to conduct a review and postmark (or fax if a fax number is provided) the notification of their decision on a prior authorization request within 10 business days for an initial submission.

PCS and Documentation that Facilitates an Affirmative Decision

In order to be provisionally affirmed, the request for prior authorization must meet all applicable rules and policies, and any applicable Local Coverage Determination (LCD) requirements for ambulance transport claims.

- Make sure the PCS is completed for the particular beneficiary and must not be more than 60 days prior to the requested start date. Only conditions specific for the beneficiary should be noted and all applicable comments should concern the beneficiary’s current condition.

- **Make sure the PCS and documentation submitted is signed with a legible signature and/or there is a signature log for the clinician’s signature.**

- Make sure the relevant documentation sent with the prior authorization request provides a clear description of the beneficiary’s current condition requiring ambulance transport. The
documentation should support the beneficiary’s condition at the time of transport and be dated prior to the requested start date of transports. This information must be from a clinician who provided service to the beneficiary, not the ambulance supplier.

The top reasons for non-affirmations are as follows:

- A PCS was not submitted, was not signed, was missing credentials, was incomplete or was more than 60 days prior to the requested start date.
- Medical documentation was not submitted with the PCS.
- Medical documentation submitted did not support what was included on the PCS.
- Medical documentation submitted did not support the beneficiary’s condition at the requested time of transport, did not include the beneficiary’s name, or in some cases, was not legible.

Key Items to be Addressed

1. PCS
   - The PCS must be signed and dated by the beneficiary’s attending physician the date it is completed.
   - The signature, credentials, and date must be readable.
   - The prefix “Dr.” is a title and not a credential.
   - Stamped signatures or file signatures are not acceptable.
   - The PCS cannot be dated more than 60 days in advance of the requested start date.
   - The PCS information must be verifiable.
   - Medical documentation must be attached that supports the PCS and that describes the beneficiary’s condition(s) that necessitate(s) the type and level of ambulance transports.
   - A signed and dated PCS does not, by itself, demonstrate that the repetitive scheduled transports are medically necessary.

2. Medical Documentation
   - Medical documentation should provide sufficient information to support the prior authorization request form and the PCS.
   - Documentation should:
     - Reveal the medical necessity of the type and level of transport services.
     - Reveal the exact origin address and destination address.
     - Specify the beneficiary, provider and date of service.
     - Capture the “what” and “why” of a beneficiary’s condition(s) that necessitate(s) the transports.
     - Support the diagnoses or the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) code(s) on the PCS with clinical assessment data and objective findings.
     - Be readable and support the beneficiary’s condition at the time of transport and be dated prior to the requested start date of the transports. While a beneficiary may present with chronic conditions that do not change, recent medical documentation must be available to indicate chronic or progressively worsening needs.
   - Documentation can include, but is not limited to:
     - Doctor’s progress notes,
     - Nursing notes,
     - History and Physical Exam,
     - Physical or occupational therapy notes,
     - Home health care notes, and
     - End stage renal disease (ESRD) monthly capitation payment provider notes.
For admission and discharge summaries for a condition itemized on the PCS, the documentation must contain statements that capture the “what” and the “why” (for example, if a beneficiary’s condition is bed-confined, documentation must indicate why the beneficiary is bed-confined).

The documentation should not contradict the PCS (for example, beneficiary is indicated as bed-confined on PCS, however, medical records document the beneficiary uses a wheelchair).

Example of Documentation that Identifies the “What” and the “Why”

Included in the Progress Note:

Patient is an 80 year old white male with a history of ESRD being treated with hemo-dialysis at ABC Dialysis Center. Wegener’s Disease, Atrial Fibrillation, severe osteoporosis, and Spinal Stenosis all treated by Dr. Smith. Recently, patient has had “bouts” of pneumonia. Patient has extremely fragile bones, to the point that any lifting of the patient even with a “Hoyer Lift” can and has resulted in dislocations and fractures. Patient has bilateral elbow flexion of 30 degrees, reduced plantar strength with a max of 1 out of 5 bilaterally and 0 degree max hip flexion bilaterally. Bilateral knee flexion is 0 degree. Patient is Alert and Oriented x4 at baseline with a GCS of 15.

Patient requires assistance in the areas of bathing, dressing, toileting and cleaning himself, transferring, unable to get up from bed, and feeding. Patient does not exercise any control over urination and defecation.

Patient is completely bed-confined. Due to contractures, weakness, and over deconditioning, patient is unable to ambulate, sit or stand. Based on the physical assessment and the physical limitations noted, the patient is on fall precautions from bed.

This patient requires stretcher for transport due to non-weight bearing, non-ambulatory, bed confined status, and patient cannot support himself for any amount of time. Monitoring is required to prevent injury or fall from stretcher.

Note: For those in Jurisdiction J-L, you may want to review Local Coverage Determination (LCD) L35162 published by the MAC, Novitas Solutions, Inc.

Methods for Sending a Prior Authorization Request Package to Your MAC

Submitters have four options for submitting prior authorization requests to their MAC:

- Fax,
- Mail,
- MAC Provider Portal, or

- Electronic Submission of Medical Documentation (esMD).

For more information about esMD, see http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/ESMD/index.html on the CMS website, or contact your MAC.

Addresses and Fax Numbers of the MACs

1. For ambulance suppliers in Jurisdiction J-L, send requests to the MAC Novitas Solutions, Inc. at:

   - Fax Number: 1-877-439-5479
   - Mailing Address:
     Novitas Solutions
     Part B Prior Authorization Request
     PO Box 3702
     Mechanicsburg, PA 17055
     OR
     Novitas Solutions
     Attention: Part B Prior Authorization Request
     2020 Technology Parkway, Suite 100
Mechanicsburg, PA 17050

- Electronic Submission of Medical Documentation (esMD): (indicate content type “81”)

2. For ambulance suppliers in Jurisdiction J-M, send requests to the MAC Palmetto GBA at:
   - Fax Number: 803-462-2702
   - Mailing Address:
     Palmetto GBA – JM MAC Prior Authorization
     PO Box 100212
     Columbia, SC, 29202-3212
   - Electronic Submission of Medical Documentation (esMD): (indicate content type “81”)

**Additional Information**

You may want to review the following educational materials on the CMS Prior Authorization Website at [http://go.cms.gov/PAAmbulance](http://go.cms.gov/PAAmbulance):

- Ambulance Prior Authorization Frequently Asked Questions (FAQs),
- Ambulance Prior Authorization Operational Guide,
- Physician/Practitioner Letter that ambulance suppliers can share with physicians and other entities to help obtain the necessary documentation in a timely manner, and
- Links to the participating MACs’ Ambulance Prior Authorization websites.

Questions can also be sent to the following CMS email address: AmbulancePA@cms.hhs.gov.

**DOCUMENT HISTORY**

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<td>February 14, 2018</td>
<td>This article was revised to provide updated information. The updates include: 1) Adding ambulance transports in Jurisdiction L: Delaware, the District of Columbia, Maryland, and Jurisdiction M: North Carolina, Virginia, or West Virginia, effective for transports on or after January 1, 2016; 2) Updating the PCS and Documentation that Facilitates an Affirmative Decision Section; 3) Updating the Medical Documentation Section; 4) Updating the Medical Documentation and adding resources in the Additional Information Section. <strong>While the updates are annotated in bold, please review the article carefully for the changes.</strong></td>
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<td>May 4, 2015</td>
<td>Initial article released</td>
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**Next Generation Accountable Care Organization – Implementation – Revised**

MLN Matters® Number: SE1613 Revised

Article Release Date: January 23, 2018

Effective Date: January 1, 2016

Implementation Date: January 1, 2016

This article was revised on January 23, 2018, to revise the “Telehealth Expansion” portion of the article and to add Attachment A to the article.

**Provider Types Affected**

This MLN Matters® Article is intended for providers who are participating in Next Generation Accountable Care Organizations (NGACOs) and submitting claims to Medicare Administrative Contractors (MACs) for certain skilled nursing facility, telehealth, and post-discharge home visit services to Medicare beneficiaries that would not otherwise be covered by Original fee-for-service (FFS) Medicare.
Provider Action Needed
This MLN Matters Special Edition Article provides information on the NGACO Model’s benefit enhancement waiver initiatives and supplemental claims processing direction. Make sure that your billing staffs are aware of these changes.

Background
The Centers for Medicare & Medicaid Services (CMS) implemented the Next Generation ACO Model (NGACO or the Model) on January 1, 2016. The Model is the first in the next generation of ACO provider-based models that tests opportunities for increased innovation around care coordination and management through greater accountability for the total cost of care.

The aim of the Model is to improve the quality of care, population health outcomes, and patient experience for the beneficiaries who choose traditional Medicare FFS through greater alignment of financial incentives and greater access to tools that may aid beneficiaries and providers in achieving better health at lower costs.

Core principles of the Model are:
• Protecting Medicare FFS beneficiaries’ freedom to seek the services and providers of their choice
• Creating a financial model with long-term sustainability
• Utilizing a prospectively set benchmark that:
  • Rewards quality
  • Rewards both attainment of and improvement in efficiency, and
  • Ultimately transitions away from updating benchmarks based on the ACO’s recent expenditures
• Engaging beneficiaries in their care through benefit enhancements that directly improve the patient experience and incentivize coordinated care from ACOs
• Mitigating fluctuations in aligned beneficiary populations and respecting beneficiary preferences through supplementing a prospective claims-based alignment process with a voluntary process, and
• Smoothing ACO cash flow and improving investment capabilities through alternative payment mechanisms.

Additional information on NGACO is available at https://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/.

Participants and Preferred Providers
NGACO defines two categories of providers/suppliers and their respective relationships to the ACO entity: Next Generation Participants and Next Generation Preferred Providers. Next Generation Participants are the core providers/suppliers in the Model. Beneficiaries are aligned to the ACO through the Next Generation Participants and these providers/suppliers are responsible for, among other things, reporting quality through the ACO and committing to beneficiary care improvement. Preferred Providers contribute to ACO goals by extending and facilitating valuable care relationships beyond the ACO. For example, Preferred Providers may participate in certain benefit enhancements. Services furnished by Preferred Providers will not be considered in alignment and Preferred Providers are not responsible for reporting quality through the ACO.
Table 5.1 Types of Providers/Suppliers and Associated Functions

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Alignment</th>
<th>Quality Reporting Through ACO</th>
<th>Eligible for ACO Shared Savings</th>
<th>PBP</th>
<th>All-Inclusive PBP</th>
<th>Coordinated Care Reward</th>
<th>Telehealth</th>
<th>3-Day SNF Rule</th>
<th>Post-Discharge Home Visit</th>
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<tr>
<td>Next Generation Participant</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td>X</td>
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<tr>
<td>Preferred Provider</td>
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This table is a simplified depiction of key design elements with respect to Next Generation Participant and Preferred Provider roles. It does not necessarily imply that this list is exhaustive with regards to possible ACO relationships and activities.

Three Benefit Enhancements

In order to emphasize high-value services and support the ability of ACOs to manage the care of beneficiaries, CMS uses the authority under section 1115A of the Social Security Act (section 3021 of the Affordable Care Act) to conditionally waive certain Medicare payment requirements as part of the NGACO Model. An ACO may choose not to implement all or any of these benefit enhancements.

3-Day SNF Rule Waiver

CMS makes available to qualified NGACOs a waiver of the 3-day inpatient stay requirement prior to admission to a SNF or acute-care hospital or Critical Access Hospital (CAH) with swing-bed approval for SNF services ("swing-bed hospital"). This benefit enhancement allows beneficiaries to be admitted to qualified Next Generation ACO SNF Participants and Preferred Providers either directly or with an inpatient stay of fewer than three days. The waiver will apply only to eligible aligned beneficiaries admitted to Next Generation ACO SNF Participants and Preferred Providers.

An aligned beneficiary will be eligible for admission in accordance with this waiver if:

• The beneficiary does not reside in a nursing home, SNF, or long-term nursing facility and receiving Medicaid at the time of the decision to admit to an SNF, and

• The beneficiary meets all other CMS criteria for SNF admission, including that the beneficiary must:
  • Be medically stable
  • Have confirmed diagnoses (for example, does not have conditions that require further testing for proper diagnosis)
  • Not require inpatient hospital evaluation or treatment; and
  • Have an identical skilled nursing or rehabilitation need that cannot be provided on an outpatient basis or through home health services.

NGACOs identify the SNF Participant and Preferred Providers with which they will partner in this waiver through the annual submission of Next Generation Participant and Preferred Provider lists.

Claims

Next Generation Model 3-day SNF rule waiver claims do not require a demo code to be manually affixed to the claim. When a qualifying stay does not exist, the Fiscal Intermediary Standard System (FISS) checks whether 1) the beneficiary is aligned to an NGACO approved to use the SNF 3-day rule waiver; 2) the SNF provider is also approved to use the waiver; and 3) the SNF is a provider for the same NGACO for which the beneficiary is aligned. Once eligibility is confirmed, demonstration code 74 (for the NGACO Model) and indicator value 4 (for the 3-day SNF rule waiver) is placed on the claim.
If an eligible NGACO SNF 3-day waiver claim includes demo code 62 (for the BPCI Model 2 SNF 3-day rule waiver), for example, the FISS will not check to validate whether the claim is a valid NGACO SNF 3-day rule waiver. CMS has instructed that FISS only validate when no demo code has been affixed and no qualifying 3-day inpatient hospital stay has been met.

To assist MACs in troubleshooting provider SNF 3-day rule waiver claim questions, CMS instructed the FISS and the Multi Carrier System (MCS) maintainers to create screens. The FISS maintainer created a Sub-menu of the 6Q – CMS Demonstrations Screen to allow for inquiry of both the NGACO Provider File Data and the NGACO Beneficiary File Data. The screen shows the following data value for this waiver: 3 Day SNF Waiver = Value 4. The MCS maintainer created two screens to allow for SNF 3-day rule waiver validation inquiry as listed:

- MCS created screen PROVIDER ACCOUNTABLE CARE ORGANIZATION (ACO) so that MACs would be able to see which ACO a provider is aligned with.
- MCS created screen BENEFICIARY ACCOUNTABLE CARE ORGANIZATION (ACO) so that MACs would be able to see which ACO a beneficiary is aligned with.

**Telehealth Expansion**

CMS makes available to qualified NGACOs a waiver of the requirement that beneficiaries be located in a rural area and at a specified type of originating site in order to be eligible to receive telehealth services. This benefit enhancement will allow payment of claims for telehealth services delivered by Next Generation ACO Participants or Preferred Providers to aligned beneficiaries in specified facilities or at their residence regardless of the geographic location of the beneficiary.

**Claims**

The telehealth services originating at the beneficiary’s home (in a rural or non-rural geographic setting) is billed under the Medicare Physician Fee Schedule (MPFS) with one of nine HCPCS G-codes used for the NGACO and Comprehensive Joint Replacement Models telehealth home visits, as listed in Attachment A. The telehealth home visit HCPCS codes are payable for beneficiaries beginning January 1, 2018. Claims submitted for telehealth home visits for the NGACO Model will be accepted when the claim contains one of nine of the NGACO specific HCPCS G-Code. CMS is associating the demonstration code 74 with the NGACO initiative. Additional information on billing and payment for the telehealth home visit HCPCS G-Codes are available in the MPFS. Future updates to the RVUs and payment for these HCPCS codes will be included in the MPFS final rules and recurring updates each year.

For those telehealth services originating in a non-rural area a provider does not need to insert a demonstration code in order for the claim to process successfully.

Notwithstanding these waivers, all telehealth services must be furnished in accordance with all other Medicare coverage and payment criteria, and no additional reimbursement will be made to cover set-up costs, technology purchases, training and education, or other related costs. In particular, the services allowed through telehealth are limited to those described under section 1834(m)(4)(F) of the Social Security Act and subsequent additional services specified through regulation.

**Post-Discharge Home Visits**

CMS makes available to qualified NGACOs waivers to allow “incident to” claims for home visits to non-homebound aligned beneficiaries by licensed clinicians under the general supervision—instead of direct supervision—of Next Generation Participants or Preferred Providers.

Auxiliary personnel, as defined in 42 C.F.R. § 410.26(a)(1), may be any employees, leased employees, or independent contractors who are licensed under applicable state law to perform the ordered services under physician (or other practitioner) supervision. A Participant or Preferred Provider may contract with licensed clinicians to provide this service and the service is billed by the Participant or Preferred Provider.

Claims for these visits will only be allowed following discharge from an inpatient facility (including, for example, inpatient prospective payment system (IPPS) hospitals, Critical Access Hospitals (CAHs), SNFs, Inpatient Rehabilitation Facilities (IRFs) and will be limited to no more than 9 visits in a 90 day period following discharge. Payment of claims for these visits will be allowed as services and supplies that are incident to the service of a physician or other practitioner as described under 42 CFR §410.26. This provision is not generally applicable to home visits; however, for purposes of this payment waiver, CMS intends to use the same definition of general supervision as outlined in this provision.
Claims

Post-discharge home visit service waiver claims must contain one of the following Evaluation and Management (E/M) Healthcare Common Procedure Coding System (HCPCS) codes:

- 99324-99337
- 99339-99340
- 99341-99350

Providers are not required to add a demonstration code to process these claims.

ADDITIONAL INFORMATION

Additional information about the Next Generation ACO Model is available at: https://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/.

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<td>January 23, 2018</td>
<td>Article revised to revise the telehealth expansion information and to add Attachment A.</td>
</tr>
<tr>
<td>November 7, 2017</td>
<td>Article revised to provide a link to MM10044 that provides instruction to MACs to implement two new benefit enhancements for performance year three (Calendar Year 2018) of the NGACO Model.</td>
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<tr>
<td>August 4, 2017</td>
<td>Initial article released</td>
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For Attachment A, see the complete CMS Medicare Learning Network (MLN) Matters (MM) Special Edition (SE)1613.

Therapy Claims with KX Modifier - Update

On January 25, 2018, CMS released instructions for processing therapy claims being held with the KX modifier with dates of receipt from January 1 through January 10, 2018.

As of January 31, 2018, these claims have been released for processing one day at a time based on the date the claim was received (first come, first processed). At this time, Noridian will hold all new therapy claims received with the KX modifier and implement a “rolling hold” of 20 days to help minimize the number of claims requiring reprocessing and the impact on beneficiaries if legislation regarding therapy caps is enacted.

Under current law, CMS may not pay electronic claims sooner than 14 calendar days (29 days for paper claims) after the date of receipt, but clean claims are generally paid within 30 days of receipt.
Low Volume Appeals Settlement

On February 5, 2018, CMS started accepting Expressions of Interest (EOIs) for its low volume appeals (LVA) settlement process. The LVA settlement option is for providers, physicians and suppliers (appellants) with fewer than 500 combined appeals pending at the Office of Medicare Hearings and Appeals (OMHA) and the Medicare Appeals Council (Council) at the Departmental Appeals Board, as of November 3, 2017, with a total billed amount of $9,000 or less per appeal.

EOIs will be accepted:

- February 5, 2018 through March 9, 2018 for appellants with NPIs ending in an even number (0, 2, 4, 6, 8)
- March 12, 2018 through April 11, 2018 for appellants with NPIs ending in an odd number (1, 3, 5, 7, 9)

If interested in participating in LVA to address pending appeals, visit CMS’ website at go.cms.gov/LVA.
Global Surgical Days for CAH Method II

MLN Matters Number: MM10425
Related Change Request (CR) Number: 10425
Related CR Release Date: January 26, 2018
Effective Date: July 1, 2018
Related CR Transmittal Number: R2013OTN
Implementation Date: July 2, 2018

PROVIDER TYPE AFFECTED
This MLN Matters® Article is intended for Critical Access Hospital (CAH) Method II providers submitting claims to A/B Medicare Administrative Contractors (A/B MACs) for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED
This article is based on Change Request (CR) 10425 which discusses the global surgical days for Method II Critical Access Hospital (CAH) providers. CR 10425 contains no new policy. It improves the implementation of existing Medicare payment policies. Make sure that your billing staffs are aware of these changes.

BACKGROUND
CR10425 is for the global surgical periods for Critical Access Hospital (CAH) Method II providers to mirror the logic historically applied to physicians and non-physician practitioners that bill their own services to Medicare’s Multi-Carrier System (MCS).

Physicians and non-physician practitioners billing on Type of Bill (TOB) 85X for professional services rendered in a Method II CAH have the option of reassigning their billing rights to the CAH. When the billing rights are reassigned to the Method II CAH, payment is made to the CAH for professional services (using revenue codes 96X, 97X, or 98X) based on the Medicare Physician Fee Schedule (MPFS) supplemental file.

The global surgical package, also called global surgery, includes all necessary services normally furnished by a surgeon before, during, and after a procedure. Medicare payment for the surgical procedure includes the pre-operative, intra-operative, and post-operative services routinely performed by the surgeon or by members of the same group with the same specialty.

Position 13-15 of the MPFS Data Base provides the postoperative periods that apply to each surgical procedure.

The payment rules for surgical procedures apply to codes with entries of 000, 010, 090, and, sometimes, YYY, and are defined below. This field provides the postoperative time frames that apply to payment for each surgical procedure or another indicator that describes the applicability of the global concept to the service.

• 000 = Endoscopic or minor procedure with related preoperative and postoperative relative values on the day of the procedure only included in the fee schedule payment amount; evaluation and management services on the day of the procedure generally not payable.
• 010 = Minor procedure with preoperative relative values on the day of the procedure and postoperative relative values during a 10-day postoperative period included in the fee schedule amount; evaluation and management services on the day of the procedure and during this 10-day postoperative period generally not payable.
• 090 = Major surgery with a (one) 1-day preoperative period and 90-day postoperative period included in the fee schedule payment amount.
• XXX = Global concept does not apply.
• YYY = A/B MAC (Part A) determines whether global concept applies and establishes postoperative period, if appropriate, at time of pricing.
Codes with “YYY” are A/B MAC (Part B)-priced codes, for which A/B MACs (Part B) determine the global period (the global period for these codes will be 0, 10, or 90 days). Note that not all A/B MAC (Part B)-priced codes have a “YYY” global surgical indicator; sometimes the global period is specified.

CAH Method II providers should follow the same guidelines as per Part B physician services that are available in the Medicare Claims Processing Manual (Pub. 100-04, Chapter 12; (Physicians/Nonphysician Practitioners), Section 40 (Surgeons and Global Surgery)).

Note that Medicare will reject line items that contain an E/M CPT code (92012, 92014, 99211-99215, 99217-99223, 99231-99236, 99238, 99239, 99241-99245, 99251-99255, 99261-99263, 99271-99275, 99291, 99292, 99301-99303, 99315, 99316, 99331-99333, 99347-99350, 99374, 99375, 99377, and 99378) that is covered by the global period using the following remittance codes:

- Group code of CO - Contractual Obligation
- Claim Adjustment Reason Code 97 – Payment is included in the allowance for another service/procedure
- Remittance Advice Remark Code M144 – Pre-/post-operative care payment is included in the allowance for the surgery/procedure.

MACs, however, will allow E/M services rendered during the global period when submitted with modifier 24 or 25, as appropriate.

**ADDITIONAL INFORMATION**


**DOCUMENT HISTORY**

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<td>January 26, 2018</td>
<td>Initial article released.</td>
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Proper Use of Modifier 59 – Revised

MLN Matters® Number: SE1418

Article Release Date: January 3, 2018

This article was revised on January 3, 2018, to conform with the latest Modifier 59 article on the NCCI website. The key update was the addition of information regarding the XE, XS, XP, and XU modifiers.

Provider Types Affected

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

Provider Action Needed

This special edition article is being provided by the Centers for Medicare & Medicaid Services (CMS) to clarify the proper use of Modifier 59. The article only clarifies existing policy. Make sure that your billing staffs are aware of the proper use of Modifier 59.

Background

The Medicare National Correct Coding Initiative (NCCI) includes Procedure-to-Procedure (PTP) edits that define when two Healthcare Common Procedure Coding System (HCPCS)/ Current Procedural Terminology (CPT) codes should not be reported together either in all situations or in most situations.

For PTP edits that have a Correct Coding Modifier Indicator (CCMI) of “0,” the codes should never be reported together by the same provider for the same beneficiary on the same date of service. If they are reported on the same date of service, the column one code is eligible for payment and the column two code is denied.

For PTP edits that have a CCMI of “1,” the codes may be reported together only in defined circumstances which are identified on the claim by the use of specific NCCI-associated modifiers. (Refer to the National Correct Coding Initiative Policy Manual for Medicare Services, Chapter 1, for general information about the NCCI program, PTP edits, CCMIs, and NCCI-associated modifiers. This manual is available in the download section at http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html).

One function of NCCI PTP edits is to prevent payment for codes that report overlapping services except in those instances where the services are “separate and distinct.” Modifier 59 is an important NCCI-associated modifier that is often used incorrectly.

The CPT Manual defines modifier 59 as follows:

“Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. Note: Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.”

Modifier 59 and other NCCI-associated modifiers should NOT be used to bypass a PTP edit unless the proper criteria for use of the modifier are met. Documentation in the medical record must satisfy the criteria required by any NCCI-associated modifier that is used.

1. Modifier 59 is used appropriately for different anatomic sites during the same encounter only when procedures which are not ordinarily performed or encountered on the same day are performed on different organs, or different anatomic regions, or in limited situations on different, non-contiguous lesions in different anatomic regions of the same organ.

One of the common uses of modifier 59 is for surgical procedures, non-surgical therapeutic procedures, or diagnostic procedures that are performed at different anatomic sites, are not ordinarily performed or
encountered on the same day, and that cannot be described by one of the more specific anatomic NCCI-associated modifiers – i.e., RT, LT, E1-E4, FA, F1-F9, TA, T1-T9, LC, LD, RC, LM, or RI. (See examples 1, 2, and 3.) From an NCCI perspective, the definition of different anatomic sites includes different organs or, in certain instances, different lesions in the same organ. However, NCCI edits are typically created to prevent the inappropriate billing of lesions and sites that should not be considered to be separate and distinct. Modifier 59 should only be used to identify clearly independent services that represent significant departures from the usual situations described by the NCCI edit. The treatment of contiguous structures in the same organ or anatomic region does not constitute treatment of different anatomic sites. For example:

- Treatment of the nail, nail bed, and adjacent soft tissue distal to and including the skin overlying the distal interphalangeal joint on the same toe or finger constitutes treatment of a single anatomic site. (See example 4.)
- Treatment of posterior segment structures in the eye constitutes treatment of a single anatomic site. (See example 5.)
- Arthroscopic treatment of structures in adjoining areas of the same shoulder constitutes treatment of a single anatomic site. (See example 6.)

2. Modifier 59 is used appropriately when the procedures are performed in different encounters on the same day.

Another common use of modifier 59 is for surgical procedures, non-surgical therapeutic procedures, or diagnostic procedures that are performed during different patient encounters on the same day and that cannot be described by one of the more specific NCCI-associated modifiers – i.e., 24, 25, 27, 57, 58, 78, 79, or 91. (See example 7) As noted in the CPT definition, modifier 59 should only be used if no other modifier more appropriately describes the relationship of the two procedure codes.

3. Modifier 59 is used inappropriately if the basis for its use is that the narrative description of the two codes is different.

One of the common misuses of modifier 59 is related to the portion of the definition of modifier 59 allowing its use to describe a “different procedure or surgery.” The code descriptors of the two codes of a code pair edit usually represent different procedures, even though they may be overlapping. The edit indicates that the two procedures should not be reported together if performed at the same anatomic site and same patient encounter as those procedures would not be considered to be “separate and distinct.” The provider should not use modifier 59 for such an edit based on the two codes being “different procedures.” (See example 8.) However, if the two procedures are performed at separate anatomic sites or at separate patient encounters on the same date of service, modifier 59 may be appended to indicate that they are different procedures on that date of service. Additionally, there may be limited circumstances sometimes identified in the National Correct Coding Initiative Policy Manual for Medicare Services (available in the downloads section at https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html) when the two codes of an edit pair may be reported together with modifier 59 when performed at the same patient encounter or at the same anatomic site.

4. Other specific appropriate uses of modifier 59

There are three other limited situations in which two services may be reported as separate and distinct because they are separated in time and describe non-overlapping services even though they may occur during the same encounter, i.e.:

A. Modifier 59 is used appropriately for two services described by timed codes provided during the same encounter only when they are performed sequentially. There is an appropriate use for modifier 59 that is applicable only to codes for which the unit of service is a measure of time (e.g., per 15 minutes, per hour). If two timed services are provided in time periods that are separate and distinct and not interspersed with each other (i.e., one service is completed before the subsequent service begins), modifier 59 may be used to identify the services. (See example 9.)

B. Modifier 59 is used appropriately for a diagnostic procedure which precedes a therapeutic procedure only when the diagnostic procedure is the basis for performing the therapeutic procedure. When a diagnostic procedure precedes a surgical procedure or non-surgical therapeutic procedure and is the basis on which the decision to perform the surgical procedure is made, that diagnostic test may be considered to be a separate and distinct procedure as long as (a) it occurs before the therapeutic procedure and is not interspersed with services that are required for the therapeutic
intervention; (b) it clearly provides the information needed to decide whether to proceed with the therapeutic procedure; and (c) it does not constitute a service that would have otherwise been required during the therapeutic intervention. (See example 10.) If the diagnostic procedure is an inherent component of the surgical procedure, it should not be reported separately.

C. Modifier 59 is used appropriately for a diagnostic procedure which occurs subsequent to a completed therapeutic procedure only when the diagnostic procedure is not a common, expected, or necessary follow-up to the therapeutic procedure. When a diagnostic procedure follows the surgical procedure or non-surgical therapeutic procedure, that diagnostic procedure may be considered to be a separate and distinct procedure as long as (a) it occurs after the completion of the therapeutic procedure and is not interspersed with or otherwise commingled with services that are only required for the therapeutic intervention, and (b) it does not constitute a service that would have otherwise been required during the therapeutic intervention. If the post-procedure diagnostic procedure is an inherent component or otherwise included (or not separately payable) post-procedure service of the surgical procedure or non-surgical therapeutic procedure, it should not be reported separately.

Use of Modifier 59 does not require a different diagnosis for each HCPCS/CPT coded procedure. Conversely, different diagnoses are not adequate criteria for use of modifier 59. The HCPCS/CPT codes remain bundled unless the procedures are performed at different anatomic sites or separate patient encounters or meet one of the other three scenarios described above.

Modifiers XE, XS, XP, and XU are effective January 1, 2015. These modifiers were developed to provide greater reporting specificity in situations where modifier 59 was previously reported and may be utilized in lieu of modifier 59 whenever possible. (Modifier 59 should only be utilized if no other more specific modifier is appropriate.) Although NCCI will eventually require use of these modifiers rather than modifier 59 with certain edits, providers may begin using them for claims with dates of service on or after January 1, 2015. The modifiers are defined as follows:

- **XE** – “Separate encounter, A service that is distinct because it occurred during a separate encounter” This modifier should only be used to describe separate encounters on the same date of service.
- **XS** – “Separate Structure, A service that is distinct because it was performed on a separate organ/structure”
- **XP** – “Separate Practitioner, A service that is distinct because it was performed by a different practitioner”
- **XU** – “Unusual Non-Overlapping Service, The use of a service that is distinct because it does not overlap usual components of the main service”

**Examples of Modifier 59 Usage**

Following are some examples developed to help guide physicians and providers on the proper use of Modifier 59 (Please remember that Medicare policy is that Modifier 59 is used appropriately for different anatomic sites during the same encounter only when procedures which are not ordinarily performed or encountered on the same day are performed on different organs, or different anatomic regions, or in limited situations on different, non-contiguous lesions in different anatomic regions of the same organ.):

**Example 1: Column 1 Code / Column 2 Code - 17000/11100**

- **CPT Code 17000** – Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettatement), all benign or premalignant lesions (eg, actinic keratoses) other than skin tags or cutaneous vascular proliferative lesions; first lesion
- **CPT Code 11100** – Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion

Modifier 59 may be reported with code 11100 if the procedures are performed at different anatomic sites on the same side of the body and a specific anatomic modifier is not applicable. If the procedures are performed on different sides of the body, modifiers RT and LT or another pair of anatomic modifiers should be used, not modifier 59.

**Example 2: Column 1 Code/Column 2 Code 47370/76942**

- **CPT Code 47370** – Laparoscopy, surgical, ablation of one or more liver tumor(s); radiofrequency
• CPT Code 76942 – Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation

CPT code 76942 should not be reported and Modifier 59 should not be used if the ultrasonic guidance is for needle placement for the laparoscopic liver tumor ablation procedure. Code 76942 may be reported with modifier 59 if the ultrasonic guidance for needle placement is unrelated to the laparoscopic liver tumor ablation procedure.

Example 3: Column 1 Code/Column 2 Code 93453/76000

• CPT Code 93453 – Combined right and left heart catheterization including intraprocedural injections(s) for left ventriculography, imaging supervision and interpretation, when performed
• CPT Code 76000 – Fluoroscopy (separate procedure), up to one hour physician time, other than 71023 or 71034 (eg, cardiac fluoroscopy)

CPT code 76000 should not be reported and Modifier 59 should not be used for fluoroscopy that is used in conjunction with a cardiac catheterization procedure. Modifier 59 may be reported with code 76000 if the fluoroscopy is performed for a procedure unrelated to the cardiac catheterization procedure.

Example 4: Column 1 Code / Column 2 Code - 11055/11720

• CPT Code 11055 - Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); single lesion
• CPT Code 11720 – Debridement of nail(s) by any method(s); one to five

CPT codes 11720 and 11055 should not be reported together for services performed on skin distal to and including the skin overlying the distal interphalangeal joint of the same toe. Modifier 59 should not be used if a nail is debrided on the same toe on which a hyperkeratotic lesion of the skin on or distal to the distal interphalangeal joint is pared. Modifier 59 may be reported with code 11720 if one to five nails are debrided and a hyperkeratotic lesion is pared on a toe other than one with a debrided toenail or the hyperkeratotic lesion is proximal to the skin overlying the distal interphalangeal joint of a toe on which a nail is debrided.

Example 5: Column 1 Code / Column 2 Code - 67210/67220

• CPT Code 67210 – Destruction of localized lesion of retina (eg, macular edema, tumors), 1 or more sessions; photocoagulation
• CPT Code 67220 – Destruction of localized lesion of choroid (eg, choroidal neovascularization); photocoagulation (eg, laser), 1 or more sessions

CPT code 67220 should not be reported and Modifier 59 should not be used if both procedures are performed during the same operative session because the retina and choroid are contiguous structures of the same organ.

Example 6: Column 1 Code / Column 2 Code - 29827/29820

• CPT Code 29827 – Arthroscopy, shoulder, surgical; with rotator cuff repair
• CPT Code 29820 – Arthroscopy, shoulder, surgical; synovectomy, partial

CPT code 29820 should not be reported and Modifier 59 should not be used if both procedures are performed on the same shoulder during the same operative session because the shoulder joint is a single anatomic structure. If the procedures are performed on different shoulders, modifiers RT and LT should be used, not Modifier 59.

Example 7: Column 1 Code / Column 2 Code - 93015/93040

• CPT Code 93015 – Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision, with interpretation and report
• CPT Code 93040 – Rhythm ECG, one to three leads; with interpretation and report

Modifier 59 may be reported if the rhythm ECG is performed at a different encounter than the cardiovascular stress test. If a rhythm ECG is performed during the cardiovascular stress test encounter, CPT code 93040 should not be reported and Modifier 59 should not be used. Modifier 59 is used appropriately when the procedures are performed in different encounters on the same day.
Example 8: Column 1 Code/Column 2 code - 34833/34820

- CPT code 34833 - Open iliac artery exposure with creation of conduit for delivery of endovascular prosthesis or for establishment of cardiopulmonary bypass, by abdominal or retroperitoneal incision, unilateral (List separately in addition to code for primary procedure)

- CPT code 34820 - Open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision, unilateral (List separately in addition to code for primary procedure)

CPT code 34833 is followed by a CPT Manual instruction that states: “(Do not report 34833 in conjunction with 33364, 33953, 33954, 33959, 33962, 33969, 33984, 34820 when performed on the same side).” Although the CPT code descriptors for 34833 and 34820 describe different procedures, they should not be reported together for the same side. Modifier 59 should not be appended to either code to report the two procedures for the same side of the body. If the two procedures were performed on different sides of the body, they may be reported with modifiers LT and RT as appropriate. However, modifier 59 is used inappropriately if the basis for its use is that the narrative description of the two codes is different.

Example 9: Column 1 Code / Column 2 Code - 97140/97530

- CPT Code 97140 – Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes

- CPT Code 97530 – Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes

Modifier 59 may be reported if the two procedures are performed in distinctly different 15 minute time blocks. For example, one service may be performed during the initial 15 minutes of therapy and the other service performed during the second 15 minutes of therapy. Alternatively, the therapy time blocks may be split. For example, manual therapy might be performed for 10 minutes, followed by 15 minutes of therapeutic activities, followed by another 5 minutes of manual therapy. CPT code 97530 should not be reported and modifier 59 should not be used if the two procedures are performed during the same time block. Modifier 59 is used appropriately when two timed procedures are performed in different blocks of time on the same day.

Example 10: Column 1 Code / Column 2 Code - 37220/75710

- CPT Code 37220 – Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty

- CPT Code 75710 – Angiography, extremity, unilateral, radiological supervision and interpretation.

Modifier 59 may be reported with CPT code 75710 if a diagnostic angiography has not been previously performed and the decision to perform the revascularization is based on the result of the diagnostic angiography. The CPT Manual defines additional circumstances under which diagnostic angiography may be reported with an interventional vascular procedure on the same artery. Modifier 59 is used appropriately for a diagnostic procedure which precedes a therapeutic procedure only when the diagnostic procedure is the basis for performing the therapeutic procedure.

Additional Information

The CMS webpage on the National Correct Coding Initiative Edits is available at http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html on the CMS website. There is a modifier 59 article on this website also.

The CPT Manual includes the definition of Modifier 59, as well as CPT codes used with Modifier 59. The manual is available at http://www.ama-assn.org/ama on the American Medical Association (AMA) website.

You may want to review MLN Matters® article MM8863 that alerts providers that CMS is establishing four new HCPCS Modifiers to define subsets of Modifier 59, Distinct Procedural Services.

Document History

- June 2, 2014 - Initial article released.
May 27, 2015 - This article was revised to provide a reference to MLN Matters Article SE1503 that advises physicians, providers and suppliers submitting bills to Medicare that additional guidance and education on the appropriate use of the new X modifiers will be introduced in a gradual, controlled fashion by CMS and that providers may continue to use Modifier -59 after January 1, 2015, in any instance in which it was correctly used before January 1, 2015. All other information is unchanged.

January 3, 2018 - Article updated to conform with latest Modifier 59 article on the NCCI website.

MUE and Bilateral Surgical Procedures – Revised
MLN Matters® Number: SE1422 Revised
Article Release Date: January 17, 2018

This article was revised with more details and examples and was re-issued on January 17, 2018. Providers who perform bilateral surgical procedures should review the entire article.

Provider Types Affected
This MLN Matters® Special Edition Article is intended for all Medicare Fee-For-Service (FFS) physicians, non-physician practitioners, providers, and other health care professionals who bill Medicare Administrative Contractors (MACs) for bilateral surgical procedures for Medicare beneficiaries using the Physician Fee Schedule (PFS).

Provider Action Needed
The purpose of this article is to inform providers that Medically Unlikely Edits (MUEs) may render certain claim lines for bilateral surgical procedures unpayable. Providers and suppliers billing using the PFS are reminded that Medicare billing instructions require claims for certain bilateral surgical procedures to be filed using a -50 modifier and One Unit of Service (UOS).

Make sure your billing staffs examine their process for filing claims for bilateral surgical procedures and services to ensure the -50 modifier is used in accordance with Medicare correct coding and claims submission instructions.

Background
Healthcare Common Procedure Coding System (HCPCS) coding for bilateral surgical procedures differs from CPT coding guidelines.

Coding claims for surgical procedures performed bilaterally depends on:

• The HCPCS code descriptor,
• The “Bilateral Indicator” assigned to the HCPCS code (that is, whether special payment rules apply), and
• The nature of the service.

The “National Correct Coding Initiative (NCCI)” manual specifies that modifier -50 is used to report bilateral surgical procedures as a single UOS. The NCCI manual warns that MUE edits based on established CMS policies may limit units of service and are predicated on the assumption that claims are coded in accordance with these Medicare instructions. Consequently, many bilateral procedures have an MUE value of 1.

Bilateral indicators only apply to the Physician Fee Schedule (PFS) and not to other Medicare payment systems.
### Bilateral Indicators

<table>
<thead>
<tr>
<th>Bilateral Indicator</th>
<th>What Does this Bilateral Indicator Mean?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td><strong>No bilateral payment adjustment</strong> 150% payment adjustment for bilateral procedures does not apply. If the procedure is reported with modifier -50 or with modifiers RT and LT, base the payment for the two sides on the lower of: (a) the total actual charge for both sides and (b) 100% of the fee schedule amount for a single code. Example: The fee schedule amount for code XXXXX is $125. The physician reports code XXXXX-LT with an actual charge of $100 and XXXXX-RT with an actual charge of $100. Payment should be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200). The bilateral adjustment is inappropriate for codes in this category (a) because of physiology or anatomy, or (b) because the code description specifically states that it is a unilateral procedure and there is an existing code for the bilateral procedure.</td>
</tr>
<tr>
<td>1</td>
<td><strong>150% Bilateral payment adjustment</strong> 150% payment adjustment for bilateral procedures applies. If the code is billed with the bilateral modifier or is reported twice on the same day by any other means (e.g., with RT and LT modifiers, or with a 2 in the units field), base the payment for these codes when reported as bilateral procedures on the lower of: (a) the total actual charge for both sides or (b) 150% of the fee schedule amount for a single code. If the code is reported as a bilateral procedure and is reported with other procedure codes on the same day, apply the bilateral adjustment before applying any multiple procedure rules.</td>
</tr>
<tr>
<td>2</td>
<td><strong>Bilateral procedure</strong> 150% payment adjustment does not apply. RVUs are already based on the procedure being performed as a bilateral procedure. If the procedure is reported with modifier -50 or is reported twice on the same day by any other means (e.g., with RT and LT modifiers or with a 2 in the units field), base the payment for both sides on the lower of (a) the total actual charge by the physician for both sides, or (b) 100% of the fee schedule for a single code. Example: The fee schedule amount for code YYYYY is $125. The physician reports code YYYYY-LT with an actual charge of $100 and YYYYY-RT with an actual charge of $100. Payment should be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200). The RVUs are based on a bilateral procedure because (a) the code descriptor specifically states that the procedure is bilateral, (b) the code descriptor states that the procedure may be performed either unilaterally or bilaterally, or (c) the procedure is usually performed as a bilateral procedure.</td>
</tr>
<tr>
<td>3</td>
<td><strong>No bilateral payment adjustment</strong> The usual payment adjustment for bilateral procedures does not apply. If the procedure is reported with modifier -50 or is reported for both sides on the same day by any other means (e.g., with RT and LT modifiers or with a 2 in the units field), base the payment for each side or organ or site of a paired organ on the lower of (a) the actual charge for each side or (b) 100% of the fee schedule amount for each side. If the procedure is reported as a bilateral procedure and with other procedure codes on the same day, determine the fee schedule amount for a bilateral procedure before applying any multiple procedure rules. Services in this category are generally radiology procedures or other diagnostic tests which are not subject to the special payment rules for other bilateral surgeries.</td>
</tr>
</tbody>
</table>
### Examples of Correct Coding for Bilateral Surgical Procedures for PFS

<table>
<thead>
<tr>
<th>Bilateral Indicator</th>
<th>Expected Units of Service if performed bilaterally</th>
<th>Modifier based on Laterality</th>
<th>HCPCS code descriptor and Explanation of Correct Coding</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
<td>50</td>
<td>23515 Open treatment of clavicular fracture, includes internal fixation, when performed. The code descriptor does not identify this procedure as a bilateral procedure (or unilateral or bilateral), so when performed bilaterally at the same operative session physicians must report the procedure with modifier “-50” as a single line item using one UOS. Do not use modifiers RT and LT when modifier -50 applies.</td>
</tr>
<tr>
<td>2</td>
<td>1</td>
<td></td>
<td>52290 Cystourethroscopy; with ureteral meatotomy, <strong>unilateral or bilateral</strong>. The code descriptor identifies this procedure as a unilateral or bilateral procedure, so when performed bilaterally at the same operative session report one UOS as a single line item and do not report the procedure with modifier “-50”.</td>
</tr>
<tr>
<td>2</td>
<td>1</td>
<td></td>
<td>64488 Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) <strong>bilateral</strong>; by injections (includes imaging guidance, when performed). The code descriptor identifies this procedure as a bilateral procedure, so when performed bilaterally at the same operative session report one UOS as a single line item and do not report the procedure with modifier “-50”.</td>
</tr>
</tbody>
</table>

### Examples of Incorrect Coding for Bilateral Surgical Procedures for PFS

<table>
<thead>
<tr>
<th>Bilateral Indicator</th>
<th>Expected Units of Service if performed bilaterally</th>
<th>Modifier based on Laterality</th>
<th>Second Modifier</th>
<th>HCPCS code descriptor and Explanation of Incorrect Coding</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
<td>RT</td>
<td>LT</td>
<td>23515 Open treatment of clavicular fracture, includes internal fixation, when performed. The code descriptor does not identify this procedure as a bilateral procedure (or unilateral or bilateral), so when performed bilaterally at the same operative session physicians must report the procedure with modifier “-50” as a single line item using one UOS. Do not use modifiers RT and LT when modifier -50 applies.</td>
</tr>
<tr>
<td>2</td>
<td>1</td>
<td>LT</td>
<td></td>
<td>52290 Cystourethroscopy; with ureteral meatotomy, <strong>unilateral or bilateral</strong>. The code descriptor identifies this procedure as a unilateral or bilateral procedure, so when performed bilaterally at the same operative session report one UOS as a single line item and do not report the procedure with modifier “-50”. Do not report the procedure using two line items using RT and LT modifiers.</td>
</tr>
</tbody>
</table>
### Request for Reopening of a Claim

For all MUE edit denials, including both MAI of 2 and 3, if the provider identifies a clerical error and the correct value is equal to or less than the MUE, the provider may request a reopening (i.e., a Clerical Error Reopening (CER)) to correct its billing of the claim as an alternative to filing a formal appeal. Providers can request a CER through their Medical Administrative Contractor. Providers are reminded this approach is allowable to redress underpayments resulting from unintentional errors, but it nonetheless delays full payment. For example, if the provider identifies a denial of a bilateral surgical service because it was billed with two UOS instead of being billed with one UOS and a -50 modifier, the provider may request a reopening to correct the coding/billing error, although providers should be aware that reopening requests do not extend the window for filing appeals. More importantly, though, the provider should bring his billing into compliance with CMS instructions, using one UOS and the -50 modifier to avoid future denials and delays in payment.

### Additional Information

You may also want to review the following publications:

- For information on Clerical Error Reopenings (CERs) consult the Claims Processing Manual Pub. 100-04 Chapter 34 and work with your Medicare Administrative Contractor.


- For information on Reporting Hospital Outpatient Services Using Healthcare Common Procedure Coding System (HCPCS) consult the Claims Processing Manual Pub. 100-04 Chapter 4 Section 20.6 - Use of Modifiers.


**DOCUMENT HISTORY**

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 17, 2018</td>
<td>This article was revised with more details and examples and was re-issued.</td>
</tr>
<tr>
<td>June 30, 2014</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>
Additional Information Required for Coverage and Pricing for Category III CPT Codes – R2

The Additional Information Required for Coverage and Pricing for Category III CPT® Codes coverage article has been revised 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.

Summary of Change: This article has been revised to move Category III CPT® code 0449T: Insertion of aqueous drainage device, without extraocular reservoir, internal approach, into the subconjunctival space; initial devise, from Group 2 to Group 4.

Effective Date: January 1, 2018

View the complete Noridian coverage article.

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Chemotherapy Administration – R12 and R13

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).

Effective Date: Multiple

Summary of Changes:

• Revision 12: Local Coverage Article updated to clarify effective 01/01/2018, providers are instructed to use 96377 for the application of on-body application injector for Neulasta® Onpro Kit. Added per CR 10454, CMS has instructed Medicare contractors to discontinue HCPCS code Q5102 and modifiers ZB and ZC beginning April 1, 2018. Q5102 with ZB modifier and Q5102 with ZC modifier should be used to bill injections for infliximab biosimilar for Inflectra® or Renflexis™ respectively only through March 31, 2018. Effective April 1, 2018, Q5103 should be billed for injection, infliximab-dyyb, biosimilar, (Inflectra®), 10mg or Q5104 injection, infliximab-abda, biosimilar, (Renflexis™), 10mg and added HCPCS code Q2041 - Axicabtagene Ciloleucel, up to 200 million autologous Anti-CD19 CAR T Cells, including leukapheresis and dose preparation procedures, per infusion.

• Revision 13: Updated to add a foot note for the prefilled syringe packaging for Cimzia® and coding guidelines for Rituxan Hycela™ under the Intramuscular and subcutaneous injections section, added HCPCS codes C9467 and Q2040 to the list of approved Chemotherapy drugs table and made other editorial changes. Updated the Patients Supplied Donated or Free-of-Charge Drug article attached under the Related Local Coverage Documents at the bottom of this article.

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### JW Modifier Billing Guidelines

The JW Modifier Billing 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 (WY).

**Article Summary:** This article explains when providers should and should not bill the JW modifier, how to calculate the units billed and added the Sources.

**Effective Date:** January 1, 2018

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### MolDX: Afirma Assay by Veracyte Billing and Coding Guidelines – R2

The MolDX: Afirma™ Assay by Veracyte 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 (WY).

**Summary of Changes:** Article is revised to add Part A claim filing information.

**Effective Date:** January 5, 2018

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MolDX: BCR-ABL Coding and Billing Guidelines – R1

The MolDX: BCR-ABL Coding and 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: Article is revised to provide updated billing instructions and reimbursement information.

Effective Date: December 1, 2017

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MolDX: CHD7 Gene Analysis Billing and Coding Guidelines – R1

The MolDX: CHD7 Gene Analysis 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 (WY).

Summary of Changes: Added Part A claim filing information.

Effective Date: January 1, 2018

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**MolDX: FDA Approved ALK Companion Diagnostic Tests Billing and Coding Guidelines Article Retirement – Effective February 27, 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:** A55186

**Article Title:** MolDX: FDA Approved ALK Companion Diagnostic Tests Billing and Coding Guidelines

**Effective Date:** February 27, 2018

**Summary:** The original article, MolDX: FDA Approved ALK Companion Diagnostic Tests Coding and Billing Guidelines, was initially written to acknowledge and address coding and billing for the two tests therein. The CPT® codes (88342, 88374, 88377) are included on the 2018 MPFS (Medicare Physician Fee Schedule). The MolDX Program has determined that these tests are not in the CPT® defined “molecular” area and as such are not under the purvey of the MolDX program and has requested Noridian to retire this article effective 02/27/2018. Noridian has reviewed this request and agrees. In addition, the CPT® codes will no longer require a Dex Z-code after the retirement date but will remain subject to reasonable and necessary utilization and review.

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

Go to [Medicare Coverage Articles](Medicare%20Coverage%20Articles)

- 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.

**MolDX: FDA-Approved BRAF Tests Billing and Coding Guidelines – R1**

The MolDX: FDA-Approved BRAF Tests 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 (WY).

**Summary of Changes:** Article is updated for consistency with the MolDX Contractor: to remove modifier 22 instructions; added Part A claim filing instructions and correct reference to and website address for DEX™ Diagnostics Exchange. Article number A54419 for Jurisdiction F Part A (JFA) was retired on January 29, 2018, and combined into Jurisdiction F Part B (JFB) article number A54420. JFA and JFB contract numbers will have the same final MCD article number.

**Effective Date:** December 14, 2017

View the locally hosted MolDX Medicare Coverage Article PDF under Covered or Excluded Tests.

Go to Noridian [Molecular Diagnostic Services (MolDX) webpage](Molecular%20Diagnostic%20Services%20(MolDX))

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MolDX: FDA-Approved EGFR Tests Billing and Coding Guidelines – R2

The MolDX: FDA-Approved EGFR Tests 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 (WY).

Summary of Changes: Article is updated for consistency with the MolDX Contractor: The entire section for cobas EGFR Mutation Test was revised, including effective date; modifier 22 instruction was removed; added Part A claim filing instructions and correct reference to and website address for DEX™ Diagnostics Exchange. Article number A54423 for Jurisdiction F Part A (JFA) was retired on January 24, 2018, and combined into Jurisdiction F Part B (JFB) article number A64424. JFA and JFB contract numbers will have the same final MCD article number.

Effective Date: December 14, 2017

View the locally hosted MolDX Medicare Coverage Article PDF under Covered or Excluded Tests.

Go to Noridian Molecular Diagnostic Services (MolDX) webpage.

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  • Once in the CMS MCD, select corresponding article title

MolDX: FDA-Approved KRAS Tests – R2

The MolDX: FDA-Approved KRAS Tests 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: Article is updated to remove modifier 22 instruction, add Part A claim filing instructions and correct reference to and website address for DEX™ Diagnostics Exchange. Article number A54501 for Jurisdiction F Part A (JFA) was retired on January 24, 2018, and combined into Jurisdiction F Part B (JFB) article number A54500. JFA and JFB contract numbers will have the same final MCD article number.

Effective Date: December 14, 2017
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- 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

**MolDX Molecular Test Registration and Claims Submission – R3**

The MolDX Molecular Test Registration and Claims Submission coverage article has been revised on the Noridian website.

**Summary of Article:** Article is updated to remove microbiology codes 87505-87507, 87631-87633, 87149-87150.

**Effective Date:** March 1, 2018

View the locally hosted Medicare Coverage Article PDF.

Go to Noridian Molecular Diagnostics Services (MolDX) webpage.

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

**MolDX: Next Generation Sequencing Billing and Coding Guidelines - R1**

The Next Generation Sequencing 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 (WY).

**Summary of Changes:** Article is revised to expand and/or clarify the Next Generation Sequencing (NGS), Targeted (aka Hot Spot) Tumor Panels and Comprehensive Genomic Profile (CGP) Testing sections consistent with the MolDX Contractor.

**Effective Date:** January 1, 2018

View the locally hosted Medicare Coverage Article PDF.

Go to Noridian MolDX Covered Tests (LCDs and 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 a 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

MolDX: RPS19 Gene Tests Billing and Coding Guidelines – R1
The MolDX: RPS19 Gene Tests 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 (WY).
Summary of Changes: Article is revised to add Part A claim filing information.
Effective Date: October 1, 2017
View the locally hosted Medicare Coverage Article PDF.
Go to Noridian MolDX Covered Tests (LCDs and 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 a 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
• Once in the CMS MCD, select corresponding article title

MolDX: SLCO1B1 Genotype Billing and Coding Guidelines – R1
The MolDX: SLCO1B1 Genotype 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 (WY).
Summary of Changes: Added Part A claim filing information
Effective Date: October 9, 2017
View the locally hosted Medicare Coverage Article PDF.
Go to Noridian MolDX Covered Tests (LCDs and 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 a 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

**MolDX: SLCO1B1 Genotype Billing and Coding Guidelines – R2**

The MolDX: SLCO1B1 Genotype 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 (WY).

**Summary of Changes:** Article was revised to add CPT 81328, SLCO1B1 gene analysis common variants code and delete CPT code 81400, molecular pathology procedure, level 1 (eg, identification of single germline variant [eg, SNP] by techniques such as restriction enzyme digestion or melt curve analysis).

**Effective Date:** January 1, 2018

View the locally hosted MolDX Medicare Coverage Article PDF under Covered or Excluded Tests.

Go to Noridian Molecular Diagnostic Services (MolDX) 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 under Covered or Excluded Tests.

To view a 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

**MolDX: SMPD1 Genetic Testing Billing and Coding Guidelines – R1**

The MolDX: SMPD1 Genetic Testing 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 (WY).

**Summary of Changes:** Added Part A claim filing information

**Effective Date:** October 9, 2017

View the locally hosted Medicare Coverage Article PDF.

Go to Noridian MolDX Covered Tests (LCDs and 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 a 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
MolDX: ThermoFisher Oncomine Dx Target Test For Non-Small Cell Lung Cancer Billing and Coding Guidelines

The MolDX: ThermoFisher Oncomine Dx Target Test For Non-Small Cell Lung Cancer Billing and Coding Guidelines coverage 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.

Summary of Article: The Oncomine Dx Target Test (Thermo Fisher Scientific, Inc., Waltham, MA) is a 23-gene panel including 3 gene targets approved by the FDA for non-small cell lung cancer from tissue specimens. The test can simultaneously identify three gene variants that are key to targeted therapy selection: EGFR, BRAF and ROS1. This article provides coverage criteria for the test.

Effective Date: June 22, 2017

View the locally hosted MolDX Medicare Coverage Article PDF under Covered or Excluded Tests.

Go to Noridian Molecular Diagnostic Services (MolDX) webpage.

To view a complete list of Noridian coverage articles:

Go to the Noridian Medicare Coverage Articles webpage

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

MolDX Vysis Kit by Abbott Coding and Billing Guidelines Article Retirement – Effective October 24, 2016

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: A54510

Article Title: MolDX Vysis® Kit by Abbott Coding and Billing Guidelines

Effective Date: October 24, 2016

Summary: This coverage article was retired and coverage was included in the MolDX: FDA Approved ALK Companion Diagnostic Tests Billing and Coding Guidelines coverage article.

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

**Molecular Diagnostic Program (MolDX) Manual**

The Molecular Diagnostic Program (MolDX®) Manual has been published on the Noridian website.

**Summary of Article:** This manual provides coverage, coding and pricing standards and requirements for services provided within the program.

**Effective Date:** Immediately

View the locally hosted Medicare Coverage Article PDF.

Go to the Noridian Molecular Diagnostics Services (MolDX) webpage.

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

**Patients Supplied Donated or Free-of-Charge Drug – R1**

The Patients Supplied Donated or Free-of-Charge Drug 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:** Article updated to change the title from Patients Supplying Their Own Drugs to Patients Supplied Donated or Free-of-Charge Drug and added Part A electronic and UB04 form billing information and Part B electronic billing information. Updated the Chemotherapy Administration article attached under the Related Local Coverage Documents at the bottom of this article.

**Effective Date:** April 1, 2018

View the locally hosted Medicare Coverage Article PDF.

Go to Noridian Medicare Coverage Articles webpage.

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

• Locate and select above listed Medicare Coverage Article.

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
DISASTER CLAIMS

Hurricane Nate and Medicare Disaster Related Alabama, Florida, Louisiana and Mississippi Claims – Revised

MLN Matters Number: SE17034 Revised
Article Release Date: January 19, 2018

This article was revised on January 19, 2018, to advise providers that the public health emergency declaration and Section 1135 waiver authority has expired as noted below. 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 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.

The Public Health Emergency declaration and Social Security Act waivers including the Section 1135 waiver authority expired as follows:

- The authority expired on January 2, 2018, for Louisiana.
- The authority expired on January 3, 2018, for Alabama and Mississippi.
- The authority expired on January 4, 2018, for Florida.

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](https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Consolidated_Medicare_FFS_Emergency_QsAs.pdf)

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

Blanket Waivers for Alabama, Florida, Louisiana and Mississippi

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

**Skilled Nursing Facilities**

- **1812(f):** This waiver of the requirement for a 3-day prior hospitalization for coverage of a skilled nursing facility stay provides temporary emergency coverage of Skilled Nursing Facility (SNF) services without a qualifying hospital stay, for those people who are evacuated, transferred, or otherwise dislocated as a 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 email when this temporary extension expires. All other competitive bidding program requirements remain in force. Note: CMS will provide notice of any changes to reporting timeframes for future events.


Replacement Prescription Fills

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

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

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

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

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

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

Requesting an 1135 Waiver

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

ADDITIONAL INFORMATION

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

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 19, 2018</td>
<td>The article was revised to include information on the expiration of the public health emergency declaration and Section 1135 waiver authority.</td>
</tr>
<tr>
<td>October 11, 2017</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>
Do Not Forward Initiative Reminder

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

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

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

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

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

Policy

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

Implementation Process

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

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

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

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

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

IRS-1099 Reporting

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

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

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

Change of Ownership Requests – Update to Crosswalk Request

Change of Ownership (CHOW) means, the removal, addition, or substitution of a partner, the merger of the provider corporation into another corporation, or the consolidation of two or more corporations. The most common example of a CHOW occurs when a provider’s CMS Certification Number (CCN), Provider Transaction Number (PTAN) or Medicare ID are bought by another entity. This is what is known as a buyer/seller CHOW.

Effective May 15, 2017 MACs no longer can request an update to re-open the claims crosswalk to assist the seller with cleanup claims. The buyer and seller are responsible for working together on payment arrangements for the seller’s claims once the CHOW is approved. This will apply to any application received on or after May 15, 2017.

This will not immediately apply to any CHOW application received before May 15, 2017. These enrollments are still able to request a crosswalk re-opening from either the Enrollment Call Center or the representative processing the application.

The request to update/re-open the crosswalk, will end on December 31, 2017. The manual matches that are currently made are valid for 90 days, from the date CMS updates/re-opens the crosswalk; or until December 31, 2017. After December 31, 2017, manual matches will no longer be available in the system for any circumstances.

The key to a CHOW is the finalized approval from the CMS Regional Office (RO). The seller is still able to submit claims and be paid until the application has been approved by CMS and finalized by the Medicare Administrative Contractor (MAC) in the Provider Enrollment, Chain and Ownership System (PECOS). If there are remaining claims that need to be submitted for the seller, while the CHOW is in process; these claims need to be submitted as soon as possible. Once Provider Enrollment receives the tie-in notification from the CMS RO, the seller is deactivated and is no longer able to submit claims. The buyer will now be in PECOS and be authorized to submit all claims and will receive all payments.

Noridian feels it is important for both parties to be aware of these system change so they may consider the impact when finalizing their terms of sale agreement.

If unsure how to complete a CHOW, or buyer/seller application; there are Enrollment on Demands (EoDs) that can be viewed that give you step by step on how to complete the application correctly the first time.

Material to reference:

MLN article published May 16, 2017
Change Request (CR) 9953 (Section to note is 9953.5)
Enrollment Application Status Tool Use Required - Effective February 5, 2018

Effective February 5, 2018, Noridian Customer Service will require providers to use the Enrollment Application Status Search self-service tool to access application related details. In the interim, Customer Service Representatives (CSRs) will educate callers on the use of this tool.

The Enrollment Application Status Search tool allows providers and suppliers to follow his/her enrollment application progress. Simply enter the Application/Reference Number or Web Tracking ID into the search field and select “View Application Status.”

If a match is identified, the results will vary depending upon the application progression. Some of the high-level progression levels are listed below.

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

Requiring providers to use this tool will allow Noridian to meet CMS requirements and our CSRs to assist with more complex inquiries which cannot be answered through this self-service tool.
Transitional Drug Add-On Payment Adjustment Implementation – Second Revision

MLN Matters Number: MM10065 Revised
Related Change Request (CR) Number: CR 10065
Related CR Release Date: January 10, 2018
Effective Date: January 1, 2018
Related CR Transmittal Number: R1999OTN
Implementation Date: January 2, 2018

This article was revised on January 10, 2018 to reflect the revised CR10065 issued on that date. The CR was revised to provide more descriptive examples for Parsabiv and Sensipar. These examples were added to the article. In addition, the CR release date, transmittal number and the Web address for accessing the CR were revised. All other information remains the same.

PROVIDER TYPE AFFECTED
This MLN Matters Article is intended for End-Stage Renal Disease (ESRD) facilities submitting claims to Medicare Administrative Contractors (MACs) for certain ESRD drugs provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED
This article informs you about Change Request (CR) 10065, which directs the MACs to implement the Transitional Drug Add-On Payment Adjustment (TDAPA). Please be sure your billing staffs are informed of this change.

BACKGROUND
In accordance with section 217(c) of the Protecting Access to Medicare Act, the Centers for Medicare & Medicaid Services (CMS) implemented a drug designation process for: (1) determining when a product is no longer an oral-only drug; and (2) including new injectable and intravenous products into the ESRD Prospective Payment System (PPS). Under the drug designation process, CMS provides payment using a TDAPA for new injectable or intravenous drugs and biologicals that qualify under 42 Code of Federal Regulations (CFR) 413.234(c)(1).

To be considered a new injectable or intravenous product, the product must be approved by the Food and Drug Administration (FDA), commercially available, assigned a Healthcare Common Procedure Coding System (HCPCS) code, and designated by CMS as a renal dialysis service. CMS considers the new injectable or intravenous product to be included in the ESRD PPS bundled payment (with no separate payment available) if used to treat or manage a condition for which there is an ESRD PPS functional category. CMS will pay for the drug or biological using a TDAPA, if the new injectable or intravenous product is used to treat or manage a condition for which there is not an existing ESRD PPS functional category. While calcimimetics are included in the bone and mineral metabolism ESRD PPS functional category, they are an exception to the drug designation process as discussed in the Calendar Year (CY) 2016 ESRD PPS final rule (80 FR 69025, 69027). CMS bases the TDAPA on payment methodologies under section 1847A of the Social Security Act which are discussed in the “Medicare Claims Processing Manual”, Chapter 17, Section 20. This payment is applicable for a period of 2 years. While the TDAPA applies to a new injectable or intravenous drug or biological, the drug or biological is not considered an outlier service.

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.

Transitional Drug Add-On Payment Adjustment
Effective January 1, 2018, injectable, intravenous, and oral calcimimetics qualify for the TDAPA. ESRD facilities should report the AX modifier (Item furnished in conjunction with dialysis services) with the HCPCS for these drugs to receive payment for these drugs using the TDAPA. While these drugs are eligible for the TDAPA, they do not qualify toward outlier calculation. Currently, calcimimetics are the only
drugs that qualify for payment using the TDAPA. ESRD facilities should not use the AX modifier for any other drug until notified by CMS.

Effective January 1, 2018, MACs will return to provider (RTP) ESRD claims (TOB 72X) when:

- HCPCS code J0604 or J0606 is present without modifier AX or
- Modifier AX is present without HCPCS code J0604 or J0606

J0604 and J0606 are drugs that are used for bone and mineral metabolism. Bone and mineral metabolism is an ESRD PPS functional category where drugs and biologicals that fall in this category are always considered to be used for the treatment of ESRD.

ESRD facilities will not receive separate payment for J0604 and J0606 with or without the AY modifier and the MACs will process the line item as covered with no separate payment under the ESRD PPS. The ESRD PPS CB requirements will be updated to include J0604 and J0606.

CR 10065 also implements the payer only value code Q8 – Total TDAPA Amount, to be used to capture the add-on payment adjustment. CR 10065 has an example of the calculation used in PRICER.

**Parsabiv Example:**

Patient is prescribed 5mg 3 times per week with a payment limit of $3.50 per 0.1 mg.

1/1/2018 HCPCS J0606, 50 units
1/1/2018 REV 821
1/3/2018 HCPCS J0606, 50 units
1/3/2018 REV 821
1/5/2018 HCPCS J0606, 50 units
1/5/2018 REV 821
1/8/2018 HCPCS J0606, 50 units
1/8/2018 REV 821
1/10/2018 HCPCS J0606, 50 units
1/10/2018 REV 821
1/12/2018 HCPCS J0606, 50 units
1/12/2018 REV 821
1/15/2018 HCPCS J0606, 50 units
1/15/2018 REV 821
1/17/2018 HCPCS J0606, 50 units
1/17/2018 REV 821
1/19/2018 HCPCS J0606, 50 units
1/19/2018 REV 821
1/22/2018 HCPCS J0606, 50 units
1/22/2018 REV 821
1/24/2018 HCPCS J0606, 50 units
1/24/2018 REV 821
1/26/2018 HCPCS J0606, 50 units
1/26/2018 REV 821
1/29/2018 HCPCS J0606, 50 units
1/29/2018 REV 821
1/31/2018 HCPCS J0606, 50 units
1/31/2018 REV 821
Q8 is assigned $2450 \((50 \times 3.50) \times 14 = $2450\)
Number of dialysis treatments for month = 14
Adjusted ESRD PPS base rate = $250.00
QIP reduction = 0.985
Cost of TDAPA drug/ number of dialysis treatments for the month = TDAPA payment per treatment
$2450/ 14 = $175
Final Payment Rate = \((\text{Adjusted ESRD PPS base rate} + \text{TDAPA payment per treatment}) \times \text{QIP reduction}\)
$418.63 = \((250.00 + 175) \times 0.985\)
$418.63 = $425 \times 0.985
The final per treatment payment rate is $418.63

**Sensipar Example:**

Patient is prescribed 1-30mg tablet per day on January 10, 2018 with a payment limit of $1.00 per 1 mg.
1/1/2018 REV 821
1/3/2018 REV 821
1/5/2018 REV 821
1/8/2018 REV 821
1/10/2018 HCPCS J0604, 660 units
1/10/2018 REV 821
1/12/2018 REV 821
1/15/2018 REV 821
1/17/2018 REV 821
1/19/2018 REV 821
1/22/2018 REV 821
1/24/2018 REV 821
1/26/2018 REV 821
1/29/2018 REV 821
1/31/2018 REV 821
Q8 is assigned $660 \((660 \times 1) = $660\)
Number of dialysis treatments for month = 14
Adjusted ESRD PPS base rate = $250.00
QIP reduction = 0.985
Cost of TDAPA drug/ number of dialysis treatments for the month = TDAPA payment per treatment
$660/ 14 = $47.14
Final Payment Rate = \((\text{Adjusted ESRD PPS base rate} + \text{TDAPA payment per treatment}) \times \text{QIP reduction}\)
$292.68 = \((250.00 + 47.14) \times 0.985\)
$292.68 = $297.14 \times 0.985
The final per treatment payment rate is $292.68
Oral or Other Forms of Injectable Drugs and Biologicals

ESRD facilities are responsible for furnishing renal dialysis services either directly or under arrangement. The one exception to this policy is oral-only drugs and biologicals that are not paid under the ESRD PPS until January 1, 2025.

CMS recognizes that ESRD facilities may have unique circumstances with regard to furnishing oral and other forms of injectable drugs and biologicals when the medication cannot be administered in the ESRD facility. For example, a pharmacy may, under arrangement with the ESRD facility, dispense the medication and provide the patient with instructions on how to self-administer the drug. In this situation, the ESRD facility is responsible for developing contractual arrangements with pharmacies and ensuring that appropriate delivery and billing of the drug is completed in accordance with the beneficiary’s plan of care.

CMS Pub. 100-02, chapter 11, section 20.3.C provides the reporting guidance for oral or other forms of renal dialysis drugs that are filled at the pharmacy or furnished directly by an ESRD facility for home use. ESRD facilities are instructed to report one line item per prescription, but only for the quantity of the drug expected to be taken during the claim billing period, that is, calendar month. ESRD facilities should use the best information they have to determine the amount expected to be taken in a given calendar month, including prescription fill information from the pharmacy and the patient’s plan of care (80 FR 37838).

ESRD facility claims include only the items and services used during the calendar month. CMS does not expect facilities to physically administer the drug to the patient, however, CMS does expect facilities to be aware of the patient’s plan of care and know the medications the patient was instructed to take for the claim’s time period, and ensure the claim reflects that plan of care.

With the implementation of TDAPA, facilities are now responsible for reporting an oral calcimimetic (J0604) on the ESRD claim. The ESRD PPS is built and operationalized around the monthly reporting of items and services that are furnished. However, we recognize that continuity of therapy may be unpredictable. For example, beneficiaries can be hospitalized, switch facilities, or change dosages all within the same calendar month. CMS recognizes that these situations may be beyond the control of the ESRD facility and that they can impact payment. ESRD facilities will need to determine the most appropriate way to furnish drugs and biologicals that ensures patients receive their required medications, while mitigating the facilities’ risk for drug costs.

Again, with regard to reporting for the oral calcimimetic (J0604), CMS expects that ESRD facilities will report the quantity of the drug expected to be taken during the calendar month using the best information available as discussed above. CMS does not expect the date of the line on the claim for the oral calcimimetic to correspond to a treatment date or the specific day that the patient received the supply of medication, however, the facility’s recordkeeping (for example, the patient’s medical record) should be consistent with the claim.

CMS expects all providers and suppliers to supply and administer all patient drugs and biologicals in a clinically approved, efficient and economical manner. CMS will closely monitor the utilization of renal dialysis services and the use of TDAPA to analyze trends, behaviors and require appropriate corrective action when necessary.

ADDITIONAL INFORMATION


DOCUMENT HISTORY

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<td>January 10, 2018</td>
<td>The article was revised to provide more descriptive examples in the Background section for Parsabiv and Sensipar. The CR release date, transmittal number and the Web address for accessing the CR were revised also. All other information remains the same.</td>
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<tr>
<td>December 29, 2017</td>
<td>The article was revised in order to add the section entitled “Oral or Other Forms of Injectable Drugs and Biologicals” starting on page 2.</td>
</tr>
<tr>
<td>August 9, 2017</td>
<td>Initial article released.</td>
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Medicare Benefit Policy Manual (Pub. 100-02, Chapter 11 - ESRD, Section 100) - Update

MLN Matters Number: MM10366
Related Change Request (CR) Number: CR 10366
Related CR Release Date: January 19, 2018
Effective Date: January 1, 2017
Related CR Transmittal Number: R240BP
Implementation Date: February 20, 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 ESRD services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

Change Request (CR) 10366 updates the “Medicare Benefit Policy Manual” (Publication 100-02, Chapter 11 (End Stage Renal Disease (ESRD)), Section 100 (Payment for Renal Dialysis Services Furnished to Individuals with Acute Kidney Injury (AKI)). Note that CR10366 contains no policy changes. Make sure that your billing staffs are aware of these updates.

BACKGROUND

On June 29, 2015, the Trade Preferences Extension Act of 2015, available at https://www.gpo.gov/fdsys/pkg/PLAW-114publ27/pdf/PLAW-114publ27.pdf was enacted in which Section 808 amended Section 1861(s)(2)(F) of the Social Security Act (42 U.S.C. 1395x(s)(2)(F)) by extending renal dialysis services paid under the Social Security Act (Section 1881(b)(14)) to beneficiaries with acute kidney injury, effective January 1, 2017.

As previously stated, CR10366 presents no new policy. It only updates the “Medicare Benefit Policy Manual” to include information communicated previously in other CRs regarding Medicare coverage or renal dialysis furnished to individuals with AKI. The updated manual section is attached to CT10366.

ADDITIONAL INFORMATION


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<td>January 19, 2018</td>
<td>Initial article released.</td>
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Handling of Claims Inappropriately Assigned Reason Code 32404

It has come to CMS’ attention that institutional claims are inappropriately rejecting with reason code 32404 when a revenue code between 030x – 031x is submitted with a laboratory HCPCS that is not a clinical diagnostic lab code. A system fix is scheduled to be implemented on March 5, 2018. In the interim, CMS will hold all institutional claims with reason code 32404 assigned except FQHC and RHC claims. Held claims will be automatically released once the fix is implemented.

Until the fix is implemented, FQHC and RHC claims will be returned to provider (RTP). As a workaround, FQHC and RHC providers are advised to remove claim line(s) that have been assigned reason code 32404 and resubmit the claim. This action will not affect payment. Providers may discontinue this workaround after March 5, 2018.

FQHC PPS for CY 2018 Recurring File Update – Revised

MLN Matters Number: MM10480 Revised
Related Change Request (CR) Number: 10480
Related CR Release Date: February 23, 2018
Effective Date: April 1, 2018
Related CR Transmittal Number: R3982CP
Implementation Date: April 2, 2018

This article was revised on February 23, 2018, to reflect the revised CR10480 issued on February 23. The article was revised to include further information in the background section, regarding payment methodology for FQHCs under the PPS.

PROVIDER TYPE AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 10480 updates the Federally Qualified Health Center Prospective Payment System (FQHC PPS) grandfathered tribal FQHC base payment rate and the Geographic Adjustment Factors (GAFs) for the FQHC Pricer. Make sure your billing staffs are aware of these changes.

BACKGROUND

Payment for FQHCs under the Prospective Payment System (PPS)

Section 10501(i)(3)(A) of the Affordable Care Act (Pub. L. 111–148 and Pub. L. 111–152) added section 1834(o) of the Social Security Act to establish a payment system for the costs of FQHC services under Medicare Part B based on prospectively set rates. In the PPS for FQHC Final Rule published in the May 2, 2014 Federal Register (79 FR 25436), the Centers for Medicare & Medicaid Services (CMS) implemented a methodology and payment rates for FQHCs under the PPS beginning on October 1, 2014. Note that:

- 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.

- Beginning in 2017, the FQHC 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 2017 base payment rate of $163.49.

- In accordance with Section 1834(o)(1)(A) of the Act, The FQHC PPS base rate is adjusted for each FQHC by the FQHC Geographic Adjustment Factor (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.
The Bipartisan Budget Act of 2018 revised the CY 2018 Work GPCI floor. Therefore, the

FQHC GAFs have been updated in order to be consistent with the statutory requirements.

Payment for Grandfathered Tribal FQHCs that were Provider-Based Clinics on or Before April 7, 2000

Effective for dates of service on or after January 1, 2016, Indian Health Service (IHS) and tribal facilities and organizations may seek to become certified as grandfathered tribal FQHCs, if they:

1. Met the conditions of 42 CFR Section 413.65(m), which is available at https://www.ecfr.gov/cgi-bin/text-idx?SID=19dd7fa703112dee60510c39b8c4c2ae&mc=true&node=pt42.2.413&rgn=div5#se42.2.413_165, on or before April 7, 2000, and

2. Have

A change in their status on or after April 7, 2000, from IHS to tribal operation, or vice versa, or

The realignment of a facility from one IHS or tribal hospital to another IHS or tribal hospital such that the organization no longer meets the Conditions of Participation (CoPs).

These grandfathered tribal FQHCs would be required to meet all FQHC certification and payment requirements. The grandfathered PPS rate equals the Medicare outpatient per visit payment rate paid to them as a provider-based department, as set annually by the IHS.

Grandfathered tribal FQHCs are paid the lesser of their charges or a grandfathered tribal FQHC PPS rate for all FQHC services furnished to a beneficiary during a medically-necessary, face-to-face FQHC visit. Note that:

1. From January 1, 2018, through December 31, 2018, the grandfathered tribal FQHC PPS rate is $383.

2. FQHC claims (TOB 77X) for grandfathered tribal FQHCs submitted with dates of service on or after January 1, 2018, through March 31, 2018, paid at the Calendar Year (CY) 2017 rate of $349 must be adjusted and paid at the CY 2018 rate of $383. These adjustments will be completed 90 days after the implementation of CR10480.

3. Grandfathered tribal FQHC claims with dates of service on or after January 1, 2019, through December 31, 2019, should be paid at the CY 2018 rate of $383 until the Centers for Medicare & Medicaid Services (CMS) provides an updated payment rate for CY 2019.

The grandfathered tribal FQHC PPS rate will not be adjusted by the FQHC GAFs or be eligible for the special payment adjustments under the FQHC PPS for new patients, patients receiving an Initial Preventive Physical Examination (IPPE) or an Annual Wellness Visit (AWV). The rate is also ineligible for exceptions to the single per diem payment that is available to FQHCs paid under the FQHC PPS. In addition, the FQHC market basket adjustment that is applied annually to the FQHC PPS base rate will not apply to the grandfathered tribal FQHC PPS rate.

ADDITIONAL INFORMATION


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<td>February 23, 2018</td>
<td>The article was revised to reflect a revised CR10480, which added further background information on the FQHC PPS rate and FQHC GAFs.</td>
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<tr>
<td>February 9, 2018</td>
<td>Initial article released.</td>
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**Laboratory NCD Edit Software Changes for April 2018**

MLN Matters Number: MM10424  
Related Change Request (CR) Number: CR10424  
Related CR Release Date: December 22, 2017  
Effective Date: October 1, 2017  
Related CR Transmittal Number: R3937CP  
Implementation Date: April 2, 2018

**PROVIDER TYPE AFFECTED**

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

**WHAT YOU NEED TO KNOW**

This article is based on Change Request (CR) 10424 which informs MACs about the changes that will be included in the April 2018 quarterly release of the edit module for clinical diagnostic laboratory services. Make sure that your billing staffs are aware of these changes.

**BACKGROUND**

CR 10424 announces the changes that will be included in the April 2018 quarterly release of the edit module for clinical diagnostic laboratory services. The National Coverage Determinations (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 the Medicare Claims Processing Manual, Chapter 16, Section 120.2, 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. CR10424 communicates requirements to MACs notifying them of changes to the laboratory edit module for laboratory NCD code lists for April 2018. Please access the following link for the NCD spreadsheets included with CR10424: https://www.cms.gov/Medicare/Coverage/DeterminationProcess/downloads/April2018.zip.

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**


**DOCUMENT HISTORY**

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<td>January 3, 2018</td>
<td>Initial article released.</td>
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Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment - Quarterly Update - Revised

MLN Matters Number: MM10445 Revised
Related Change Request (CR) Number: CR10445
Related CR Release Date: March 14, 2018
Effective Date: January 1, 2018, for new HCPCS codes, otherwise April 1, 2018
Related CR Transmittal Number: R3999CP
Implementation Date: April 2, 2018

This article was revised on March 15, 2018, to reflect an updated Change Request (CR). That CR removed the list of new codes with a QW modifier that were effective as of April 1, 2018 from the policy section. All other information remains the same.

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

PROVIDER ACTION NEEDED
CR 10445 which informs the MACs about the changes in the April 2018 quarterly update to the Clinical Laboratory Fee Schedule (CLFS). Make sure that your billing staffs are aware of these changes.

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

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

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

New Codes
The following new codes will be MAC priced, until they are addressed at the annual Clinical Laboratory Public Meeting, which will take place in July, 2018. The following “U” codes shall have HCPCS Pricing Indicator Code - 22 = Price established by A/B MACs Part B (e.g., gap-fills, A/B MACs Part B established panels) instead of Pricing Indicator - 21 = Price Subject to National Limitation Amount. (Code, Long Descriptor, Short Descriptor, Effective Date, Type of Service (TOS))

- 0024U Glycosylated acute phase proteins (GlycA), nuclear magnetic resonance spectroscopy, quantitative GLYCA NUC MR SPECTRSC QUAN 1/1/2018 5
- 0025U Tenofovir, by liquid chromatography with tandem mass spectrometry (LC-MS/MS), urine, quantitative TENOFOVIR LIQ CHROM UR QUAN 1/1/2018 5
- 0026U Oncology (thyroid), DNA and mRNA of 112 genes, next-generation sequencing, fine needle aspirate of thyroid nodule, algorithmic analysis reported as a categorical result (“Positive, high probability of malignancy” or “Negative, low probability of malignancy”) ONC THYR DNA&MRNA 112 GENES 1/1/18 5
• 0027U JAK2 (Janus kinase 2) (eg, myeloproliferative disorder) gene analysis, targeted sequence analysis exons 12-15 JAK2 GENE TRGT SEQ ALYS 1/1/18 5

• 0028U CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism) gene analysis, copy number variants, common variants with reflex to targeted sequence analysis CYP2D6 GENE CPY NMR CMN VRNT 1/1/18 5

• 0029U Drug metabolism (adverse drug reactions and drug response), targeted sequence analysis (ie, CYP1A2, CYP2C19, CYP2C9, CYP2D6, CYP3A4, CYP3A5, CYP4F2, SLCO1B1, VKORC1 and rs12777823) RX METAB ADVRS TRGT SEQ ALYS 1/1/18 5

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

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

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

• 0033U HTR2A (5-hydroxytryptamine receptor 2A), HTR2C (5-hydroxytryptamine receptor 2C) (eg, citalopram metabolism) gene analysis, common variants (ie, HTR2A rs7997012 [c.614-2211T>C], HTR2C rs3813929 [c.-759C>T] and rs1414334 [c.551-3008C>G]) HTR2A HTR2C GENES 1/1/18 5


The following new code is effective January 1, 2018:

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

Deleted Codes

The following codes are deleted effective January 1, 2018:

• Existing code 0004U is to be deleted.
• Existing code 0015U is to be deleted.
• Existing code 81281 is to be deleted.
• Existing code 81282 is to be deleted.
• Existing code 81280 is to be deleted.

Code Update

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

ADDITIONAL INFORMATION


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<td>March 15, 2018</td>
<td>The article was revised to reflect an updated CR. That CR removed the list of new codes with a QW modifier that were effective as of April 1, 2018 from the policy section.</td>
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<tr>
<td>February 9, 2018</td>
<td>Initial article released.</td>
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Clinical Laboratory Fee Schedule – Medicare Travel Allowance Fees for Collection of Specimens

MLN Matters Number: MM10448
Related Change Request (CR) Number: 10448
Related CR Release Date: December 22, 2017
Effective Date: January 1, 2018
Related CR Transmittal Number: R3942CP
Implementation Date: January 22, 2018

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

WHAT YOU NEED TO KNOW
Change Request (CR) 10448 revises the payment of travel allowances when billed on a per mileage basis using Health Care Common Procedure Coding System (HCPCS) code P9603 and when billed on a flat-rate basis using HCPCS code P9604 for Calendar Year (CY) 2018. Make sure your billing staff is aware of these changes.

BACKGROUND
Medicare Part B allows payment for a specimen collection fee and travel allowance, when medically necessary, for a laboratory technician to draw a specimen from either a nursing home patient or homebound patient under Section 1833(h)(3) of the Social Security Act (the Act). Payment for these services is made based on the Clinical Laboratory Fee Schedule (CLFS).

The travel codes allow for payment either on a per mileage basis for code P9603 or on a flat rate per trip basis for P9604. Payment of the travel allowance is made only if a specimen collection fee is also payable. The travel allowance is intended to cover the estimated travel costs of collecting a specimen including the laboratory technician’s salary and travel expenses. Your MAC has the discretion to choose either a mileage basis or a flat rate, and how to set each type of allowance. Many MACs established local policy to pay based on a flat rate basis only.

Under either method, when one trip is made for multiple specimen collections (for example, at a nursing home), the travel payment component is prorated based on the number of specimens collected on that trip, for both Medicare and non-Medicare patients, either at the time the claim is submitted by the laboratory or when the flat rate is set by the MAC.

The per mile travel allowance (P9603) is to be used in situations where the average trip to the patients’ homes is longer than 20 miles round trip, and is to be prorated in situations where specimens are drawn from non-Medicare patients in the same trip.

The allowance per mile was computed using the Federal mileage rate of $0.545 per mile plus an additional $0.45 per mile to cover the technician’s time and travel costs. MACs have the option of establishing a higher per mile rate in excess of the minimum $1.00 per mile if local conditions warrant it. The minimum mileage rate will be reviewed and updated throughout the year, as well as in conjunction with the CLFS, as needed. At no time will the laboratory be allowed to bill for more miles than are reasonable, or for miles that are not actually traveled by the laboratory technician.

The per flat-rate trip basis travel allowance (P9604) for CY2018 is $10.00.

ADDITIONAL INFORMATION
**LABORATORY**

**DOCUMENT HISTORY**

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<tr>
<td>January 2, 2018</td>
<td>Initial article released.</td>
</tr>
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</table>
SSI/Medicare Beneficiary Data for IPPS Hospitals, IRFs, and LTCH - Fiscal Year 2016

MLN Matters Number: MM10527  
Related Change Request (CR) Number: 10527  
Related CR Release Date: March 16, 2018  
Effective Date: April 16, 2018  
Related CR Transmittal Number: R2043OTN  
Implementation Date: April 16, 2018

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

PROVIDER ACTION NEEDED
Change Request (CR) 10527 informs MACs about updated data for determining the disproportionate share adjustment for Inpatient Prospective Payment System (IPPS) hospitals and the low-income patient adjustment for Inpatient Rehabilitation Facilities (IRFs), as well as payments, as applicable, for Long Term Care Hospital (LTCH) discharges (for example, discharges paid the IPPS comparable amount under the short-stay outlier payment adjustment). Make sure that your billing staffs are aware of these changes.

BACKGROUND
Section 9105 of the Consolidated Omnibus Budget Reconciliation Act of 1985 provides that for discharges occurring on or after May 1, 1986, an additional payment must be made to IPPS hospitals serving a disproportionate share of low-income patients. The additional payment is determined by multiplying the federal portion of the Diagnosis-Related Group (DRG) payment by the DSH adjustment factor, and beginning for discharges occurring on or after October 1, 2014, the additional payment is determined by multiplying the DRG payment by the DSH adjustment factor reduced by 75 percent. (See 42 CFR 412.106.)

Under the IRF PPS, IRFs will receive an additional payment amount to account for the cost of furnishing care to low-income patients. The additional payment is determined by multiplying the federal prospective payment by the low-income patient adjustment formula (See 42 CFR 412.624(e)(2)).

Under the LTCH PPS, the payment adjustment for Short-Stay Outlier (SSO) cases at 42 CFR 412.529 requires the calculation of an amount comparable to the amount that would otherwise be paid under the IPPS (that is, the “IPPS comparable amount.”). This calculation includes an “IPPS Comparable” DSH adjustment, where applicable, that is determined using the best available SSI data at the time of claim payment (See 42 CFR 412.529(d)(4)).

UPDATED DATE FILES
The SSI/Medicare beneficiary data for hospitals are available electronically and contain the name of the hospital, Centers for Medicare & Medicaid Services (CMS) certification number, SSI days, total Medicare days, and the ratio of days for patients entitled to Medicare Part A attributable to SSI recipients. The files are located at the following CMS website addresses:

IPPS: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.html

IRF: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/SSIData.html

LTCH: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/download.html

The data is used for settlement purposes for IPPS hospitals and IRFs with cost reporting periods beginning and during Fiscal Year (FY) 2016 (cost reporting periods beginning on or after October 1, 2015, and before October 1, 2016), except when explicitly directed otherwise by CMS.
LTCH

ADDITIONAL INFORMATION


DOCUMENT HISTORY

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 16, 2018</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>
**FilmArray BioFire Coding**

Noridian is now covering the FilmArray® BioFire test when used in accordance with its FDA approved indications and such use is reasonable and necessary. To bill for this test use CPT code 87507, Infectious agent detection by nucleic acid (dna or rna); gastrointestinal pathogen (eg, clostridium difficile, e. coli, salmonella, shigella, norovirus, giardia), includes multiplex reverse transcription, when performed, and multiplex amplified probe technique, multiple types or subtypes, 12-25 targets.

**Cardiovascular Stress Testing, Including Exercise and/or Pharmacological Stress and Stress Echocardiography 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:** L36889

**LCD Title:** Cardiovascular Stress Testing, Including Exercise and/or Pharmacological Stress and Stress Echocardiography

**Effective Date:** July 17, 2017

**Summary of Changes:** Addition of the following ICD-10 Codes were added to Group I codes that support medical necessity per LCD reconsideration:

- I08.1: Rheumatic disorders of both mitral and tricuspid valves
- I08.2: Rheumatic disorders of both aortic and tricuspid valves
- I08.3: Combined rheumatic disorders of mitral, aortic and tricuspid valves

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


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

**Duplex Scan of Lower Extremity Arteries Draft LCD Retirement – Effective March 21, 2018**

The following JF Draft Local Coverage Determination (LCD) 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:** DL37340

**LCD Title:** Duplex Scan of Lower Extremity Arteries

**Effective Date:** March 21, 2018

**Rationale:** LCDs are retired due to lack of evidence of current need(s) for the education and/or edits or in some cases because the material is addressed by a National Coverage Determination (NCD), a coverage provision in a CMS interpretative manual, another LCD or an article. Retirement does not mean that medical necessity has changed or that the LCD no longer reflects appropriate criteria. The guidance in the retired LCD may be helpful in assessing medical necessity.

Based on the annual review of data Noridian is retiring the Draft LCD.

To access the Noridian Retired LCDs from our website, follow the instructions below.
Go to https://med.noridianmedicare.com/web/jfa/policies/lcd/retired

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

**Electrocardiograms Final LCD – Effective March 26, 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:** L37283

**LCD Title:** Electrocardiograms

**Effective Date:** March 26, 2018

**Summary of LCD:** Updated the language referenced from the IOM 100-4, Chapter 13, Section 100.1 from carriers to A/B MACs (B) and add the following new 2018 ICD-10 codes described within the coverage indications of this LCD:

- E85.81 Light chain (AL) amyloidosis
- E85.82 Wild-type transthyretin-related (ATTR) amyloidosis
- E85.89 Other amyloidosis
- I21.9 Acute myocardial infarction, unspecified
- I21.A1 Myocardial infarction type 2
- I21.A9 Other myocardial infarction type
- 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
• R06.03 Acute respiratory distress

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.

Erythropoietin Stimulating Agents (ESA) LCD Retirement – Effective January 1, 2018

The following JF Local Coverage Determination (LCD) 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: L34202
LCD Title: Erythropoietin Stimulating Agents (ESA)
Effective Date: January 1, 2018

Rationale: This LCD is retired due to the material being addressed by a very comprehensive National Coverage Determination (NCD) and detailed coverage provisions in CMS interpretative manuals. Retirement does not mean that medical necessity has changed.

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

Go to https://med.noridianmedicare.com/web/jfa/policies/lcd/retired

• The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
• On the “Retired LCDs” page, select the state of interest.
• This link will redirect you to the CMS website.
• Select “Retired LCDs” and click Submit.
• Locate the above listed CMS Medicare Coverage Database (MCD) number and LCD title and select the title of interest.

Facet Joint Injections, Medial Branch Blocks, and Facet Joint Radiofrequency Neurotomy 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: L34995
LCD Title: Facet Joint Injections, Medial Branch Blocks, and Facet Joint Radiofrequency Neurotomy
Effective Date: November 2, 2016

Summary of Changes: LCD clarified to indicate it is inappropriate to bill for fluoroscopy (CPT® codes 77002 or 77003) with a 59 modifier when the procedure(s) billed on that date of service for the same patient by the same provider are included in the CPT® description of the procedure(s) performed under General Information.

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.

Heliocobacter Pylori Infection Testing Draft LCD Published for Review and Comments

The following draft Local Coverage Determinations (LCD) have been published for review and comment on the Noridian website for the following contract numbers: 02101 (AK), 03101 (AZ), 02201 (ID), 03201 (MT), 03301 (ND), 02301 (OR), 03401 (SD), 03501 (UT), 02401 (WA) and 03601 (WY).

LCD Title: Heliocobacter Pylori Infection Testing
Medicare Coverage Database Number: DL37626
Comment period: February 1, 2018 – April 13, 2018

See the Noridian Draft LCDs webpage to access the draft LCDs and address details for comment submission.

When sending comments, providers must reference the specific policy to which they are related and email or mail them to:
policy.drafts@noridian.com

• Noridian Medicare
  Attention: Draft LCD Comments
  PO Box 6781
  Fargo, ND 58103-6781

Hyperbaric Oxygen Therapy Draft LCD Retirement – Effective March 9, 2018

The following JF Draft Local Coverage Determination (LCD) 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: DL36686
LCD Title: Hyperbaric Oxygen Therapy
Effective Date: March 9, 2018

Rationale: After further review of the submitted comments and in consideration of new requirements this Draft LCD is retired. While all coverage for hyperbaric oxygen therapy is dictated by National Coverage Determination (NCD) 20.29, this draft attempted to operationally define the covered indications for the purposes of medical review of claims. Due to new requirements, this LCD will have to be redrafted at some point in the future. The guidance in the retired Draft LCD may be helpful in assessing medical necessity.

To access the Noridian Retired Draft LCD follow the instructions below.

Go to the CMS Medicare Coverage Database Archive Site

• The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
In Vitro Chemosensitivity & Chemoresistance Assays Draft LCD Published for Review and Comments

The following draft Local Coverage Determinations (LCD) have been published for review and comment on the Noridian website for the following contract numbers: 02101 (AK), 03101 (AZ), 02201 (ID), 03201 (MT), 03301 (ND), 02301 (OR), 03401 (SD), 03501 (UT), 02401 (WA) and 03601 (WY).

**LCD Title:** In Vitro Chemosensitivity & Chemoresistance Assays

**Medicare Coverage Database Number:** DL37630

**Comment period:** February 1, 2018 – April 13, 2018

See the Noridian Draft LCDs webpage to access the draft LCDs and address details for comment submission.

When sending comments, providers **must reference the specific policy** to which they are related and email or mail them to:

policy.draft@noridian.com

- Noridian Medicare
  Attention: Draft LCD Comments
  PO Box 6781
  Fargo, ND 58103-6781

Monitored Anesthesia Care (MAC) Draft LCD Retirement – Effective March 23, 2018

The following JF draft Local Coverage Determination (LCD) 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:** DL34100

**LCD Title:** Monitored Anesthesia Care (MAC)

**Effective Date:** March 23, 2018

LCDs are retired due to lack of evidence of current need(s) for the education and/or edits or in some cases because the material is addressed by a National Coverage Determination (NCD), a coverage provision in a CMS interpretative manual, another LCD or an article. Retirement does not mean that medical necessity has changed or that the LCD no longer reflects appropriate criteria. The guidance in the retired LCD may be helpful in assessing medical necessity.

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

Go to [https://med.noridianmedicare.com/web/jfa/policies/lcd/retired](https://med.noridianmedicare.com/web/jfa/policies/lcd/retired)

- The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
  - On the “Retired LCDs” page, select the state of interest.
- This link will redirect you to the CMS website.
  - Select “Retired LCDs” and click Submit.
  - Locate the above listed CMS Medicare Coverage Database (MCD) number and LCD title and select the title of interest.
Micro-Invasive Glaucoma Surgery (MIGS) Draft LCD Published for Review and Comments

The following draft Local Coverage Determinations (LCD) have been published for review and comment on the Noridian website for the following contract numbers: 02101 (AK), 03101 (AZ), 02201 (ID), 03201 (MT), 03301 (ND), 02301 (OR), 03401 (SD), 03501 (UT), 02401 (WA) and 03601 (WY).

**LCD Title:** Micro-Invasive Glaucoma Surgery (MIGS)

**Medicare Coverage Database Number:** DL37661

**Comment period:** February 1, 2018 – April 13, 2018

See the Noridian Draft LCDs webpage to access the draft LCDs and address details for comment submission.

When sending comments, providers must reference the specific policy to which they are related and email or mail them to:

policy.drafts@noridian.com

- Noridian Medicare
  Attention: Draft LCD Comments
  PO Box 6781
  Fargo, ND 58103-6781

MolDX: Approved Gene Testing Article Retirement – November 7, 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).

**Article Title:** MolDX: Approved Gene Testing

**Effective Date:** November 7, 2017

**Summary:** This article is retired November 7, 2017, and replaced with the article titled MolDX Approved Molecular Tests for Reimbursement.

View the locally hosted MolDX Medicare Coverage Article PDF under Covered or Excluded Tests.

Go to Noridian Molecular Diagnostic Services (MolDX) 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 under Covered or Excluded Tests.

To view a 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
MolDX: BRCA1 and BRCA2 Genetic Testing 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: L36163

LCD Title: MolDX: BRCA1 and BRCA2 Genetic Testing

Effective Date: November 2, 2017

Summary of Changes: The policy is revised for the following reasons:

The description was changed for the CPT code 81432 to Hereditary breast cancer-related disorders (eg, hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer); genomic sequence analysis panel, must include sequencing of at least 10 genes, always including BRCA1, BRAC2, CDH1, MLH1, MSH2, MSH6, PALB2, PTEN, STK11, and TP53, effective 01/01/2018.

Added ICD-10 CM C48.1, Malignant neoplasm of specified parts of peritoneum, effective 11/02/2017.

Revisions made in the Indications and Limitations and/or Medical Necessity section to be consistent with the MolDX Contractor.

At this time, 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included in this LCD are applicable as noted in this policy.

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


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

MolDX: CFTR Gene Analysis Billing and Coding Guidelines – R1

The MolDX: CFTR Gene Analysis 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 (WY).

Summary of Changes: Article is revised to add Part A claim filing information and correct Z code reference and website.

Effective Date: October 17, 2016

View the locally hosted MolDX Medicare Coverage Article PDF under Covered or Excluded Tests.

Go to Noridian Molecular Diagnostic Services (MolDX) 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 under Covered or Excluded Tests.

To view a 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

**MolDX: Corus CAD Assay Draft LCD Published for Review and Comments**

The following draft Local Coverage Determinations (LCD) have been published for review and comment on the Noridian website for the following contract numbers: 02101 (AK), 03101 (AZ), 02201 (ID), 03201 (MT), 03301 (ND), 02301 (OR), 03401 (SD), 03501 (UT), 02401 (WA) and 03601 (WY).

**LCD Title:** MolDX: Corus® CAD Assay

**Medicare Coverage Database Number:** DL37675

**Comment period:** February 1, 2018 – April 13, 2018

See the Noridian Draft LCDs webpage to access the draft LCDs and address details for comment submission.

When sending comments, providers must reference the specific policy to which they are related and email or mail them to:

policy.drafts@noridian.com

• Noridian Medicare
  Attention: Draft LCD Comments
  PO Box 6781
  Fargo, ND 58103-6781

**MolDX: CYP2C19, CYP2D6, CYP2C9, and VKORC1 Genetic Testing 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:** L36312

**LCD Title:** MolDX: CYP2C19, CYP2D6, CYP2C9, and VKORC1 Genetic Testing

**Effective Date:** October 1, 2017

**Summary of Changes:** LCD is revised to remove Title XVIII of the Social Security Act, §1862(a)(1)(D) items and services related to research and experimentation from the CMS National Coverage Policy section.

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


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

• On the “Active LCDs” page, locate the above listed LCD title.

• This link will direct you to the locally hosted copy of the Active LCD. You may also view the LCD on the CMS MCD by selecting the appropriate state link on the left side of the page and locating the LCD title.
MolDX: Cystatin C Measurement Draft LCD Published for Review and Comments

The following draft Local Coverage Determinations (LCD) have been published for review and comment on the Noridian website for the following contract numbers: 02101 (AK), 03101 (AZ), 02201 (ID), 03201 (MT), 03301 (ND), 02301 (OR), 03401 (SD), 03501 (UT), 02401 (WA) and 03601 (WY).

LCD Title: MolDX: Cystatin C Measurement

Medicare Coverage Database Number: DL37618

Comment period: February 1 – April 13, 2018

See the Noridian Draft LCDs webpage to access the draft LCDs and address details for comment submission.

When sending comments, providers must reference the specific policy to which they are related and email or mail them to:

policydraft@noridian.com

• Noridian Medicare
  Attention: Draft LCD Comments
  PO Box 6781
  Fargo, ND 58103-6781

MolDX: GeneSight Assay for Refractory Depression 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: L36325

LCD Title: MolDX: GeneSight® Assay for Refractory Depression

Effective Date: March 8, 2018

Summary of Changes: LCD was revised to replace “…as defined by the 17-item Hamilton Rating Scale for Depression (HAM-D17) score of 14 or greater…” with “based upon DSM-V criteria” in the first paragraph of Indications and Limitations. Added information relating to physician boards and KX modifier billing requirements. Under Sources of Information, added 2. American Psychiatric Association (APA). Removed the section on documentation requirements.

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: Guardant360 Plasma-Based Comprehensive Genomic Profiling in Non-Small Cell Lung Cancer (NSCLC) Draft LCD Published for Review and Comments

The following draft Local Coverage Determinations (LCD) have been published for review and comment on the Noridian website for the following contract numbers: 02101 (AK), 03101 (AZ), 02201 (ID), 03201 (MT), 03301 (ND), 02301 (OR), 03401 (SD), 03501 (UT), 02401 (WA) and 03601 (WY).

**LCD Title:** MolDX: Guardant360® Plasma-Based Comprehensive Genomic Profiling in Non-Small Cell Lung Cancer (NSCLC)

**Medicare Coverage Database Number:** DL37651

**Comment period:** February 1 – April 13, 2018

See the Noridian Draft LCDs webpage to access the draft LCDs and address details for comment submission.

When sending comments, providers must reference the specific policy to which they are related and email or mail them to:

policydraft@noridian.com

- Noridian Medicare
  Attention: Draft LCD Comments
  PO Box 6781
  Fargo, ND 58103-6781

MolDX: MDS FISH Draft LCD Published for Review and Comments

The following draft Local Coverage Determinations (LCD) have been published for review and comment on the Noridian website for the following contract numbers: 02101 (AK), 03101 (AZ), 02201 (ID), 03201 (MT), 03301 (ND), 02301 (OR), 03401 (SD), 03501 (UT), 02401 (WA) and 03601 (WY).

**LCD Title:** MolDX: MDS FISH

**Medicare Coverage Database Number:** DL37622

**Comment period:** February 1, 2018 – April 13, 2018

See the Noridian Draft LCDs webpage to access the draft LCDs and address details for comment submission.

When sending comments, providers must reference the specific policy to which they are related and email or mail them to:

policy.drafts@noridian.com

- Noridian Medicare
  Attention: Draft LCD Comments
  PO Box 6781
  Fargo, ND 58103-6781

MolDX: MGMT Promoter Methylation Analysis 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), 02401 (WA) and 03601 (WY).

**Medicare Coverage Database (MCD) Number:** L36192

**LCD Title:** MolDX: MGMT Promoter Methylation Analysis LCD

**Effective Date:** January 1, 2018

**Summary of Changes:** The policy is revised to comply with the 21st Century Cures Act.
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: NSCLC, Comprehensive Genomic Profile Testing 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:** L36198  
**LCD Title:** MolDX: NSCLC, Comprehensive Genomic Profile Testing  
**Effective Date:** January 1, 2018  
**Summary of Changes:** The policy is revised to remove the “CDD” from the title and to comply with the 21st Century Cures Act. The “Title XVIII of the Social Security Act, §1862(a)(1)(D) items and services related to research and experimentation” from the CMS National Coverage Policy Section is also removed.

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: Oncotype DX Genomic Prostate Score for Men with Favorable Intermediate Risk Prostate Cancer Final LCD – Effective March 18, 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:** L37321  
**LCD Title:** MolDX: Oncotype DX® Genomic Prostate Score for Men with Favorable Intermediate Risk Prostate Cancer  
**Effective Date:** March 18, 2018

**Summary of LCD:** This LCD provides limited coverage for the Oncotype DX® Genomic Prostate Score (Genomic Health®) (hereafter GPS) to help determine which patients with favorable intermediate-risk, needle biopsy proven prostate cancer, can be conservatively managed rather than treated with definitive surgery or radiation therapy.

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.

**Nerve Blockade for Treatment of Chronic Pain and Neuropathy 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:** L35457  
**LCD Title:** Nerve Blockade for Treatment of Chronic Pain and Neuropathy  
**Effective Date:** October 1, 2017

**Summary of Changes:** LCD clarified to indicate it is inappropriate to bill for fluoroscopy (CPT® codes 77002 or 77003) with a 59 modifier when the procedure(s) billed on that date of service for the same patient by the same provider are included in the CPT® description of the procedure(s) performed under Coverage Indications, Limitations and/or Medical Necessity.

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

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

**Nerve Blockade for Treatment of Chronic Pain and Neuropathy LCD – R12**
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:** L35457  
**LCD Title:** Nerve Blockade for Treatment of Chronic Pain and Neuropathy  
**Effective Date:** October 1, 2017

**Summary of Changes:** LCD revised to remove duplicate diagnosis codes from the ICD-10 Codes that DO NOT Support Medical Necessity section which are listed in the Group 1 Asterisk section and noted as non-covered when billed with Group 2 CPT codes. Also removed the following CPT codes and ICD-10 diagnosis codes as coverage criteria is explained in LCD L34076.

- CPT codes:
  - 64455 - INJECTION(S), ANESTHETIC AGENT AND/OR STEROID, PLANTAR COMMON DIGITAL NERVE(S) (EG, MORTON’S NEUROMA)
  - 64632 - DESTRUCTION BY NEUROLYTIC AGENT; PLANTAR COMMON DIGITAL NERVE.

- ICD-10 codes:
  - G56.01 - Carpal tunnel syndrome, right upper limb
  - G56.02 - Carpal tunnel syndrome, left upper limb
  - G56.03 - Carpal tunnel syndrome, bilateral upper limb
  - G57.51 - Tarsal tunnel syndrome, right lower limb
• G57.52 - Tarsal tunnel syndrome, left lower limb
• G57.53 - Tarsal tunnel syndrome, bilateral lower limbs
• G57.61 - Lesion of plantar nerve, right lower limb
• G57.62 - Lesion of plantar nerve, left lower limb
• G57.63 - Lesion of plantar nerve, bilateral lower limbs

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.

Non-Covered Services LCD – R24

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: January 1, 2018

Summary of Changes: The Non-Covered Services LCD has been revised to remove from Group 1, Category III CPT® code 0449T; Insertion of aqueous drainage device, without extraocular reservoir, internal approach, into the subconjunctival space; initial device.

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.

Percutaneous Vertebral Augmentation 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: L34106

LCD Title: Percutaneous Vertebral Augmentation

Effective Date: October 1, 2015

Summary of Changes: Under Coverage Indications, Limitations and/or Medical Necessity, removal of the following:

• The medical record must contain assessment of patient condition and response to treatment at one month, three months and 6 months post procedure unless the patient is enrolled in a registry.
Telephone follow up with documentation of outcomes is acceptable. Documentation of at least two (2) unsuccessful and reasonable attempts to contact the patient may substitute for the 3-6 month follow up evaluations.

- Enrollment in a registry with an outcomes documentation schedule consistent with that described in this LCD is an acceptable substitute for medical records’ follow up documentation. Any acceptable registry must be compliant with the principles established in the AHRQ’s “Registries for Evaluating Patient Outcomes: A User’s Guide”. (See bibliography.) Noridian knows of one such registry currently available for enrollment.

The link to the registry is: [http://www.benchmarkmedical.com/VCF Registry/](http://www.benchmarkmedical.com/VCF Registry/). This homepage describes the registry as well as registration resources.

Additional Source added to Bibliography

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

Go to [https://med.noridianmedicare.com/web/jfa/policies/lcd/active.](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 LCD” page, locate the above listed LCD title.
- 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.

**Plastic Surgery 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:** L37020

**LCD Title:** Plastic Surgery

**Effective Date:** October 1, 2015

**Summary of Changes:** Verbiage for Group 4 Coding for Reduction Mammaplasty changed to add: Use one of the C50.xx ICD-10 codes listed as a secondary diagnosis with primary diagnosis N65.1.

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

Go to [https://med.noridianmedicare.com/web/jfa/policies/lcd/active.](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 LCD” 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.

**Positron Emission Tomography Scans Coverage – R13**

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 end date coverage for A9580, effective December 15, 2017, and to delete the following ICD-10 codes from List II effective October 1, 2015, per Change Request 10473:
• C44.91 - Basal cell carcinoma of skin, unspecified
• C57.9 - Malignant neoplasm of female genital organ, unspecified

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.

Repetitive Transcranial Stimulation (rTMS) in Adults with Treatment Resistant Major Depressive Disorder Final LCD – Effective May 14, 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: L37088

LCD Title: Repetitive Transcranial Stimulation (rTMS) in Adults with Treatment Resistant Major Depressive Disorder

Effective Date: May 14, 2018

Summary of LCD: Transcranial Magnetic Stimulation (TMS) is a non-invasive treatment that uses pulsed magnetic fields to induce an electric current in a localized region of the cerebral cortex. An electromagnetic coil placed on the scalp induces focal current in the brain that temporarily modulates cerebral cortical function. Capacitor discharge provides electrical current in alternating on/off pulses. Stimulation parameters may be adjusted to alter the excitability of the targeted structures in specific cortical regions. Repetitive TMS (rTMS) has been investigated as treatment for pharmacoresistant depression. The LCD addresses TMS parameters which include cranial location, stimulation frequency, duration, and intensity. TMS is delivered in outpatient settings without anesthesia or analgesia.

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.

Transcranial Doppler Studies Draft LCD Retirement – Effective March 21, 2018

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

Medicare Coverage Database Number: DL37346

LCD Title: Transcranial Doppler Studies

Effective Date: March 21, 2018

Rationale: LCDs are retired due to lack of evidence of current need(s) for the education and/or edits or in some cases because the material is addressed by a National Coverage Determination (NCD), a coverage provision in a CMS interpretative manual, another LCD or an article. Retirement does not mean that medical
necessity has changed or that the LCD no longer reflects appropriate criteria. The guidance in the retired LCD may be helpful in assessing medical necessity.

Additionally, some coding descriptions and guidance from CMS contained in this LCD have been modified and new specific HCPCS codes created for some of the indications contained within the LCD. Based on the annual review of data and considering newly created HCPCS coding, Noridian is retiring the LCD.

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

Go to [https://med.noridianmedicare.com/web/jfa/policies/lcd/retired](https://med.noridianmedicare.com/web/jfa/policies/lcd/retired)

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

**MolDX Molecular Test Registration and Claims Submission**

**MolDX Test Registration**

The MolDX program includes the designated range of CPT codes in each the following CPT Code Categories. Every molecular test billed by any laboratory or facility within MolDX and our Medicare-partner jurisdictions (Noridian, WPS, CGS, PGBA) must obtain a Z-code for each molecular test prior to claim submission.

<table>
<thead>
<tr>
<th>Code Category/Description</th>
<th>2018 MolDX Code Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1</td>
<td>81161 - 81383</td>
</tr>
<tr>
<td>Tier 2</td>
<td>81400 - 81408</td>
</tr>
<tr>
<td>Genomic Sequencing and other MA</td>
<td>81410 - 81471</td>
</tr>
<tr>
<td>Molecular Multianalyte Assays (MAA)</td>
<td>81490 - 81595</td>
</tr>
<tr>
<td>MAA Proprietary Codes</td>
<td>All Codes</td>
</tr>
<tr>
<td>Immunology</td>
<td>86152 - 86153</td>
</tr>
<tr>
<td>Microbiology</td>
<td>87505 - 87507, 87631 - 87633, 87149 - 87150</td>
</tr>
<tr>
<td>PLA</td>
<td>All Codes</td>
</tr>
<tr>
<td>Cytology</td>
<td>88120 - 88121</td>
</tr>
<tr>
<td>Not otherwise classified (NOC)</td>
<td>81479, 81599, 84999, 85999, 86849, 87999, 88199, 88299, 88399, 89398</td>
</tr>
</tbody>
</table>

To access and obtain a DEX Z-code TM identifier, follow these steps:

Go to the [DEX TM Diagnostics Exchange](https://med.noridianmedicare.com/web/jfa/policies/lcd/retired)

- Select “Register My Organization” and follow the prompts, including participation in the MolDX program.
- An email with a user name and a link for activating your account will be sent to you once Change Healthcare activates your account.
- Once you have completed the registration of your organization and your account is activated, you will have access to add test information.

DEX access enables the following functions:

- Review specific test information
- Review each DEX Z-Code TM identifier
• Request edits for tests
• Register new tests

For questions, email MolDX@PalmettoGBA.com.

As the individual listed in the DEX Z-Code™ identifier application, the username is specific to the contact person designated by each laboratory. Please do not forward or share this information. Colleagues within your organization who want to register may apply for a public user account at http://app.dexzcodes.com. A public user account requires a valid email address and allows a view of public information.

Within 45 business days of a complete and valid registration, the DEX Z-CodeTM identifier will be assigned for tests.

The MolDX team will review the registry information to determine if a test meets the Medicare criteria for coverage. For more information, please refer to MolDX Frequently Asked Questions.

**MolDX Claim Submission**

The claim line for molecular diagnostic tests must contain the appropriate CPT code and test identifier (DEX Z-Code™) associated with the test.

For CPT NOC codes (81479, 81599, 84999, 85999, 86849, 87999, 88199, 88299, 88399, and 89398), the test specific DEX Z-Code™ is submitted in the SV101-7 (5010A1-837P) or SV202-7 (5010A1-837I) claim line detail field. For CPT non-NOC codes, providers may either use the SV101-7 or SV202-7 (preferred) or the NTE field to submit this required information.

Providers billing Part A for molecular tests performed by a proprietary or reference laboratory must obtain the DEX Z-Code™ for the molecular test(s) from the performing laboratory. Part A providers billing for molecular services performed by a hospital-based laboratory must register and obtain a unique DEX Z-Code™ for each molecular test in the MolDX code ranges designated above. Part A providers will need to specify which lines are billed for MolDX and the appropriate DEX Z-CodeTM per line within the remarks section of the claim.

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-Code™

**Correct FISS Remarks Samples:**

Sample 1: ID for a test on line one - Line 1 (HCPCS ZB123)

Sample 2: IDs for two molecular tests on line one and line two:

• Line 1 (HCPCS ZB123)
• Line 2 (HCPCS ZD456)

**Revision History**

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Revision History</th>
</tr>
</thead>
<tbody>
<tr>
<td>February 1, 2018</td>
<td>Article is revised to update the description and or code range in the above table. The 30 day time frame for test registration assignment of a DEX Z-CodeTM identifier is changed to 45 business days.</td>
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</table>
ICD-10 and Other Coding Revisions to NCDs - Revised

MLN Matters Number: MM10318 Revised
Related Change Request (CR) Number: 10318
Related CR Release Date: January 18, 2018
Effective Date: April 1, 2018 - Unless otherwise noted in CR10318
Related CR Transmittal Number: R2005OTN
Implementation Date: January 29, 2018 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

This article was revised on January 19, 2018, to reflect a revised CR10318 issued on January 18. In the article, the CR release date, MAC implementation 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 physicians and other providers submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

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

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

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

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

CR10318 makes coding and clarifying adjustments to the following NCDs:

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

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

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

ADDITIONAL INFORMATION


DOCUMENT HISTORY

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<tr>
<th>Date of Change</th>
<th>Description</th>
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<tbody>
<tr>
<td>January 19, 2018</td>
<td>The article was revised due to a revised CR10318 issued on January 18. In the article, the CR release date, MAC implementation date, transmittal number, and the Web address of the CR are revised. All other information remains the same.</td>
</tr>
<tr>
<td>November 16, 2017</td>
<td>Initial article released.</td>
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</table>
ICD-10 and Other Coding Revisions to NCDs – Revised

MLN Matters Number: MM10473 Revised
Related Change Request (CR) Number: 10473
Related CR Release Date: February 28, 2018
Effective Date: July 1, 2018
Related CR Transmittal Number: R20390TN
Implementation Date: April 2, 2018 for local MAC; July 2, 2018 - for shared system edits

This article was revised on March 1, 2018, to reflect an updated Change Request (CR). That CR corrected instructions in business requirement 7 (NCD210.3), including the spreadsheet for MACs. The CR release date, transmittal number and link to the transmittal also changed. All other information remains the same.

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

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

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.

CR10473 makes coding and clarifying adjustments to the following NCDs:
• NCD20.5 Extracorporeal Immunoadsorption (ECI) Using Protein A Columns
• NCD110.18 Aprepitant
• NCD110.21 Erythropoiesis Stimulating Agents (ESAs)
• NCD150.3 Bone Mineral Density Studies
• NCD190.1 Histocompatibility Testing
• NCD190.11 PT/INR
• NCD210.3 Colorectal Cancer Screening
• NCD210.4.1 Counseling to Prevent Tobacco Use
MEDICAL POLICIES

- NCD210.6 Hepatitis B Virus Screening
- NCD220.4 Mammograms
- NCD220.6.17 PET for Solid Tumors
- NCD250.4 Actinic Keratosis (AKs)

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

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

ADDITIONAL INFORMATION


DOCUMENT HISTORY

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<tr>
<td>March 1, 2018</td>
<td>This article was revised to reflect an updated CR. That CR corrected instructions in business requirement 7 (NCD210.3), including the spreadsheet for MACs. The CR release date, transmittal number and link to the transmittal also changed.</td>
</tr>
<tr>
<td>February 21, 2018</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>
MLN Connects – January 4, 2018
MLN Connects® for Thursday, January 4, 2018

View this edition as a PDF

News & Announcements
• CMS Launches Data Submission System for Clinicians in the Quality Payment Program
• CMS Updates Website to Compare Hospital Quality
• Patients over Paperwork: Get Updates on Burden Reduction
• Quality Payment Program: Qualified Registries and QCDRs
• Quality Payment Program Resources
• EHR Incentive Program Hospitals: Use QNet to Attest
• Medicare Diabetes Prevention Program Resources
• Post-Acute Care Quality Reporting Program Section GG Web-based Training
• Hospice Compare Update
• Are You Prepared for a Health Care Emergency?
• Get Your Patients Off to a Healthy Start in 2018

Provider Compliance
• Hospice Election Statements Lack Required Information or Have Other Vulnerabilities — Reminder

Upcoming Events
• Low Volume Appeals Settlement Option Call — January 9
• ESRD QIP: Final Rule for CY 2018 Call — January 23
• Medicare Learning Network Publications & Multimedia
• Dementia Care Call: Audio Recording and Transcript — New
• Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians Booklet — Revised

MLN Connects – January 11, 2018
MLN Connects® for Thursday, January 11, 2018

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News & Announcements
• New Payment Model to Improve Quality, Coordination, and Cost-effectiveness for Both Inpatient and Outpatient Care
• SNF Quality Reporting Program Confidential Feedback Reports
• Hospital Quality Reporting: Updated CY 2018 QRDA I Schematron
• January is Cervical Health Awareness Month

Provider Compliance
• Proper Use of the KX Modifier for Part B Immunosuppressive Drug Claims — Reminder

Upcoming Events
• New Medicare Card Project Special Open Door Forum — January 23
• ESRD QIP: Final Rule for CY 2018 Call — January 23
• Medicare Learning Network Publications & Multimedia
MLN Connects – January 18, 2018
MLN Connects® for Thursday, January 18, 2018
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News & Announcements

- 2018 Value Modifier Results and Payment Adjustment Factor
- Final DMEPOS Quality Standards for Therapeutic Shoe Inserts
- Glaucoma Awareness Month: Make a Resolution for Healthy Vision

Provider Compliance

- CMS Provider Minute Video: CT Scans — Reminder

Upcoming Events

- New Medicare Card Project Special Open Door Forum — January 23
- ESRD QIP: Final Rule for CY 2018 Call — January 23
- MIPS Annual Call for Measures and Activities Webinar — February 5
- Comparative Billing Report on Opioid Prescribers Webinar — February 21

Medicare Learning Network Publications & Multimedia

- QRUR Video Presentation — New
- Low Volume Appeals Settlement Call: Audio Recording and Transcript — New
- Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians Web-based Training — Revised
- How to Use the Medicare Coverage Database Booklet — Revised
- Behavioral Health Integration Services Fact Sheet — Revised

MLN Connects Special Edition – January 22, 2018

MAC Operations Continue During Shutdown

During the time that the partial government shutdown is in effect, Medicare Administrative Contractors will continue to perform all functions related to Medicare fee-for-service claims processing and payment.

MLN Connects – January 25, 2018
MLN Connects® for Thursday, January 25, 2018
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News & Announcements

- VA, HHS Announce Partnership to Strengthen Prevention of Fraud, Waste and Abuse Efforts
- CMS Updates Open Payments Data
- Improved Open Payments Data Website
- IRF and LTCH Quality Reporting Programs: Submission Deadline February 15
- Panel on Development of Potentially Preventable Hospitalization Measures for HHAs: Nominations due February 22
- SNF Quality Reporting Program: Submission Deadline Extended to May 15
Hospice Quality Reporting Program: Quality Measure User’s Manual Version 2
Continue Seasonal Influenza Vaccination through January and Beyond

Provider Compliance
Reporting Changes in Ownership — Reminder

Upcoming Events
Low Volume Appeals Settlement Option Call — February 13
Home Health Review and Correct Reports Webinar — March 6

Medicare Learning Network Publications & Multimedia
Low Volume Appeals Settlement Call: Video Presentation — New
Hurricane Nate and Medicare Disaster Related Alabama, Florida, Louisiana and Mississippi Claims MLN Matters Article — Updated
Swing Bed Services Fact Sheet — Revised

MLN Connects Special Edition – January 26, 2018

In this Edition:
Therapy Cap Claims Rolling Hold
New Medicare Card: Web Updates
New Medicare Card: When Will My Medicare Patients Receive Their Cards?

Therapy Cap Claims Rolling Hold
CMS is immediately releasing for processing held therapy claims with the KX modifier with dates of receipt beginning January 1-10; CMS will also implement a “rolling hold” to minimize impact if legislation to extend the outpatient therapy caps exceptions process is enacted.

New Medicare Card: Web Updates
To help you prepare for the transition to the Medicare Beneficiary Identifier (MBI) on Medicare cards beginning April 1, 2018, review the new information about remittance advices.
Beginning in October 2018, through the transition period, when providers submit a claim using a patient’s valid and active Health Insurance Claim Number (HICN), CMS will return both the HICN and the MBI on every remittance advice. Here are examples of different remittance advices:

Medicare Remit Easy Print (Medicare Part B providers and suppliers)

PC Print for Institutions
Standard Paper Remits: FISS (Medicare Part A/Institutions), MCS (Medicare Part B/Professionals), VMS (Durable Medicare Equipment)

Find more new information on the New Medicare Card provider webpage.

New Medicare Card: When Will My Medicare Patients Receive Their Cards?
Starting April 2018, CMS will begin mailing new Medicare cards to all people with Medicare on a flow basis, based on geographic location and other factors. Learn more about the Mailing Strategy. Also starting April 2018, your patients will be able to check the status of card mailings in their area on Medicare.gov.

For More Information:
Mailing Strategy
Questions from Patients? Guidelines
New Medicare Card overview and provider webpages
MLN Connects – February 15, 2018
MLN Connects® for Thursday, February 15, 2018
View this edition as a PDF

News & Announcements
- MIPS Reporting Deadlines Fast Approaching: 10 Things to Do and Know
- Quality Payment Program: Performance Scores for 2017 Claims Data
- Diabetic Self-Management Training Accreditation Program: New Webpage and Helpdesk
- Measures of Hospital Harm: Comment by February 16
- EHR Incentive Program: Accepting Proposals for New Measures by June 29
- New Option for Submission of Medicare Cost Reports

Provider Compliance
- Home Health Care: Proper Certification Required — Reminder

Claims, Pricers & Codes
- January 2018 OPPS Pricer File

Upcoming Events
- Improving Accessibility of Provider Settings Webinar — February 21
- ESRD QIP: Final Rule for CY 2018 Call — February 22
- 2018 QCDR Measures Workgroup Webinar — February 27
- Serving Adults with Disabilities on the Autism Spectrum Webinar — February 28
- MIPS Quality Data Submission Webinar — February 28
- Palliative and Hospice Care for Adults with Disabilities Webinar — March 7
- Low Volume Appeals Settlement Option Update Call — March 13
- Open Payments: The Program and Your Role Call — March 14
- MIPS Attestation for Advancing Care Information and Improvement Activities Webinar — March 14

Medicare Learning Network Publications & Multimedia
- Medicare Enrollment Resources Educational Tool — Revised
- PECOS FAQs Booklet — Revised
- PECOS for DMEPOS Suppliers Booklet — Revised
- Safeguard Your Identity and Privacy Using PECOS Booklet — Revised
- PECOS for Provider and Supplier Organizations Booklet — Revised
- PECOS Technical Assistance Contact Information Fact Sheet — Revised
- Health Professional Shortage Area Physician Bonus Program Fact Sheet — Revised
- Medicare Secondary Payer Booklet – Reminder
- Beneficiaries in Custody under a Penal Authority Fact Sheet — Reminder
MLN Connects – February 22, 2018
MLN Connects® for Thursday, February 22, 2018

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News & Announcements

• Low Volume Appeals Settlement Process

Provider Compliance

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

Upcoming Events

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

Medicare Learning Network Publications & Multimedia

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

MLN Connects Special Edition – February 28, 2018


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

With regard to payment for outpatient therapy services, the law repeals application of the Medicare outpatient therapy caps but retains the former cap amounts as a threshold above which claims must include the KX modifier as a confirmation that services are medically necessary as justified by appropriate documentation in the medical record; and retains the targeted medical review process, but at a lower threshold amount. It also extends several recently expired Medicare legislative provisions affecting health care providers and beneficiaries, including the Medicare physician fee schedule work geographic adjustment floor, add-on payments for ambulance services and home health rural services, changes to the payment adjustment for low volume hospitals, and the Medicare dependent hospital program.
In addition, with regard to Section 53111 – Medicare Payment Update for Skilled Nursing Facilities, the Centers for Medicare & Medicaid Services has received questions from stakeholders about the impact of the FY 2019 Skilled Nursing Facility (SNF) update due to section 53111 of the BBA of 2018. To help answer these questions, we are providing information about the estimated market basket update for FY 2019 based on currently available data. This estimate may be updated in the Notice of Proposed Rulemaking for the FY 2019 SNF Prospective Payment System (PPS).

Read the full summary.

MLN Connects – March 1, 2018

MLN Connects® for Thursday, March 1, 2018

View this edition as a PDF

News & Announcements

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

Provider Compliance

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

Upcoming Events

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

Medicare Learning Network Publications & Multimedia

- Provider Compliance Tips for PAP Devices and Accessories Including CPAP Fact Sheet — New
- Provider Compliance Tips for Oral Anticancer Drugs and Antiemetic Drugs Used in Conjunction Fact Sheet — New
- Provider Compliance Tips for Bariatric Surgery Fact Sheet — New
- Provider Compliance Tips for Diabetic Shoes Fact Sheet — New
- Provider Compliance Tips for Lower Limb Orthoses Fact Sheet — New
• Provider Compliance Tips for Enteral Nutrition Fact Sheet — New
• Provider Compliance Tips for Immunosuppressive Drugs Fact Sheet — New
• Provider Compliance Tips for Ambulance Services Fact Sheet — Revised
• Provider Compliance Tips for Clinic ESRD Services (Part A Non-DRG) Fact Sheet — Revised
• Provider Compliance Tips for CT Scans Fact Sheet — Revised
• Medicare Part D Vaccines and Vaccine Administration Fact Sheet — Revised
• Medicare Part B Immunization Billing Educational Tool — Revised
• Screening Pap Tests and Pelvic Examinations Booklet — Revised
• Medicare Enrollment for Physicians, NPPs, and Other Part B Suppliers Booklet — Revised
• Hospital Outpatient Prospective Payment System Booklet — Revised

MLN Connects – March 8, 2018
MLN Connects® for Thursday, March 8, 2018
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News & Announcements
• MyHealthEData Initiative Puts Patients at the Center of the US Health Care System
• New Medicare Card Transition Begins In Less Than a Month
• MACRA Funding Opportunity: Measure Development for the Quality Payment Program
• IRF and LTCH Compare Refresh
• Quality Payment Program: Submit 2017 Participation Data through March 31
• EHR Incentive Program: Hospitals Submit Proposals for New Measures until June 29
• PEPPER for Short-term Acute Care Hospitals
• DME Supplier Feedback on Telephone Discussion and Reopening Process Demonstration
• EHR Incentive Programs FAQs
• Antipsychotic Drug Use in Nursing Homes: Trend Update
• Help Your Patients Go Further With Food

Provider Compliance
• Bill Correctly for Device Replacement Procedures — Reminder

Claims, Pricers & Codes
• April 2018 Average Sales Price Files

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

Medicare Learning Network® Publications & Multimedia
• Provider Compliance Tips for Glucose Monitors Fact Sheet — New
MLN Connects – March 15, 2018
MLN Connects® for Thursday, March 15, 2018

News & Announcements

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

Provider Compliance
- Provider Compliance Tips for Hospital Beds and Accessories

Claims, Pricers & Codes

- Integrated OCE Files for April 2018

Upcoming Events

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

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

MLN Connects – March 22, 2018

MLN Connects® for Thursday, March 22, 2018

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News & Announcements

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

Provider Compliance

- Billing for Stem Cell Transplants — Reminder

Upcoming Events

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

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

MLN Connects – March 29, 2018

MLN Connects® for Thursday, March 29, 2018

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News & Announcements

- Patients Over Paperwork: Empowering Patients Through Data
- MIPS Data Submission Deadline: March 31
- Transitions from Hospice Care, Followed by Death or Acute Care Draft Measure: Comment Period Ends April 25
- Open Payments Review and Dispute Period: April 1 through May 15
- Qualified Medicare Beneficiary Claims: Replacement RAs
- MACRA Patient Relationship Categories and Codes
- Advanced Diagnostic Laboratory Tests: Applications and Guidance
- HIMSS18 Presentations
- Hospice Quality Reporting Program Video Series: Navigating HQRP Websites
- Hospice Item Set Coding Video Series
- Physician Compare Quality Measure TEP Summary Report
- Administrative Simplification: Reaching Compliance with ASETT Video

Provider Compliance

- Provider Compliance Tips for Diabetic Test Strips

Upcoming Events

- Comparative Billing Report on Spinal Orthoses Suppliers Webinar — May 2
- LTCH Quality Reporting Program In-Person Training Event — May 8 and 9
- IRF Quality Reporting Program In-Person Training Event — May 9 and 10
Medicare Learning Network® Publications & Multimedia

- Adjustments to QMB Claims Processed under CR 9911 MLN Matters Article — New
- April Quarterly Update for 2018 DMEPOS Fee Schedule MLN Matters Article — New
- Low Volume Appeals Settlement Call: Audio Recording and Transcript — New
- Open Payments Call: Audio Recording and Transcript — New
- E/M Services Listening Session: Audio Recording and Transcript — New
- Prohibition on Billing Dually Eligible Individuals Enrolled in the QMB Program MLN Matters Article — Revised
- April 2018 I/OCE Specifications Version 19.1 MLN Matters Article — Revised
- April 2018 Update of the Hospital OPPS MLN Matters Article — Revised
EDISS Remittance Advice Process Change

Based on recent CMS direction involving suppression of Standard Paper Remittance Advice (SPR), outlined in Change Request (CR) 10151, EDISS is implementing a process change for Medicare 835 Remittance Advice recipients. CR10151 eliminates the issuance of SPRs to providers/suppliers who have been receiving ERA. More details around the CR can be found in the CMS Medicare Learning Network (MLN) Matters (MM)10151.

EDISS is implementing these changes effective immediately to address this CR:

Part A providers who unenroll from the 835 transaction in EDISS Connect will have their ERA option removed from the standard system and will not be moved back to a paper option. Part A providers have the option of viewing Remittance Advice information in the Noridian Medicare Portal (NMP) but this option is not a full Remittance Advice. Part A Remittance Advice in NMP are claim level, single line ERAs only.

To view a Remittance Advice in NMP, providers will need to register for NMP access.

For more information on NMP registration and functionality go to the Noridian Medicare Portal (NMP) page of the Noridian website.

NMP Advantages Over the IVR

Although the Interactive Voice Response (IVR) is a great option to access patient, claim, and provider details, the Noridian Medicare Portal (NMP) is a more efficient, no cost, alternative. Check out the NMP advantages over the IVR.

<table>
<thead>
<tr>
<th>NMP</th>
<th>IVR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Users enter information using computer keyboard</td>
<td>Callers must follow voice prompts and use telephone touch-tone keypad or voice recognition to enter information (factors include accent and mispronunciation)</td>
</tr>
<tr>
<td>Users able to view information as it is entered (incorrect entries easily/quickly identified)</td>
<td>Callers must wait for an audio response to verify information entered</td>
</tr>
<tr>
<td>Users able to view immediate inquiry results</td>
<td>Callers must wait for audio response to hear inquiry results</td>
</tr>
<tr>
<td>Users can download and save viewed information</td>
<td>Callers able to hear inquiry results only</td>
</tr>
<tr>
<td>Offers “How To” tutorials</td>
<td>No tutorials available</td>
</tr>
<tr>
<td>Continuous updates with increased access coming soon</td>
<td>No future enhancements planned</td>
</tr>
</tbody>
</table>

Referring providers to the self-service options is a requirement per CMS Internet Only Manual (IOM), Publication 100-09, Medicare Beneficiary and Provider Communication Manual, Chapter 6, Section 50.1. “Providers shall be required to use IVRs to access claim status and beneficiary eligibility information. CSRs shall refer providers back to the IVR if they have questions about claims status or eligibility that can be handled by the IVR … Each MAC has the discretion to also require that providers use the Internet-based provider portal for claim status and eligibility inquiries if the portal has these functionalities.”
I/OCE Specifications Version 19.1 – April 2018

MLN Matters Number: MM10514
Related Change Request (CR) Number: 10514
Related CR Release Date: March 2, 2018
Effective Date: April 1, 2018
Related CR Transmittal Number: R3989CP
Implementation Date: April 2, 2018

PROVIDER TYPES 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) 10514 provides the Integrated Outpatient Code Editor (I/OCE) instructions and specifications for the I/OCE that will be used in the Outpatient Prospective Payment System (OPPS) and non-OPPS for hospital inpatient departments, Community Mental Health Centers (CMHCs), all non-OPPS providers, and for limited services when provided in a home health agency not under the Home Health Prospective Payment System (HH PPS) or to a hospice patient for the treatment of a non-terminal illness. Make sure your billing staffs are aware of these updates.

BACKGROUND

CR10514 informs the MACs, including the Home Health and Hospice (HH&H MAC) and the Fiscal Intermediary Shared System (FISS), that the I/OCE is being updated for April 1, 2018. The I/OCE routes all institutional outpatient claims (which includes non-OPPS hospital claims) through a single integrated OCE. The I/OCE specifications are available at http://www.cms.gov/OutpatientCodeEdit/.

The following table summarizes the modifications of the I/OCE for the April 2018 V19.1 update. Readers should also read through the entire CR10514 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>Modifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/1/2018</td>
<td></td>
<td>Update the program to remove the logic that assigns HCPCS level modifier V3 to the line level output for OPPS claims submitted with drug HCPCS lines with Status Indicator (SI) = K that are reported with modifier JG.</td>
</tr>
<tr>
<td>4/1/2018</td>
<td>72</td>
<td>Implement program logic to bypass edit 72 when a HCPCS is present from a specified list for Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) claims (see quarterly data files for HCPCS subject to edit 72 bypass).</td>
</tr>
<tr>
<td>4/1/2018</td>
<td>104</td>
<td>Implement new edit 104: Service not eligible for all-inclusive rate (LIR). Edit criteria: RHC claim with bill type 71x contains a line reported with modifier CG that is not eligible for the RHC all-inclusive rate.</td>
</tr>
<tr>
<td>7/1/2017</td>
<td>105</td>
<td>Implement new edit 105: Claim reported with pass-through device prior to FDA approval for procedure (LID). Edit criteria: A procedure is reported with a pass-through device prior to the FDA approval date for the procedure paired with the device. The line item denial is returned on the device line.</td>
</tr>
<tr>
<td>4/1/2018</td>
<td>106</td>
<td>Implement new edit 106: Add-on code reported without required primary procedure code (LID). Edit criteria: A Type I add-on code is reported on a non-OPPS claim without any of its defined primary codes. The disposition is set to line item denial and is applied to the line with the add-on code.</td>
</tr>
<tr>
<td>Date</td>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>------------</td>
<td>------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>4/1/2018</td>
<td>107</td>
<td>Implement new edit 107: Add-on code reported without required contractor-defined primary procedure code (LID). Edit criteria: A Type II add-on code is reported on a non-OPPS claim without any primary code from the contractor-defined list. The disposition is set to line item denial and is applied to the line with the add-on code.</td>
</tr>
<tr>
<td>4/1/2018</td>
<td>108</td>
<td>Implement new edit 108: Add-on code reported without required primary procedure or without required contractor-defined primary procedure code (LID). Edit criteria: A Type III add-on code is reported on a non-OPPS without any of its defined primary codes, or without any of the primary codes from the contractor-defined list. The disposition is set to line item denial and is applied to the line with the add-on code.</td>
</tr>
<tr>
<td>4/1/2018</td>
<td>22</td>
<td>Add the following new modifiers to the valid modifier list: VM: Mdpp virtual make-up session QA: Avg sta day/night o2 &lt; 1 lpm QB: Avg day/nite o2 &gt; 4 lpm/port QR: Avg sta day/night o2 &gt; 4 lpm</td>
</tr>
<tr>
<td>4/1/2018</td>
<td>94, 103</td>
<td>Update the program logic to deactivate edits 94 and 103 associated with the reporting of biosimilar HCPCS codes with manufacturer modifier. Note: biosimilar manufacturer modifiers ZA, ZB and ZC are deleted.</td>
</tr>
<tr>
<td>4/1/2018</td>
<td></td>
<td>Update Section 6.1 of documentation (Medical Visit Processing) to include additional examples of conditions for claims containing multiple medical visits. Note: no change to logic.</td>
</tr>
<tr>
<td>4/1/2018</td>
<td></td>
<td>Update Section 6.12 of documentation (Special Processing for Drugs and Biologicals) by removing the paragraph regarding the assignment of the HCPCS level modifier, V3 for HCPCS with SI = K.</td>
</tr>
<tr>
<td>4/1/2018</td>
<td></td>
<td>Update the following lists for the release (see quarterly data files): HCPCS modifier list Biosimilar HCPCS list Complexity-adjusted comprehensive Ambulatory Payment Classification (APC) code pairs Skin substitute products (edit 87) Device offset code pairs (Mid-Quarter effective date 8/25/2017) Add on Type I (new code list for edit 106) Add on Type II (new code list for edit 107) Add on Type III (new code list for edit 108) FQHC/RHC bypass edit 72 (new code list) RHC CG modifier not payable list (new code list) Services not recognized under OPPS (edit 62) Services reportable to DMERC (edit 61) Services not billable to the MAC (edit 72)</td>
</tr>
<tr>
<td>4/1/2018</td>
<td>20, 40</td>
<td>Make all HCPCS/APC/Sl changes as specified by CMS (quarterly data files)</td>
</tr>
<tr>
<td>4/1/2018</td>
<td></td>
<td>Implement version 24.1 of the National Correct Coding Initiative (NCCI) (as modified for applicable outpatient institutional providers).</td>
</tr>
</tbody>
</table>

**ADDITIONAL INFORMATION**


**DOCUMENT HISTORY**

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2, 2018</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>
Hospital OPPS – April 2018 Update – Revised

MLN Matters Number: MM10515 Revised
Related Change Request (CR) Number: CR10515
Related CR Release Date: March 20, 2018
Effective Date: April 1, 2018
Related CR Transmittal Number: R4005CP
Implementation Date: April 2, 2018

This article was revised on March 22, 2018, to reflect an updated Change Request (CR) that updated the number of drugs and biologicals with OPPS pass-through status effective April 1, 2018, from twelve to eleven and to remove HCPCS code J0606, Injection, etelcalcetide, 0.1 mg, from Table 5, Attachment A in the CR (page 5 in this article) since its status indicator remains “K” for the April update. All other information remains the same.

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

CR 10515 describes changes to the OPPS to be implemented in the April 2018 update. Make sure your billing staffs are aware of these changes.

BACKGROUND

The April 2018 Integrated Outpatient Code Editor (I/OCE) will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, Status Indicator (SI), and Revenue Code additions, changes, and deletions identified in CR 10515. The April 2018 revisions to I/OCE data files, instructions, and specifications are provided in the forthcoming April 2018 I/OCE CR.


1. New Separately Payable Procedure Code

Effective April 1, 2018, HCPCS Code C9749 is added and is described in the following table.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>OPPS SI</th>
<th>OPPS APC</th>
<th>OPPS Payment Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9749</td>
<td>Repair nasal stenosis w/imp</td>
<td>Repair of nasal vestibular lateral wall stenosis with implant(s)</td>
<td>J1</td>
<td>5164</td>
<td>$2,199.06</td>
</tr>
</tbody>
</table>

2. Multianalyte Assays with Algorithmic Analyses (MAAA) CPT Coding Change Effective January 1, 2018

The AMA CPT Editorial Panel established one new MAAA code, specifically, 0011M, effective January 1, 2018. Because the code was released on December 1, 2017, it was too late to include in the January 2018 OPPS Update. Instead, this code is being included in the April 2018 Update with an effective date of January 1, 2018. The following table lists the long descriptor and SI for CPT code 0011M.
### MAAA CPT Coding Change Effective January 1, 2018

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Long Descriptor</th>
<th>OPPS SI</th>
<th>OPPS APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>0011M</td>
<td>Oncology, prostate cancer, mRNA expression assay of 12 genes (10 content and 2 housekeeping), RT-PCR test utilizing blood plasma and/or urine, algorithms to predict high-grade prostate cancer risk</td>
<td>A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

### 3. Proprietary Laboratory Analyses (PLA) CPT Coding Changes Effective January 1, 2018

The AMA CPT Editorial Panel established 11 new PLA CPT codes, specifically, CPT codes 0024U through 0034U and deleted two PLA codes, specifically, CPT codes 0004U and 0015U, effective January 1, 2018. Because the codes were released on December 1, 2017, it was too late to include them in the January 2018 OPPS Update. Instead, they are being included in the April 2018 Update with an effective date of January 1, 2018.

The following table lists the long descriptors and status indicators for CPT codes 0024U through 0034U. For more information on OPPS status indicators “A” and “Q4”, refer to OPPS Addendum D1 of the CY 2018 OPPS/ASC final rule. CPT codes 0024U through 0034U have been added to the April 2018 I/OCE with an effective date of January 1, 2018. These codes, along with their short descriptors and status indicators, are also listed in the April 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).

#### Proprietary Laboratory Analyses (PLA) CPT Coding Changes Effective January 1, 2018

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Long Descriptor</th>
<th>OPPS SI</th>
<th>OPPS APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>0004U</td>
<td>Infectious disease (bacterial), DNA, 27 resistance genes, PCR amplification and probe hybridization in microarray format (molecular detection and identification of AmpC, carbapenemase and ESBL coding genes), bacterial culture colonies, report of genes detected or not detected, per isolate</td>
<td>D</td>
<td>N/A</td>
</tr>
<tr>
<td>0015U</td>
<td>Drug metabolism (adverse drug reactions), DNA, 22 drug metabolism and transporter genes, real-time PCR, blood or buccal swab, genotype and metabolizer status for therapeutic decision support</td>
<td>D</td>
<td>N/A</td>
</tr>
<tr>
<td>0024U</td>
<td>Glycosylated acute phase proteins (GlycA), nuclear magnetic resonance spectroscopy, quantitative</td>
<td>Q4</td>
<td>N/A</td>
</tr>
<tr>
<td>0025U</td>
<td>Tenofovir, by liquid chromatography with tandem mass spectrometry (LC-MS/MS), urine, quantitative</td>
<td>Q4</td>
<td>N/A</td>
</tr>
<tr>
<td>0026U</td>
<td>Oncology (thyroid), DNA and mRNA of 112 genes, next-generation sequencing, fine needle aspirate of thyroid nodule, algorithmic analysis reported as a categorical result (“Positive, high probability of malignancy” or “Negative, low probability of malignancy”)</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>0027U</td>
<td>JAK2 (Janus kinase 2) (eg, myeloproliferative disorder) gene analysis, targeted sequence analysis exons 12-15</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>0028U</td>
<td>CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism) gene analysis, copy number variants, common variants with reflex to targeted sequence analysis</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>0029U</td>
<td>Drug metabolism (adverse drug reactions and drug response), targeted sequence analysis (ie, CYP1A2, CYP2C19, CYP2C9, CYP2D6, CYP3A4, CYP3A5, CYP4F2, SLC01B1, VKORC1 and rs12777823)</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>0030U</td>
<td>Drug metabolism (warfarin drug response), targeted sequence analysis (ie, CYP2C9, CYP4F2, VKORC1, rs12777823)</td>
<td>A</td>
<td>N/A</td>
</tr>
</tbody>
</table>
4. Reassignment of Skin Substitute Product from the Low Cost Group to the High Cost Group

One skin substitute product, HCPCS code Q4180, has been reassigned from the low cost skin substitute group to the high cost skin substitute group based on updated pricing information. The product is listed in the following table.

Reassignment of Skin Substitute Product from the Low Cost Group to the High Cost Group Effective April 1, 2018

<table>
<thead>
<tr>
<th>CY 2018 HCPCS Code</th>
<th>CY 2018 Short Descriptor</th>
<th>CY 2018 SI</th>
<th>Low/High Cost Skin Substitute</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q4180</td>
<td>Revita, per sq cm</td>
<td>N</td>
<td>High</td>
</tr>
</tbody>
</table>

5. Drugs, Biologicals, and Radiopharmaceuticals

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

For CY 2018, payment for nonpass-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 - 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. Updated payment rates effective April 1, 2018 and drug price restatements can be found in the April 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](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html).

b. Drugs and Biologicals with OPPS Pass-Through Status Effective April 1, 2018

Eleven drugs and biologicals have been granted OPPS pass-through status effective April 1, 2018. These items, along with their descriptors and APC assignments, are identified in the following table.

Drugs and Biologicals with OPPS Pass-Through Status Effective April 1, 2018

<table>
<thead>
<tr>
<th>HCPSCS Code</th>
<th>Long Descriptor</th>
<th>APC</th>
<th>Status Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9462</td>
<td>Injection, delafloxacin, 1 mg</td>
<td>9462</td>
<td>G</td>
</tr>
<tr>
<td>C9463</td>
<td>Injection, aprepitant, 1 mg</td>
<td>9463</td>
<td>G</td>
</tr>
<tr>
<td>C9464</td>
<td>Injection, rolapitant, 0.5 mg</td>
<td>9464</td>
<td>G</td>
</tr>
<tr>
<td>C9465</td>
<td>Hyaluronan or derivative, Durolane, for intra-articular injection, per dose</td>
<td>9465</td>
<td>G</td>
</tr>
<tr>
<td>C9466</td>
<td>Injection, benralizumab, 1 mg</td>
<td>9466</td>
<td>G</td>
</tr>
<tr>
<td>C9467</td>
<td>Injection, rituximab and hyaluronidase, 10 mg</td>
<td>9467</td>
<td>G</td>
</tr>
</tbody>
</table>
c. 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 first date of the quarter at 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.

d. Changes to Biosimilar Biological Product HCPCS Codes and Modifiers

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

Revised Descriptors for Q5101

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>APC</th>
<th>Status Indicator</th>
<th>Added Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5101</td>
<td>Injection, zarxio</td>
<td>Injection, filgrastim-sndz, biosimilar, (zarxio), 1 microgram</td>
<td>1822</td>
<td>G</td>
<td>07/01/2015</td>
</tr>
</tbody>
</table>

In addition, effective April 1, 2018, HCPCS codes Q5103, Injection, infliximab-dyyb, biosimilar, (inflectra), 10 mg, and Q5104, Injection, infliximab-abda, biosimilar, (renflexis), 10 mg will replace HCPCS code Q5102, Inj., infliximab biosimilar. The following table describes coding changes, status indicator, APC assignments, and effective dates for biosimilar biological product HCPCS codes.

Changes to Biosimilar Biological Product HCPCS Codes

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>APC</th>
<th>Status Indicator</th>
<th>Added Date</th>
<th>Termination Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5102</td>
<td>Inj., infliximab biosimilar</td>
<td>Injection, infliximab, biosimilar, 10 mg</td>
<td>1847</td>
<td>G</td>
<td>07/01/2016</td>
<td>03/31/2018</td>
</tr>
<tr>
<td>Q5103</td>
<td>Injection, inflectra</td>
<td>Injection, infliximab-dyyb, biosimilar, (inflectra), 10 mg</td>
<td>1847</td>
<td>G</td>
<td>04/01/2018</td>
<td></td>
</tr>
<tr>
<td>Q5104</td>
<td>Injection, renflexis</td>
<td>Injection, infliximab-abda, biosimilar, (renflexis), 10 mg</td>
<td>9036</td>
<td>G</td>
<td>04/01/2018</td>
<td></td>
</tr>
</tbody>
</table>

The new biosimilar payment policy also makes the use of modifiers that describe the manufacturer of a biosimilar product unnecessary. Therefore, modifiers ZA, ZB, and ZC will be discontinued for dates of service on or after April 1, 2018. However, please note that HCPCS code Q5102 and the requirement to use applicable biosimilar modifiers remain in effect for dates of service prior to April 1, 2018.
6. Use of Modifier “FY”

As stated in the CY 2018 OPPS/ASC final rule, section 502 of Division O, title V of the Consolidated Appropriations Act, 2016 (Pub. L. 114-113), which was enacted on December 18, 2015, contains provisions to incentivize the transition from traditional X-ray imaging to digital radiography. As permitted by section 1833(t)(16)(F)(iv) of the Social Security Act (the Act), CMS implemented modifier “FY” (X-ray taken using computed radiography technology/cassette-based imaging) to enable providers under the OPPS to appropriately report computed radiography services. Effective January 1, 2018, hospital outpatient facilities are required to use this modifier with the applicable HCPCS code(s) to describe an imaging service that is an X-ray taken using computed radiography technology.

In this same final rule, CMS also stated that section 1833(t)(16)(F)(ii) of the Act provides for a phased-in reduction in payment in the case of an imaging service that is an X-ray taken using computed radiography technology (as defined in section 1848(b)(9)(C) of the Act). Payment for such a service (including the X-ray component of a packaged service) furnished during CY 2018, 2019, 2020, 2021, or 2022, that would otherwise be determined under section 1833(t) of the Act (without application of subparagraph (F)(ii) and before application of any other adjustment), will be reduced by 7 percent, and if such a service is furnished during CY 2023 or a subsequent year, by 10 percent. For purposes of this reduction, computed radiography technology is defined in section 1848(b)(9)(C) of the Act as cassette-based imaging which utilizes an imaging plate to create the image involved.

CMS notes that section 1833(t)(16)(F)(ii) refers to an imaging service that is an X-ray taken using computed radiography technology. Where the imaging service is comprised of multiple images that include both X-rays taken using computed radiography technology and images taken using digital radiography, CMS does not believe the payment reduction would apply to that service. Instead, the payment adjustment applies to an imaging service that is an X-ray taken using computed radiography technology where the X-ray taken using computed radiography technology is not combined with digital radiography in the same imaging service.

7. 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


DOCUMENT HISTORY

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 22, 2018</td>
<td>This article was revised to reflect an updated CR that updated the number of drugs and biologicals with OPPS pass-through status effective April 1, 2018, from twelve to eleven and to remove HCPCS code J0606, Injection, etelcalcetide, 0.1 mg, from Table 5, Attachment A in the CR (page 5 in this article) since its status indicator remains “K” for the April update.</td>
</tr>
<tr>
<td>March 6, 2018</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>
OPPS Providers with Multiple Service Locations Billing Requirements

MLN Matters Number: SE18002
Related Change Request (CR) Number: 9613; 9907
Related CR Release Dates: August 5, 2016; February 5, 2017
Effective Date: January 1, 2017
Related CR Transmittal Numbers: R17040TN and R17830TN
Implementation Date: January 3, 2017 for CR9613 and July 3, 2017 for CR9907

PROVIDER TYPES AFFECTED
This MLN Matters® Special Edition Article is intended for Outpatient Prospective Payment System (OPPS) providers that have multiple service locations submitting claims to Medicare A/B Medicare Administrative Contractors (MACs).

WHAT YOU NEED TO KNOW
This article conveys enforcement editing requirements for the Medicare Claims Processing Manual, Chapter 1, and Section 170 which describes Payment Bases for Institutional Claims. These requirements are not new requirements. Previously, these requirements were discussed in CRs 9613 and 9907, both of which were effective on January 1, 2017. MLN Matters articles for CRs 9613 and 9907 are available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9613.pdf and https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9907.pdf, respectively. Make sure your billing staff is aware of these instructions.

BACKGROUND
Increasingly, hospitals operate off-campus, outpatient, provider-based department of a hospital’s facilities. In some cases, these additional locations are in a different payment locality than the main provider. In order for Medicare Physician Fee Schedule (MPFS) and OPPS payments to be accurate, the service facility address of the off-campus, outpatient, provider-based department of a hospital facility is used to determine the locality in these cases.

Additionally, in accordance with Section 1833(t)(21) of the Act, as added by section 603 of the Bipartisan Budget Act of 2015 (Pub. L. 114-74), Non-excepted services provided at an off-campus, outpatient, provider-based department of a hospital were required to be identified as non-excepted items and services billed on an institutional claim and to be paid under the MPFS and not the OPPS rates.

Claim level information:
Medicare outpatient service providers report the service facility location for off-campus, outpatient, provider-based department of a hospital facilities in the 2310E loop of the 837 institutional claim transaction. Direct Data Entry (DDE) submitters also are required to report the service facility location for off-campus, outpatient, provider-based department of a hospital facilities. Paper submitters report the service facility address information in Form Locator (FL) “01” on the paper claim form. For MPFS services, Medicare systems use this service facility information to determine the applicable payment method or locality whenever it is present.

Additionally, Medicare systems will validate service facility location to ensure services are being provided in a Medicare enrolled location. The validation will be exact matching based on the information submitted on the Form CMS-855A submitted by the provider and entered into the Provider Enrollment, Chain and Ownership System (PECOS). Providers need to ensure that the claims data matches their provider enrollment information.

When all the services rendered on the claim are from the billing provider address, providers are:

- To report the billing provider address only in the billing provider loop and not to report any service facility location.

When all the services rendered on the claim are from one campus of a multi-campus provider that report a billing provider address, providers are:
• To report the campus address where the services were rendered in the service facility location if the service facility address is different from the billing provider address.

When all the services rendered on the claim are from the same off-campus, outpatient, provider-based department of a hospital facilities, providers are:

• To report the off-campus, outpatient, provider-based department service facility address in the service facility provider loop.

When there are services rendered on the claim from multiple locations:

• If any services on the claim were rendered at the billing provider address, providers should report the billing provider address only in the billing provider loop 2010AA and do not report the service facility location in loop 2310E.

• If no services on the claim were rendered at the billing provider address, providers should report the service facility address from the first registered encounter of the “From” date on the claim.

NM1 - SERVICE FACILITY LOCATION NAME – 60 Characters 837I – 25, UB-04
N3 - SERVICE FACILITY LOCATION ADDRESS
N302 – 55 Characters 837I – not on UB-04 paper form
N4 - SERVICE FACILITY LOCATION CITY, STATE, ZIP CODE
N401 City Name – 30 Characters 837I – 12 Characters on the UB-04
N402 State Code – 2 Characters 837I – 2 Characters on the UB-04
N403 Postal Code – 15 Characters 837I – 9 Characters on the UB-04

Line level information:

In the CY 2015 OPPS Final Rule (79 FR 66910-66914), the Centers for Medicare & Medicaid Services (CMS) created a HCPCS modifier for hospital claims that is to be reported with each claim line with a HCPCS for outpatient hospital items and services furnished in off-campus provider-based department (PBD) of a hospital. This 2-digit modifier was added to the HCPCS annual file as of January 1, 2015, with the label “PO.” Reporting of this new modifier was voluntary for CY 2015, with reporting required beginning on January 1, 2016.

In accordance with Section 1833(t)(21) of the Act, as added by section 603 of the Bipartisan Budget Act of 2015 (Pub. L. 114-74), CMS established a new modifier “PN” (Non-excepted service provided at an off-campus, outpatient, provider-based department of a hospital) to identify and pay non-excepted items and services billed on an institutional claim. Effective January 1, 2017, non-excepted off-campus provider-based departments of a hospital are required to report this modifier on each claim line with a HCPCS for non-excepted items and services. The use of modifier “PN” will trigger a payment rate under the MPFS. CMS expects the PN modifier to be reported with each non-excepted line item and service including those for which payment will not be adjusted, such as separately payable drugs, clinical laboratory tests, and therapy services; with reporting required beginning on January 1, 2017.

As a result, effective January 1, 2017, excepted off-campus provider-based departments of a hospital must continue to report existing modifier “PO” (Services, procedures and/or surgeries provided at off-campus provider-based outpatient departments) for all excepted items and services with a HCPCS furnished.

Billing Examples

<table>
<thead>
<tr>
<th>No.</th>
<th>Service Facility</th>
<th>Billing Provider</th>
<th>Service Facility Address</th>
<th>Modifier Used</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Billing provider (Main Campus) Only</td>
<td>Yes</td>
<td>N/A</td>
<td>No “PO” or “PN” Modifier required on billing provider services.</td>
</tr>
<tr>
<td></td>
<td>Billing Provider (Main Campus), Excepted Off-Campus</td>
<td>Yes</td>
<td>N/A</td>
<td>No “PO” or “PN” Modifier required on Main Campus services. Modifier “PO” required on services with a HCPCS from Excepted Off-Campus.</td>
</tr>
<tr>
<td>---</td>
<td>---------------------------------------------------</td>
<td>-----</td>
<td>-----</td>
<td>----------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>3</td>
<td>Billing Provider (Main Campus), Non-Excepted Off-Campus</td>
<td>Yes</td>
<td>N/A</td>
<td>No “PO” or “PN” Modifier required on Main Campus services. Modifier “PN” required on services with a HCPCS from Non-Excepted Off-Campus.</td>
</tr>
<tr>
<td>4</td>
<td>Billing Provider (Main Campus), Campus of Multi-Campus provider*</td>
<td>Yes</td>
<td>N/A</td>
<td>No “PO” or “PN” Modifier required on billing provider services or other Campus services of a Multi-Campus.</td>
</tr>
<tr>
<td>5</td>
<td>Campus of Multi-Campus provider*</td>
<td>Yes</td>
<td>Yes</td>
<td>Campus Address*</td>
</tr>
<tr>
<td>6</td>
<td>Billing Provider (Main Campus), Excepted Off-Campus, Non-Excepted Off-Campus</td>
<td>Yes</td>
<td>N/A</td>
<td>No “PO” or “PN” Modifier required on Billing Provider services. Modifier “PO” required on services with a HCPCS from Excepted Off-Campus. Modifier “PN” required on services with a HCPCS from Non-Excepted Off-Campus.</td>
</tr>
<tr>
<td>7</td>
<td>Billing Provider (Main Campus), Campus of Multi-Campus provider*, Excepted Off-Campus, Non-Excepted Off-Campus</td>
<td>Yes</td>
<td>N/A</td>
<td>No “PO” or “PN” Modifier required on billing provider services or other Campus services of a Multi-Campus. Modifier “PO” required on services with a HCPCS from Excepted Off-Campus. Modifier “PN” required on services with a HCPCS from Non-Excepted Off-Campus.</td>
</tr>
<tr>
<td>8</td>
<td>Campus of Multi-Campus provider*, Excepted Off-Campus, Non-Excepted Off-Campus</td>
<td>Yes</td>
<td>Yes</td>
<td>Campus Address*</td>
</tr>
<tr>
<td>9</td>
<td>Excepted Off-Campus</td>
<td>Yes</td>
<td>Yes</td>
<td>Modifier “PO” required on all services with a HCPCS.</td>
</tr>
<tr>
<td></td>
<td>Case Study</td>
<td>Yes/No Details</td>
<td>Modifier Details</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>------------</td>
<td>----------------</td>
<td>-----------------</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Non-Excepted Off-Campus</td>
<td>Yes</td>
<td>Yes</td>
<td>Modifier “PN” required on all services with a HCPCS.</td>
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<td>11</td>
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<td>Yes</td>
<td>Yes First Registered Encounter</td>
<td>Modifier “PO” required on services with a HCPCS from Excepted Off-Campus. Modifier “PN” required on services with a HCPCS from Non-Excepted Off-Campus.</td>
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<td>Yes</td>
<td>Yes First Registered Encounter</td>
<td>Modifier “PO” required on all services with a HCPCS.</td>
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<td>13</td>
<td>Non-Excepted Off-Campus, Non-Excepted Off-Campus</td>
<td>Yes</td>
<td>Yes First Registered Encounter</td>
<td>Modifier “PN” required on all services with a HCPCS.</td>
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**ADDITIONAL INFORMATION**

**DOCUMENT HISTORY**

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<td>March 15, 2018</td>
<td>Initial article released.</td>
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Counting Units for Therapy Codes

Counting units for therapy services can be complicated; therefore, we are providing guidance. But first, you must understand the difference between timed codes and untimed codes in order to determine how to bill units correctly.

**Timed Codes**

Several Current Procedural Terminology (CPT) codes used for therapy modalities, procedures, and tests and measurements specify that direct (one-on-one) time spent with the patient is 15 minutes. Report procedure codes for services delivered on any single calendar day using CPT codes and the appropriate number of 15 minute units of service. Services provided for a single timed CPT code that is less than 8 minutes should not be billed.

Report the CPT code for the time actually spent in the delivery of the modality requiring constant attendance and therapy services. Pre- and post-delivery services are not to be counted in determining the treatment service time. The time counted is the time the patient is treated.

When more than one service represented by 15 minute timed codes is performed in a single day, the total number of minutes of service determines the number of timed units billed.

The chart below provides time intervals for billing units based on treatment time in minutes.

<table>
<thead>
<tr>
<th>Units</th>
<th>Number of Minutes</th>
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<tbody>
<tr>
<td>1</td>
<td>≥ 8 minutes through 22 minutes</td>
</tr>
<tr>
<td>2</td>
<td>≥ 23 minutes through 37 minutes</td>
</tr>
<tr>
<td>3</td>
<td>≥ 38 minutes through 52 minutes</td>
</tr>
<tr>
<td>4</td>
<td>≥ 53 minutes through 67 minutes</td>
</tr>
<tr>
<td>5</td>
<td>≥ 68 minutes through 82 minutes</td>
</tr>
<tr>
<td>6</td>
<td>≥ 83 minutes through 97 minutes</td>
</tr>
<tr>
<td>7</td>
<td>≥ 98 minutes through 112 minutes</td>
</tr>
<tr>
<td>8</td>
<td>≥ 113 minutes through 127 minutes</td>
</tr>
</tbody>
</table>

**Examples**

The following examples illustrate how to count the appropriate number of units for the total therapy minutes provided.

**Example 1**

- 24 minutes of neuromuscular reeducation, 97112
- 23 minutes of therapeutic exercise, 97110
- 47 minutes total treatment time

The 47 total treatment time falls within the range for 3 units (see chart).

Each service was performed for more than 15 minutes and should be billed for at least 1 unit, but the total allows 3 units. In this instance, report 2 units of 97112 and 1 unit of 97110, assigning more timed units to the service that took the most time.

**Example 2**

- 20 minutes of neuromuscular reeducation, 97112
- 20 minutes therapeutic exercise, 97110
- 40 minutes total treatment time

The 40 total treatment time falls within the range for 3 units (see chart).

Each service was performed for at least 15 minutes and should be billed for at least 1 unit, but the total allows 3 units. Since the time for each service is the same, choose either code for 2 units and bill the other for 1 unit. Do not bill 3 units for either one of the codes.
Example 3
• 33 minutes of therapeutic exercise, 97110
• 7 minutes of manual therapy, 97140
• 40 minutes total treatment time
The 40 total treatment time falls within the range for 3 units (see chart).
In this instance, you would bill 2 units of 97110 and 1 unit of 97140. You count the first 30 minutes of 97110 as 2 full units. Then, compare the remaining time for 97110 (33-30=3 minutes) to the time spent on 97140 (7 minutes) and bill the larger, which is 97140.

Example 4
• 18 minutes of therapeutic exercise, 97110
• 13 minutes of manual therapy, 97140
• 10 minutes of gait training, 97116
• 8 minutes of ultrasound, 97035
• 49 minutes total treatment time
The 49 total treatment time falls within the range for 3 units (see chart).
Bill the procedures you spent the most time providing. Bill 1 unit for 97110, 97116, and 97140. You may not bill for the ultrasound (97035) because the total time of timed units that can be billed is constrained by the total timed code treatment minutes (i.e., you may not bill 4 units for less than 53 minutes regardless of how many services were performed). You would still document the ultrasound in the treatment notes.

Untimed Codes
The units for untimed codes are reported based on the number of times the procedure is performed, as described in the healthcare common procedure coding system (HCPCS) code definition (often once per day). When reporting service units for codes where the procedure is not defined by a specific timeframe (untimed codes), a 1 is entered in the units field.

Note: The units for untimed codes are based upon the number of times the procedure is performed regardless of the number of minutes spent.
The following are examples of untimed codes:
• Evaluations/Re-evaluations (97161-97168)
• Group therapy (97150)
• Supervised modalities (97012)

Reference
Outpatient Therapy Cap Repeal and KX Modifier Use

On February 9, 2018, Congress passed the Bipartisan Budget Act of 2018. This legislation contains a number of provisions that extend certain Medicare Fee for Service (FFS) policies, one permanently repeals the outpatient therapy caps beginning on January 1, 2018.

Section 50202 of the Act repeals Medicare provisions affecting the outpatient therapy caps. This section requires:

• Medicare claims no longer be subject to the therapy cap;
• Threshold for medical review be lowered; and
• Submission of the KX modifier for claims in excess of the prior therapy cap amount for claims with dates of service on and after January 1, 2018.

A Change Request (CR) will be released to provide instructions on reprocessing claims impacted by this legislation. MACs will no longer be holding claims submitted with the KX modifier. Please be on the alert for additional information, which will provide direction on this and other provisions of the new legislation.
SPR Suppression in 45 Days if Also Receiving ERA – Revised

MLN Matters Number: MM10151 Revised
Related Change Request (CR) Number: 10151
Related CR Release Date: December 28, 2017
Effective Date: January 1, 2018
Related CR Transmittal: R1994OTN
Implementation Date: January 2, 2018

This article was revised on December 29, 2017, to reflect the revised CR10151 issued on December 28, 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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December 22, 2017  This article was revised 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.

August 7, 2017  Initial article released.

**RARC, CARC, MREP and PC Print Update**

**MLN Matters Number:** MM10489  
**Related Change Request (CR) Number:** 10489  
**Related CR Release Date:** February 16, 2018  
**Effective Date:** July 1, 2018  
**Related CR Transmittal Number:** R3980CP  
**Implementation Date:** July 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) 10489 updates the Remittance Advice Remark Codes (RARC) and Claims Adjustment Reason Code (CARC) lists and instructs Medicare Shared System Maintainers (SSMs) to update Medicare Remit Easy Print (MREP) and PC Print. Be sure your staff are aware of these changes and obtain the updated MREP and PC Print software if they use that software.

**BACKGROUND**

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

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

The Shared System Maintainers (SSMs) have the responsibility to implement code deactivation, making sure that any deactivated code is not used in original business messages and allowing the deactivated code in derivative messages. SSMs must make sure that Medicare does not report any deactivated code on or after the effective date for deactivation as posted on the Washington Publishing Company (WPC) website. If any new or modified code has an effective date past the implementation date specified in CR 10489, MACs must implement on the date specified on the WPC website, available at: [http://wpc-edi.com/Reference/](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. For this recurring CR, the MACs and the SSMs must get the complete list for both CARC and RARC from the WPC website to obtain the comprehensive lists for both code sets and determine the changes that are included on the code list since the last code update, CR 10270 (see MLN Matters article MM10270).

**ADDITIONAL INFORMATION**

## REIMBURSEMENT

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RHC and FQHC Medicare Benefit Policy Manual Chapter 13 Update - Revised

MLN Matters Number: MM10350 Revised
Related Change Request (CR) Number: 10350
Related CR Release Date: January 9, 2018
Effective Date: January 22, 2018
Related CR Transmittal Number: R239BP
Implementation Date: January 22, 2018

This article was revised on January 10, 2018, to reflect a revised CR10350 issued on January 9. In the article, the effective and implementation dates are revised. Also, 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 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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