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Noridian Part A Customer Service Contact

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- Interactive Voice Response (IVR)
- Provider Contact Center (PCC)
- Provider Enrollment
- EDISS
- User Security (including NMP)

Text Teletype Calls (TTY) – 877-261-4163
Monday – Friday 8 a.m. – 6 p.m. CT

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 these or any other claims.

Additional Information


Effective Date: January 1, 2005
Implementation Date: January 4, 2005
2018 JF Part A Quarterly Ask-the-Contractor Teleconferences

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

- January 17, 2018
- May 16, 2018
- September 19, 2018

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

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

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

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.

We look forward to your participation in these important calls.

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Alcohol Misuse Screening and Counseling

About 38 million adults in the United States drink too much. Only one in six adults have talked to a health professional. Alcohol screening and brief counseling has been proven to work and talking to your patient is the first step!

All Medicare beneficiaries are eligible for alcohol screening. Medicare beneficiaries who screen positive are eligible for counseling if both of the following are met:

- Competent and alert at the time counseling is provided.
- Counseling is furnished by qualified primary care physician or other primary care practitioners in a primary care setting.

Learn more about this positive preventive benefit on the Centers for Medicare & Medicaid Services (CMS) MLN Educational Tool, Medicare Preventive Services.
**FYI**

**EDISS to End Support of Modem Technology – October 1, 2018**

**For All Current Modem Users**

Technology and connectivity services have advanced through the years and modem technology has outlived its relevancy within the healthcare industry. EDI Support Services (EDISS) at Noridian will no longer support modem functionally after October 1, 2018 for any EDI transactions. Any provider or vendor who uses a modem for connectivity and data exchange with EDISS will need to find alternative methods for their connectivity.

If your facility is already submitting directly to EDISS with an NSV or use a billing service or clearinghouse, no action will be needed.

Network Service Vendors (NSVs) offer many affordable, user-friendly connectivity options which allow submitters a secure SFTP internet connection for file transfers. Submitters currently using modems may not be aware of the alternative connectivity options available to them.

A listing of NSVs already doing business with Noridian can be found in the “EDISS to End Support of Modem Technology” article on the EDI Support Services website. Selecting the individual links for each NSV will take you to their respective websites for more information.

Noridian and EDISS cannot assist with making this decision for your organization. Research should be conducted within your facility to determine which NSV will fit your needs.

**ACT Questions and Answers - May 16, 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 verbal and/or telephone orders required to be signed by the practitioner prior to submitting a claim for a Skilled Nursing Facility (SNF) stay?**

A1. Yes. See CMS Internet Only Manual (IOM), Publication 100-02, Chapter 1, Section 10.2.(B)(2)(b) and CMS IOM, Publication 100-08, Chapter 3, Section 3.3.2.4.

**Q2. If a beneficiary’s apnea-hypopnea index (AHI) is 0 (zero), but the respiratory distress index (RDI) is 15, can this be used to qualify the beneficiary for a Continuous Positive Airway Pressure (CPAP) device? And, if it is acceptable, does it have to be a home sleep study only when using the RDI, or can it also be used to qualify beneficiaries that had a facility based sleep study?**

A2. Either the RDI or AHI may be used in split-night studies. As a reminder, polysomnography should document that CPAP eliminates, or nearly eliminates, the respiratory events during Rapid Eye Movement (REM) and Non-Rapid Eye Movement (NREM) sleep. See the Noridian Polysomnography and Other Sleep Studies Local Coverage Determination (LCD).

**Q3. In Chapter 3 on page O-4 of the Resident Assessment Instrument (RAI) 3.0 User’s Manual, it is explained that there are specific criteria to be met for infection isolation modifier (O0100M2). Will Noridian clarify these criteria?**

A3. The questioner is talking about an RAI Minimum Data Set matrix code used in determining the Resource Utilization Group (RUG) rate. Unfortunately, Noridian is unable to provide guidance as to what is and is not acceptable in this situation; instead, we will refer the questioner to the CMS RAI User’s Manual Appendix B, to locate the email address for the State RAI coordinator to resolve questions on this matter.

**Q4. How are discharge status codes in the range of 81-95 to be used? And, do these discharge status codes count towards the Hospital Readmissions Reduction Program (HRRP) reduction?**

A4. These codes are used in the context of anticipating readmission to the originating/discharging facility. There is a downfall to this: per the 2014 IPPS Final Rule, reimbursement to the originating facility is impacted by the use of these readmission discharge status codes. The readmission discharge status codes are geared for DRGs 280 – 282. See Federal Register / Vol. 78, No. 160 / Monday, August 19, 2013 / Rules and Regulations for additional information.
Q5. Does Noridian have a mechanism to bill ultrafiltration on Advanced Kidney Injury (AKI) claims?
A5. Noridian has provided guidance not to bill 90999 on a claim with AKI services, per CMS Change Request (CR)9598. See the Acute Kidney Injury (AKI) and ESRD Facilities webpage for additional information.

Q6. Is Medical Decision Making (MDM) required to be one of the “two out of three” elements in the case of an established beneficiary for Evaluation and Management (E/M) services?
A6. This is entirely dependent upon the physician’s documentation and if an additional work plan will be developed.

Q7. When a beneficiary is admitted to a Critical Access Hospital (CAH) and transferred within two days of admission, is the CAH required to provide the Important Message from Medicare (IM)? Or, because the beneficiary is being transferred, is it the receiving facility’s responsibility?
A7. If the beneficiary was admitted as an inpatient to the CAH, and their transfer resulted in a discharge from the CAH, then the CAH must provide the IM.

Q8. Is the Axogen nerve wrap, CPT code 64999, covered when billed with carpal tunnel surgery?
A8. Nerve wrap is not separately billable from carpal tunnel surgery, according to CPT. It is more appropriate to bill CPT 64721 for the carpal tunnel surgery, which includes the nerve wrap.

Q9. Is a CAH required to have a signed physician order on file to perform lab work if the ordering physician is from another facility and has the order, or intent to order, on file at their separate facility?
A9. The CAH must be able to support that the service was ordered, or that there was an intent to order. Therefore, it is advisable to keep a copy of the order, requisition, or any other piece which identifies intent, with the beneficiary’s medical record. There are many denials that occur for this reason: the rendering provider gets audited, submits their documentation (which doesn’t contain an order, or intent), and the ordering provider is unable or unwilling to submit the order; the rendering provider then receives the recoupment.

Q10. When can Long Term Care Hospital (LTCH) providers expect the reprocessing of claims for the extension of the “blended payment rate?”
A10. Noridian just completed mass adjustments per CMS CR10480. Claims submitted on/after 4/1/18 have already taken into account the -4.6% adjustment.

Q11. What is the correct way to bill, and receive reimbursement for, a provider who completes a SNF visit, but practices outside of the SNF?
A11. Services provided under consolidated billing arrangements must be provided by Medicare certified providers that are licensed to provide the service involved. The physician must have an arrangement with the SNF, whereby, the facility bills for the services rendered. It is also possible for the physician to directly bill Part B. See CMS IOM, Publication 100-04, Chapter 6, Section 80.5 for additional information.

Q12. A secondary payer is requesting Medicare’s payment be refunded to them. The beneficiary’s eligibility is Bill Option Code 1. Can Noridian explain a bit about this option code?
A12. Bill Option Code 1 is for a Health Care Prepayment Plan. If this must be corrected, reach out to the insurer to update their file, as this is not a Medicare-oriented question. See CR5538 for additional information.

Q13. If the services were performed two days prior from the signed date of the ABN, is the Advance Beneficiary Notice of Noncoverage (ABN) valid?
A13. No. The ABN must be delivered prior to the rendered service. If the beneficiary does not get written notice when it is required, he/she may not be held financially liable if Medicare denies payment, and the provider or supplier may be financially liable if Medicare does not pay.

Q14. If a beneficiary is in the Emergency Room (ER) and crosses a midnight, but doesn’t receive services on the second day, should that be billed with a single date of service (DOS) or with a span of two days?
A14. The from and through dates of services on the claim must reflect the time the beneficiary was present in the facility, whether the beneficiary received services on those days or not.

Q15. If there’s no hydration order, but hydration medicines are given, what CPT codes can be billed? And, may providers bill a therapeutic administration for the hydration (if there is no order)?

A15. If there is no order, providers cannot bill for the hydration service. A valid order is required to support the physician wanted the service to take place. Documentation must also support the medical necessity for hydration and that it was administered over at least 31 minutes. Providers may not bill a therapeutic administration for hydration if there is no order. If there is an order for the therapeutic drugs, providers may bill for those, along with the therapeutic administration.

Q16. Please describe how to locate the updated April Lab National Coverage Determinations (NCDs)?

A16. Access the appropriate Lab NCDs - ICD-10. Select the appropriate month and year from the Downloads section at the bottom of the page.

Q17. A Fetal Non-Stress Test (FNST) is performed as an outpatient in a CAH Method II by a registered nurse (RN) and the physician is not present. CPT 59025 is billed along with an E/M (incident to) on an 85X type of bill (TOB). Is the professional component billable for an interpretation of the CPT 59025 and is it billed on the 85X TOB?

A17. CPT 59025 does have the capacity to be split by processional component (PC)/technical component (TC) for CAH Method II.

Q18. Can a Federally Qualified Health Center (FQHC) bill Part B, or issue an ABN, if

Physician performs a procedure only visit and there’s no qualifying CPT on that day (e.g. CPT 17110) and there wasn’t an E/M?

Physician performs a CPT 99211, which is not a qualifying CPT, for an FQHC visit?

A18. The physician can bill Part B directly; however, the FQHC cannot receive a facility payment.

Q19. What should providers do when Ongoing Responsibility for Medicals (ORMs) are denying because a payer that should be primary to Medicare has filed an ORM?

A19. Providers should bring their claim-specific examples to the Provider Contact Center (PCC).

Q20. HCPCS J7999 is required to be reported as a compounded drug, even though it’s really a packaged service that has to do with the anesthesia. When billed, the code hits out for Medically Unlikely Edit (MUE). Does Noridian have any insight on this issue?

A20. The CMS National Correct Coding Initiative (NCCI) determines the allowable values for several HCPCS codes. HCPCS J7999 is an unclassified code that has an MUE of six. Providers should contact NCCI whenever they feel the allowable amount of units requires an update.

Q21. How can providers determine if a beneficiary is incarcerated? Claims have denied because the beneficiary is shown as incarcerated in the Common Working File (CWF).

A21. If able, ask the beneficiary. If that is not an option, use an internet search engine to query the beneficiary’s name in any public record.

Q22. Will Medicare support payment of a private room if the physician states in the inpatient admission order why a psychiatric lockdown unit with a private room was ordered for the patient?

A22. Medicare may make payment for this type of scenario. See CMS IOM, Publication 100-02, Chapter 1, Section 10.1.2.
Educational Events That Are Full

The Noridian Provider Outreach & Education staff (POE) enjoys your participation in the regularly offered educational events. These events are often in high demand. To provide the best experience, certain events may have limited availability depending on the event or topic being presented.

If an event is “Full” when trying to register, that event has reached its maximum capacity. There is no ability to add registrants over the capacity amount. POE encourages registrants to continue watching the Schedule of Events for additional events being offered.

Interactive Voice Response (IVR) Authentication

Providers and third-party representatives are required to authenticate the facility or provider they’re inquiring about, even when calling to speak with a Noridian Contact Center Customer Service Representative (CSR). Callers must enter authentication information into the phone using the keypad or speaking aloud.

Authentication information entered into the IVR will display for the CSR allowing him/her to be ready to assist the caller with inquiries.

- National Provider Identifier (NPI);
- Provider Transaction Access Number (PTAN); and
- Last five digits of TIN (Tax Identification Number)

Note: If unable to authenticate via the IVR, ensure the correct line of business has been selected when asking for General Inquiries.

- Select Part A when submitting claims via UB-04 form or electronic equivalent
- Select Part B when submitting claims via CMS-1500 or electronic equivalent

Information obtained through the IVR may also be found in the Noridian Medicare Portal (NMP). View the NMP Advantages Over the IVR article to learn more about the NMP benefits.

View the IVR webpage for availability, authentication details, call-in tips, call flow, guide, conversion tool, flowchart, and resources.

Medically Unlikely Edit (MUE) Tool Available

Noridian now offers a MUE tool providers can use to aid in their billing processes. Providers can enter a CPT or HCPCS code and the MUE tool will return the frequency limitation as established by CMS. The Noridian tool provides the same information and the same date availability as the CMS website. The MUE look-up tool is found on Browse by Provider Type pages under Educational Resources as well as the Tools page of our website.

Providers should be aware when using this tool, it does not guarantee successful billing and that varying circumstances should be taken into consideration when submitting the appropriate units of service on all claims. Noridian also recommends that providers only bill for the units of service that are supported by medical records for that beneficiary as these must be available in the event of a claim review to support payment.

We hope you find this tool a helpful way to decrease the burden associated with claim denials and subsequent inquiries and/or redeterminations.
Medicare Beneficiary Identifier (MBI) Page Updated

Noridian has been diligently working to update the content of the MBI webpage to better serve our providers. Easy access to updated information will help providers with this transition. Information on the below topics can be found on the MBI webpage.

- Transition Period
- MBI Format
- Mailing Schedule
- How to Prepare
- Implementation

Off-label Drug Indications

CMS has established five drug compendia as authoritative sources on drug benefit category for cancer drugs. Noridian uses the evidentiary levels of efficacy discussed in these compendia to determine whether a drug may be covered for a given indication.

View the complete details on the Determination of Approved and Accepted Off-label Drug Indications webpage.

Supervised Exercise Therapy for Symptomatic Peripheral Artery Disease – Fifth Revision

MLN Matters Number: MM10295 Revised
Related Change Request (CR) Number: 10295
Related CR Release Date: May 11, 2018
Effective Date: May 25, 2017
Related CR Transmittal Number: R207NCD and R4049CP
Implementation Date: July 2, 2018

The article was revised on May 15, 2018, to clarify that one of the requirements of the SET program is it must be conducted in a hospital outpatient setting or in a physician’s office. 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:
FYI

- 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.

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 CPT 93668 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 code:

- 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.
FYI

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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<tr>
<td>May 15, 2018</td>
<td>The article was revised to clarify that one of the requirements of the SET program is it must be conducted in a hospital outpatient setting or in a physician’s office. All other information remains the same.</td>
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<tr>
<td>May 14, 2018</td>
<td>The article was revised to reflect a revised CR issued on May 11. The CR was revised to remove place of service code edit requirements. The article was revised accordingly. Also, in the article, the CR release date, transmittal numbers and the Web address of the CR are revised. All other information remains the same.</td>
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<tr>
<td>April 11, 2018</td>
<td>The article was revised to clarify that the SET program must be provided in a physician’s office (Place of Service code 11). All other information remains the same.</td>
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<tr>
<td>April 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. In addition, the article and CR were revised to delete place of service codes 19 and 22 as acceptable places of service for CPT 93668. All other information remains the same.</td>
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<tr>
<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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**E/M Service Documentation Provided by Students (Manual Update) – Revised**

MLN Matters Number: MM10412 Revised
Related Change Request (CR) Number: 10412
Related CR Release Date: May 31, 2018
Effective Date: January 1, 2018
Related CR Transmittal Number: R4068CP
Implementation Date: March 5, 2018

This article was revised on June 1, 2018, to reflect an updated Change Request (CR) that corrected typos in the CR and part of the manual update under Section 100.1.1. The transmittal number, CR released date and link to the transmittal also changed. All other information is unchanged.

**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

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


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<td>June 1, 2018</td>
<td>This article was revised to reflect an updated CR that corrected typos in the CR and part of the manual update under Section 100.1.1. The transmittal number, CR released date and link to the transmittal also changed.</td>
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Medical Genetics and Genomics – New Physician Specialty Code

MLN Matters Number: MM10457
Related Change Request (CR) Number: 10457
Related CR Release Date: April 27, 2018
Effective Date: October 1, 2018
Related CR Transmittal Number: R304FM and R4039CP
Implementation Date: October 1, 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) 10457 which informs MACs that CMS has established a new physician specialty code for Medical Genetics and Genomics (D3).

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

BACKGROUND

Physicians self-designate their Medicare physician specialty on the Medicare enrollment application (CMS-855I or CMS-855O) or Internet-based Provider Enrollment, Chain and Ownership System (PECOS) when they enroll in the Medicare program. Medicare physician specialty codes describe the specific/unique types of medicine that physicians (and certain other suppliers) practice. The Centers for Medicare & Medicaid Services (CMS) uses specialty codes for programmatic and claims processing purposes. CMS has established a new physician specialty code for Medical Genetics and Genomics. The new code is D3. MACs will accept and recognize the new code of D3.
ADDITIONAL INFORMATION


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Diagnosis Code Update for Add-On Payment for Blood Clotting Factor Administered to Hemophilia Inpatients – Second Revision

MLN Matters Number: MM10474 Revised
Related Change Request (CR) Number: 10474
Related CR Release Date: May 24, 2018
Effective Date: July 1, 2018
Related CR Transmittal Number: R4062CP
Implementation Date: July 2, 2018

This article was revised on May 25, 2018, to reflect the revised CR10474 issued on May 24 to correct the code description for ICD-10-CM D68.32. In the article, the code description is corrected and 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 (Hemorrhagic disorder due to extrinsic circulating antiocoagulants) 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

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-Office/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**


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**Institutional Billing for No Cost Items**

MLN Matters Number: MM10521  
Related Change Request (CR) Number: 10521  
Related CR Release Date: March 30, 2018  
Effective Date: January 1, 2009  
Related CR Transmittal Number: R4013CP  
Implementation Date: June 29, 2018

**PROVIDER TYPES AFFECTED**

This MLN Matters® article is intended for Institutions (Part A) billing Medicare Administrative Contractors (MACs) for no cost items provided to Medicare beneficiaries.

**WHAT YOU NEED TO KNOW**

Change Request (CR) 10521 provides clarification of the billing instructions specific to drugs provided at no cost when claims processing edits prevent drug administration charges from being billed when the claim does not contain a covered/billable drug charge. This is not a new policy but a reminder of the policy in place. Please make sure your billing staffs are aware of this clarification.

**BACKGROUND**

The Medicare Claims Processing Manual Chapter 32 - Billing Requirements for Special Services section 67.2 outlines institutional billing for no cost items as follows.

Institutional providers should not have to report the usage of a no cost item. However, for some claims (for example, Outpatient Prospective Payment System (OPPS) claims), providers may be required to bill a no cost item due to claims processing edits that require an item (even if received at no cost) to be billed along with an associated service (for example, a specified device must be reported along with a specified implantation procedure).

For OPPS claims, when a drug is provided at no cost, claims processing edits prevent drug administration charges from being billed when the claim does not contain a covered/billable drug charge. Therefore, for drugs provided at no cost in the hospital outpatient department, providers must report the applicable drug HCPCS code and appropriate units with a token charge of less than $1.01 for the item in the covered charge field and mirror this less than $1.01 amount reported in the non-covered charge field. Providers must also bill the corresponding drug administration charge with the appropriate drug administration CPT or HCPCS code.
ADDITIONAL INFORMATION

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Provider/Supplier Reporting of Adverse Legal Actions

MLN Matters Number: MM10558
Related Change Request (CR) Number: 10558
CR Release Date: June 1, 2018
Effective Date: April 30, 2018
Related CR Transmittal Number: R797PI
Implementation Date: April 30, 2018

PROVIDER TYPE AFFECTED
This MLN Matters Article is intended to update the Medicare provider and supplier community on what Final Adverse Action(s) need to be timely reported to the Centers for Medicare & Medicaid Services (CMS).

WHO SHOULD REPORT FINAL ADVERSE ACTION(S)
- Medicare providers or suppliers with new or unreported Final Adverse Action(s)
- Those individuals listed on an application as having managing control or an ownership interest

WHAT FINAL ADVERSE ACTION(S) SHOULD BE REPORTED
Historically, CMS deemed Medicare Payment Suspensions and CMS-Imposed Medicare Revocations to be reportable Final Adverse Actions. In an effort to reduce provider and supplier burden, CMS NO LONGER requires Medicare Payment Suspensions and CMS-Imposed Medicare Revocations to be reported.
The updated list of reportable Final Adverse Actions is as follows:
- Felony and Misdemeanor conviction(s) within 10 years
- Current or Past Suspension(s)/Revocation(s) of a medical license
- Current or Past Suspension(s)/Revocation(s) of an accreditation
- Current or Past Suspension(s) or Exclusion(s) imposed by the U.S. Department of Health and Human Service’s Office of Inspector General (OIG)
- Current or Past Debarment(s) from participation in any Federal Executive Branch procurement or non-procurement program
- Medicaid exclusion(s), revocation(s) or termination(s) of any billing number
- Any other Current or Past Federal Sanction(s)

Please note that all final adverse actions should be reported, regardless of whether any of the records have been expunged or are pending appeal.

WHEN SHOULD FINAL ADVERSE ACTION(S) BE REPORTED
Providers and suppliers shall timely report all new or unreported Final Adverse Actions on any applications submitted to CMS. Final Adverse Actions must be reported by providers and suppliers within time frames specified in 42 CFR § 424.516.
HOW SHOULD FINAL ADVERSE ACTION(S) BE REPORTED

Providers and suppliers shall disclose reportable Final Adverse Legal Actions on any CMS 855 or CMS 20134 application submitted to CMS. As it applies, the sections of the application(s) that providers must complete are:

- Section 3
- Section 5B
- Section 6B
- Section 7

If a final adverse action is disclosed on a CMS-855 application, a provider/supplier must attach all applicable documentation related to the adverse action.

Please note that documentation, concerning the final adverse action, must be furnished regardless of whether the adverse action occurred in a state different from that in which the provider/supplier seeks enrollment or is enrolled.

It is important that you comply with these reporting requirements. Failure to do so could result in the revocation of your Medicare billing privileges.

ADDITIONAL INFORMATION


DOCUMENT HISTORY

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 7, 2018</td>
<td>Initial article released.</td>
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</table>

Telehealth Billing Requirement Revisions for Distant Site Services

MLN Matters Number: MM10583
Related Change Request (CR) Number: 10583
Related CR Release Date: April 27, 2018
Effective Date: October 1, 2018
Related CR Transmittal Number: R4026CP
Implementation Date: October 1, 2018

PROVIDER TYPE AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) implements requirements for billing modifier GT for Telehealth Distant Site Services. As of January 1, 2018, the GT modifier is only allowed on institutional claims billed by a Critical Access Hospital (CAH) Method II. Make sure your billing staffs are aware of this requirement.

BACKGROUND

Previous guidance instructed providers to submit claims for telehealth services using the appropriate procedure code along with the telehealth modifier GT (via interactive audio and video telecommunications systems). In the Calendar Year (CY) 2017 Physician Fee Schedule (PFS) final rule, payment policies regarding Medicare’s use of a new Place of Service (POS) Code describing services furnished via telehealth (POS 02) were finalized and implemented through CR9726. The new POS code became effective January 1, 2017.
In the CY 2018 PFS final rule, the requirement to use the GT modifier was eliminated for all professional claims. CR10152, which implemented that policy, included a business requirement instructing MACs to be aware that the GT modifier is only allowed for distant site services billed by Method II CAHs on type of bill 85X with a revenue code 96X, 97X, or 98X or with a service line that contains HCPCS code Q3014. As of January 1, 2018, the GT modifier is only allowed on institutional claims billed under CAH Method II. If the GT modifier is billed by other provider types, the claim line will be rejected with the following remittance codes:

- Group Code CO - Contractual obligation
- Claim Adjustment Reason Code 4 - The procedure code is inconsistent with the modifier used or a required modifier is missing. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 07/01/2017

ADDITIONAL INFORMATION


DOCUMENT HISTORY

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 27, 2018</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>

ICD-10 and Other Coding Revisions to NCDs - Correction

MLN Matters Number: MM10622
Related Change Request (CR) Number: 10622
Related CR Release Date: May 4, 2018
Effective Date: October 1, 2018
Related CR Transmittal Number: R2076OTN
Implementation Date: October 1, 2018

This message is being sent to correct the title of MM10622.

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 10622 constitutes a maintenance update of International Code of Diseases, 10th Revision (ICD-10) conversions and other coding updates specific to National Coverage Determinations (NCDs). These NCD coding changes are the result of newly available codes, coding revisions to NCDs released separately, or coding feedback received. Please follow the link below for the NCD spreadsheets included with this CR: https://www.cms.gov/Medicare/Coverage/DeterminationProcess/downloads/CR10622.zip.

BACKGROUND

Previous NCD coding changes appear in ICD-10 quarterly updates that are available at https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html, along with other CRs implementing new policy NCDs. Edits to ICD-10, and other coding updates specific to NCDs, will be included in subsequent quarterly releases as needed.

No policy-related changes are included with these 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
FYI

for Medicare & Medicaid Services (CMS) 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.

CR10622 makes coding and clarifying adjustments to the following NCDs:

- NCD 110.18 Aprepitant
- NCD 150.3 Bone Mineral Density Studies
- NCD 190.11 Prothrombin Time/International Normalized Ratio (PT/INR)
- NCD 220.6.16 Positron Emission Tomography (PET) for Infection/Inflammation
- NCD 220.6.17 PET for Solid Tumors
- NCD 220.13 Percutaneous Image-Guided Breast Biopsy

When denying claims associated with the attached NCDs, except where otherwise indicated. A/B MACs will use:

- 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 and Medicare Summary Notice (MSN) 8.81 per instructions in CR 7228/TR 2148.

ADDITIONAL INFORMATION


DOCUMENT HISTORY

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>May 9, 2018</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>

HCPCS Drug/Biological Code Changes – July 2018 Update – Second Revision

MLN Matters Number: MM10624 Revised
Related Change Request (CR) Number: 10624
Related CR Release Date: June 26, 2018
Effective Date: July 1, 2018
Related CR Transmittal Number: R4078CP
Implementation Date: July 2, 2018

This article was revised on June 26, 2018, to reflect a revised CR issued on June 26. In the article, the new codes of Q5105 and Q5106 are added. The Type of Service Code for CPT code 90739 is updated to 1, V. Also, the CR release date, transmittal number, and the Web address of the CR are revised. All other information is the same.
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) 10624 informs MACs of updated drug/biological HCPCS codes. The HCPCS code set is updated on a quarterly basis. The July 2018 HCPCS file includes six new HCPCS codes: Q9991, Q9992, Q9993, Q9995, Q5105, and Q5106. Please make sure your billing staffs are aware of these updates.

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

- **Q9991**
  - Short Description: Buprenorph xr 100 mg or less
  - Long Description: Injection, buprenorphine extended-release (sublocade), less than or equal to 100 mg
  - Type of Service (TOS) Code: 1
  - Medicare Physician Fee Schedule Data Base (MPFSDB) Status Indicator: E

- **Q9992**
  - Short Description: Buprenorphine xr over 100 mg
  - Long Description: Injection, buprenorphine extended-release (sublocade), greater than 100 mg
  - TOS Code: 1
  - MPFSDB Status Indicator: E

- **Q9993**
  - Short Description: Inj., triamcinolone ext rel
  - Long Description: Injection, triamcinolone acetonide, preservative-free, extended-release, microsphere formulation, 1 mg
  - TOS Code: 1,P
  - MPFSDB Status Indicator: E

- **Q9995**
  - Short Description: Inj. emicizumab-kxwh, 0.5 mg
  - Long Description: Injection, emicizumab-kxwh, 0.5 mg
  - TOS Code: 1
  - MPFSDB Status Indicator: E

- **Q5105**
  - Short Description: Inj Retacrit esrd on dialysi
  - Long Description: Injection, epoetin alfa, biosimilar, (Retacrit) (for esrd on dialysis), 100 units
  - TOS Code: 1, L
  - MPFSDB Status Indicator: E

- **Q5106**
  - Short Description: Inj Retacrit non-esrd use
  - Long Description: Injection, epoetin alfa, biosimilar, (Retacrit) (for non-esrd use), 1000 units
FYI

- TOS Code: 9
- MPFSDB Status Indicator: E

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

ADDITIONAL INFORMATION


DOCUMENT HISTORY

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 26, 2018</td>
<td>The article was revised to reflect a revised CR issued on June 26. In the article, the new codes of Q5105 and Q5106 are added. The Type of Service Code for CPT code 90739 is updated to 1, V. Also, the CR release date, transmittal number, and the Web address of the CR are revised. All other information is the same.</td>
</tr>
<tr>
<td>May 14, 2018</td>
<td>This article was revised to reflect a revised CR issued on May 11. In the article, a sentence is added to show that Part B payment for Q9995 includes the clotting factor furnishing fee. Also, the CR release date, transmittal number, and the Web address of the CR are revised. All other information is the same.</td>
</tr>
<tr>
<td>April 20, 2018</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>

MPFSDB July 2018 Update

MLN Matters Number: MM10644
Related Change Request (CR) Number: 10644
Related CR Release Date: May 18, 2018
Effective Date: January 1, 2018
Related CR Transmittal Number: R4053CP
Implementation Date: July 2, 2018

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) 10644 amends payment files issued to MACs based upon 2018 Medicare Physician Fee Schedule (MPFS) Final Rule. Make sure your billings staffs are aware of these changes.

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) issued payment files to the MACs based upon the 2018 Medicare Physician Fee Schedule (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.

CR 10644 presents a summary of the changes for the July update to the 2018 MPFSDB. Unless otherwise stated, these changes are effective for dates of service on and after January 1, 2018. The following tables show those changes.

<table>
<thead>
<tr>
<th>CPT/HCPCS &amp; MOD</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0511</td>
<td>Change PC/TC indicator to “0”</td>
</tr>
<tr>
<td>G0512</td>
<td>Change PC/TC indicator to “0”</td>
</tr>
<tr>
<td>G0460*</td>
<td>Change Status = A, Work RVU = 2.25, Non-Facility PE RVU = 2.89, Facility PE RVU = .94, Malpractice RVU = .34, Mult Proc = 2, Bilat Surg = 0, Asst Surg = 1, Co-Surg = 0, Team Surge = 0, Global Days = 000</td>
</tr>
</tbody>
</table>
FYI

<table>
<thead>
<tr>
<th>Code</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>71045</td>
<td>Facility and Non-Facility PE RVU changed to 0.42</td>
</tr>
<tr>
<td>71045 TC</td>
<td>Facility and Non-Facility PE RVU changed to 0.35</td>
</tr>
</tbody>
</table>

* The work RVU of G0460 was valued at the work RVU of one billing of Current Procedural Terminology (CPT) code 11042 (1.01) plus two billings of CPT code 11045 (0.50), along with a single billing of CPT codes 99195 (0.00) and 38213 (0.24) to cover the lab portion of the work. The direct PE inputs were crosswalked from CPT code 11042 along with the inclusion of additional clinical labor, supplies, and equipment based on CMS determination of what would be typical and medically necessary for the procedure.

The following "Q" codes are effective for services performed on or after July 1, 2018 (see MM10624 for additional information).

<table>
<thead>
<tr>
<th>Code</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q9991</td>
<td>Procedure Status = E; there are no RVUs, payment policy indicators do not apply</td>
</tr>
<tr>
<td>Q9992</td>
<td>Procedure Status = E; there are no RVUs, payment policy indicators do not apply</td>
</tr>
<tr>
<td>Q9993</td>
<td>Procedure Status = E; there are no RVUs, payment policy indicators do not apply</td>
</tr>
<tr>
<td>Q9995</td>
<td>Procedure Status = E; there are no RVUs, payment policy indicators do not apply</td>
</tr>
</tbody>
</table>

The following new CPT Category III codes have been added for dates of service July 1, 2018, and after:

<table>
<thead>
<tr>
<th>Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>0505T</td>
<td>Ev fempop artl revsc</td>
<td>Endovenous femoral-poplite arterial revascularization, with transcatheter placement of intravascular stent graft(s) and closure by any method, including percutaneous or open vascular access, ultrasound guidance for vascular access when performed, all catheterization(s) and intraprocedural roadmapping and imaging guidance necessary to complete the intervention, all associated radiological supervision and interpretation, when performed, with crossing of the occlusive lesion in an extraluminal fashion</td>
</tr>
<tr>
<td>0506T</td>
<td>Mac pgmt opt dns meas</td>
<td>Macular pigment optical density measurement by heterochromatic flicker photometry, unilateral or bilateral, with interpretation and report</td>
</tr>
<tr>
<td></td>
<td>hfp</td>
<td></td>
</tr>
<tr>
<td>0507T</td>
<td>Near ifr 2img mibmn glnd</td>
<td>Near-infrared dual imaging (ie, simultaneous reflective and trans-illuminated light) of meibomian glands, unilateral or bilateral, with interpretation and report</td>
</tr>
<tr>
<td></td>
<td>i&amp;r</td>
<td></td>
</tr>
<tr>
<td>0508T</td>
<td>Pls echo us b1 dns meas</td>
<td>Pulse-echo ultrasound bone density measurement resulting in indicator of axial bone mineral density, tibia</td>
</tr>
<tr>
<td></td>
<td>tib</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>HCP/C Mod</th>
<th>0505T</th>
<th>0506T</th>
<th>0506T TC</th>
<th>0507T</th>
<th>0507T TC</th>
<th>0507T TC</th>
<th>0508T</th>
<th>0508T TC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Status</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Muti</td>
<td>0</td>
<td>7</td>
<td>7</td>
<td>7</td>
<td>7</td>
<td>7</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Bilat</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Asst Surg</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Co- Surg</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Team Surg</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>PC/TC</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Global</td>
<td>YYY</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
</tbody>
</table>
FYI

<table>
<thead>
<tr>
<th>Diag</th>
<th>Supv</th>
<th>09</th>
<th>09</th>
<th>09</th>
<th>01</th>
<th>09</th>
<th>09</th>
<th>01</th>
<th>09</th>
<th>09</th>
<th>01</th>
</tr>
</thead>
</table>

Note: Pre, intra and post-operative percentages for CPT codes 0505T-0508T are all “0.00.”

ADDITIONAL INFORMATION


DOCUMENT HISTORY

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<tr>
<th>Date of Change</th>
<th>Description</th>
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<tbody>
<tr>
<td>May 21, 2018</td>
<td>Initial article released.</td>
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</table>

ASP Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files – July 2018 Quarterly Update

MLN Matters Number: MM10667
Related Change Request (CR) Number: 10667
Related CR Release Date: May 25, 2018
Effective Date: July 1, 2018
Related CR Transmittal Number: R4061CP
Implementation Date: July 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) 10667 instructs MACs to download and implement the July 2018 and, if released, the revised April 2018, January 2018, October 2017, and July 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 July 2, 2018, with dates of service July 1, 2018, through September 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: July 2018 ASP and ASP NOC -- Effective Dates of Service: July 1, 2018, through September 30, 2018
- 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
FYI

- File: July 2017 ASP and ASP NOC -- Effective for Dates of Service of July 1, 2017, through September 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

<table>
<thead>
<tr>
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<th>Description</th>
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</thead>
<tbody>
<tr>
<td>May 25, 2018</td>
<td>Initial article released</td>
</tr>
</tbody>
</table>

I/OCE Specification Version 19.2 – July 2018

MLN Matters Number: MM10699
Related Change Request (CR) Number: 10699
Related CR Release Date: June 1, 2018
Effective Date: July 1, 2018
Related CR Transmittal Number: R4065CP
Implementation Date: July 2, 2018

PROVIDER TYPE AFFECTED

This MLN Matters Article is intended for 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) 10699 provides the I/OCE instructions and specifications for the I/OCE that will be utilized under the Outpatient Prospective Payment System (OPPS) and non-OPPS for hospital outpatient departments, community mental health centers, all non-OPPS providers, and for limited services when provided in a home health agency not under HH PPS or to a hospice patient for the treatment of a non-terminal illness. Please make sure your billing staffs are aware of these updates.

BACKGROUND

CR10699 informs the Part A/B MACs Part A, the A/B MACs Part Home Health and Hospice (HHH) and the Fiscal Intermediary Shared System (FISS) that the I/OCE is being updated for July 1, 2018. The I/OCE routes all institutional outpatient claims (which includes non-OPPS hospital claims) through a single I/OCE.

The I/OCE is used under the OPPS and non-OPPS for hospital outpatient departments, community mental health centers, all non-OPPS providers, and for limited services when provided in a home health agency not under HH PPS or to a hospice patient for the treatment of a non-terminal illness.

The modifications of the I/OCE for the July 2018 V19.2 release are summarized in the table below. Readers should also read through the entire specifications document and note the highlighted sections, which also indicate changes from the prior release of the software. The I/OCE specifications will be posted on the Centers for Medicare & Medicaid Services (CMS) website at http://www.cms.gov/OutpatientCodeEdit/.
### Table 1: July 2018 I/OCE Modifications

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Edits Affected</th>
<th>Modification</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/1/2018</td>
<td>18</td>
<td>Implement new program logic retroactively (1/1/18) to allow Anesthesia code 01402 (Status Indicator (SI) = C) reported with procedure code 27447 to package by changing its SI from C to N. If 01402 is reported with any other procedure the SI remains a C and will process as usual.</td>
</tr>
<tr>
<td>1/1/2016</td>
<td>38</td>
<td>Update program logic retroactively (1/1/16) to exclude procedures with SI=J2 from satisfying edit 38.</td>
</tr>
<tr>
<td>4/1/2018</td>
<td>106,107,108</td>
<td>Update logic for Add-on Code Editing to apply the applicable edits on both add-on procedure line items, if reporting multiple add-on codes without one or both primary procedures.</td>
</tr>
<tr>
<td>7/1/2018</td>
<td>6,20,22, 40,106, 107,108</td>
<td>Update the program logic to include edits (6, 20, 22, 40, 106, 107, and 108) to applicable bill types retroactively to the edits activation date. This includes the documentation update to the edits applied by bill type tables, see table for updates.</td>
</tr>
<tr>
<td>7/1/2018</td>
<td>6,22</td>
<td>Implement logic to include a condition in which lines submitted on a 32x bill type (HHA) with revenue code 0023 do not have edit 6 or 22 applied.</td>
</tr>
<tr>
<td>7/1/2018</td>
<td>22</td>
<td>Add the following new modifier to the valid modifier list QO – Qualified cdsm consulted</td>
</tr>
<tr>
<td>7/1/2018</td>
<td></td>
<td>Update the Add-on Code Editing section to include additional conditions for editing. This includes an update to the Edit Descriptions and Reason for Edit Generation table.</td>
</tr>
<tr>
<td>7/1/2018</td>
<td></td>
<td>Update the I/OCE Execution and Processing Flowchart to include Rural Health Clinic (RHC) in the Federally Qualified Health Center (FQHC) objects mentioned in processing.</td>
</tr>
<tr>
<td>7/1/2018</td>
<td></td>
<td>Update to Hospice Processing section to note the logic that is discontinued by edit 61 and 72 being removed from bill type 81x and 82x (1/1/14).</td>
</tr>
<tr>
<td>7/1/2018</td>
<td></td>
<td>Update to Biosimilar HCPCS Processing section to note that Edits 94 and 103 are discontinued, effective 4/1/18.</td>
</tr>
<tr>
<td>7/1/2018</td>
<td></td>
<td>Update the Pass-through Device Processing section to change language from device-intensive procedure pairing to procedure and pass-through device pairings.</td>
</tr>
<tr>
<td>7/1/2018</td>
<td></td>
<td>Make all HCPCS/APC/SI changes as specified by CMS (quarterly data files).</td>
</tr>
<tr>
<td>7/1/2018</td>
<td></td>
<td>Update the following lists for the release (see quarterly data files): Add on Type I (edit 106) Add on Type II (edit 107) Add on Type III (edit 108) Comprehensive Ambulatory Payment Classification (APC) Ranking Comprehensive APC Exclusions Procedure and Sex Conflict (edit 8) RHC CG Modifier not Payable Skin Substitute Product (edit 86) Non-covered service (edit 9)</td>
</tr>
<tr>
<td>7/1/2018</td>
<td>20, 40</td>
<td>Implement version 24.2 of the National Correct Coding Initiative (NCCI) (as modified for applicable outpatient institutional providers).</td>
</tr>
</tbody>
</table>

**ADDITIONAL INFORMATION**

DMEPOS Fee Schedule – July 2018 Update

MLN Matters Number: MM10707
Related Change Request (CR) Number: 10707
Related CR Release Date: June 8, 2018
Related CR Transmittal Number: R4072CP
Effective Date: January 1, 2018 for fees for code Q0477, June 1, 2018 for CMS-1687-IFC-related rural and blended fees, July 1, 2018 for all other changes
Implementation Date: July 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 DME, Prosthetics, Orthotics, and Supplies (DMEPOS) items or services paid under the DMEPOS fee schedule.

PROVIDER ACTION NEEDED
Change Request (CR) 10707 provides the July 2018 Medicare DMEPOS fee schedule quarterly update listing fee schedule amounts for 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. Also, the files for this update include the July 2018 DMEPOS Rural ZIP code file containing the Third Quarter 2018 Rural ZIP code changes.

BACKGROUND
Sections 1834(a), (h), and (i) of the Social Security Act (the Act) require payment for 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) §414.102, for parenteral and enteral nutrition, splints, casts and Intraocular Lenses (IOLs) inserted in a physician’s office.

Additionally, 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 adjusting 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.


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.
Key changes in this update are as follows:

**Interim Final Rule with Comment Period (CMS-1687-IFC)**

The interim final rule with comment period (CMS-1687-IFC) entitled “Transitional 50/50 Blended Rates to Provide Relief in Rural Areas and Non-Contiguous Areas” was published in the Federal Register on Friday, May 11, 2018. The IFC amends the regulations to increase the fee schedule amounts for items furnished from June 1, 2018 through December 31, 2018, in rural areas and non-contiguous areas (Alaska, Hawaii, and United States territories) not subject to the CBP. This change requires new 2018 rural and non-contiguous fee schedules to be calculated for HCPCS codes for certain DME and PEN adjusted using competitive bidding information effective June 1, 2018. The new rural and non-contiguous fee schedule amounts are based on a blend of 50 percent of the adjusted fee schedule amount and 50 percent of the unadjusted fee schedule amounts updated by the covered item updates specified in sections 1834(a)(14) and 1842(s)(B) of the Act. For areas other than rural or non-continuous areas, the fee schedules for DME and PEN codes with adjusted fee schedule amounts will continue to be based on 100 percent of the adjusted fee schedule amounts from June 1, 2018 through December 31, 2018.

Because the revised rural and non-contiguous fee schedule amounts are based in part on unadjusted fee schedule amounts, the fees for certain items included in the 2008 Original Round One CBP, denoted with the HCPCS pricing modifier, are added back to the fee schedule file only for items furnished in rural and non-contiguous areas. Background information and a list of the applicable KE HCPCS codes was issued in Transmittal 1630, CR 6270, dated November 7, 2008. (See the related MLN Matters article MM6270 at [https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6270.pdf](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6270.pdf).) Beginning June 1, 2018 through December 31, 2018, the rural and non-contiguous KE fee schedule amounts will be based on a blend of 50 percent of the adjusted fee schedule amount and 50 percent of the unadjusted KE fee schedule amount updated by the covered item updates specified in sections 1834(a)(14) and 1842(s)(B) of the Act. The non-rural fees for these KE codes will be populated with zeros on the fee schedule file since KE is not a valid option for areas without blended fees.

For certain accessories used with base equipment included in the CBP in 2008 (for example, power wheelchairs, walkers, and negative pressure wound therapy pumps), the unadjusted fee schedule amounts include a 9.5 percent reduction in accordance with Federal law if these accessories were also included in the 2008 CBP. The 9.5 percent fee reduction only applies to these accessories when they are furnished for use with the base equipment included in the 2008 CBP. Beginning June 1, 2018, in cases where accessories included in the 2008 CBP are furnished for use with base equipment that was not included in the 2008 CBP (for example, manual wheelchairs, canes and aspirators), for beneficiaries residing in rural or non-contiguous, non-competitive bid areas, suppliers should append the KE modifier to the HCPCS code for the accessory. Suppliers should not use the KE modifier with accessories that were included in the 2008 CBP and furnished for use with base equipment that was not included in the 2008 CBP when these accessories are furnished to beneficiaries residing in non-rural, non-competitive bid areas.

Also, because the IFC results in a change to the 2018 fee schedule amounts for the various classes of oxygen and oxygen equipment, the annual oxygen budget neutrality adjustment for 2018 is recomputed and the adjustments to the stationary oxygen equipment, mandated by regulations at section 414.226(c)(6), will be applied to the fees on the June 1, 2018 file.

DMEPOS and PEN fee schedule files containing the revised rural and non-contiguous 50/50 blend fees were transmitted in May to the Part B and DME MACs for the June 1, 2018 implementation. However, the DMEPOS Institutional Claim (FI) fee schedule file was not updated with the revised rural and non-contiguous 50/50 blend in June. The July 2018 DMEPOS fee schedule FI file will incorporate the 50/50 blend rural and non-contiguous fees with a June 1, 2018 effective date. As part of the July 2018 DMEPOS fee schedule file update, HHHMACs shall adjust any impacted 50/50 blend claims processed for dates of service between June 1, 2018 and June 30, 2018 that are brought to their attention by the supplier.

MACs will not search for and adjust claims for HCPCS codes with revised 50/50 blend fees appearing on the July 2018 DMEPOS FI file with effective dates of June 1, 2018 for dates of service June 1, 2018 through June 30, 2018. However, they will adjust these claims when you bring them to their attention for dates of service June 1, 2018 through June 30, 2018.
Other Changes

As part of this update, the fee schedules for HCPCS code Q0477 (Power Module Patient Cable for Use with Electric or Electric/Pneumatic Ventricular Assist Device, Replacement Only) are revised and effective for dates of service on or after January 1, 2018. If you resubmit impacted claims, MACs will adjust previously processed claims for code Q0477 with dates of service on or after January 1, 2018.

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 at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html.

ADDITIONAL INFORMATION


DOCUMENT HISTORY

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<tr>
<th>Date of Change</th>
<th>Description</th>
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<tr>
<td>June 11, 2018</td>
<td>Initial article released.</td>
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IOM, Medicare Claims Processing Manual, Publication 100-04, Chapter 18, Preventive and Screening Services and Chapter 35, IDTF - Update

MLN Matters Number: MM10735
Related Change Request (CR) Number: 10735
Related CR Release Date: June 8, 2018
Effective Date: July 9, 2018
Related CR Transmittal Number: R4071CP
Implementation Date: July 9, 2018

PROVIDER TYPES AFFECTED

This MLN Matters article is intended for Independent Diagnostic Testing Laboratories (IDTFs) billing Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

WHAT YOU NEED TO KNOW

Change Request (CR) 10735 updates Medicare Claims Processing Manual, Chapter 18 - Preventive and Screening Services and Chapter 35 - Independent Diagnostic Testing Facility (IDTF) to include requirements and payment policies for screening mammography services furnished by IDTFs. CR10735 does not convey any policy changes. Instead, it just documents current policy in the Medicare Claims Processing Manual.

BACKGROUND

If an IDTF furnishes any type of mammography service (screening or diagnostic), it must have a Food and Drug Administration (FDA) certification to perform such services. However, an entity that only performs diagnostic mammography services should not be enrolled as an IDTF.

Screening mammographies (including those that are self-referred) are payable by Medicare when performed in and by an IDTF entity.

ADDITIONAL INFORMATION


DOCUMENT HISTORY

<table>
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<th>Date of Change</th>
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<tr>
<td>June 8, 2018</td>
<td>Initial article released.</td>
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Claim Status Category and Claim Status Codes Update

MLN Matters Number: MM10777
Related Change Request (CR) Number: 10777
Related CR Release Date: June 1, 2018
Effective Date: October 1, 2018
Related CR Transmittal Number: R4066CP
Implementation Date: October 1, 2018

PROVIDER TYPE AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 10777 updates, as needed, the Claim Status and Claim Status Category Codes used for the Accredited Standards Committee (ASC) X12 276/277 Health Care Claim Status Request and Response and ASC X12 277 Health Care Claim Acknowledgment transactions. Make sure your billing staffs are aware of these updates.

BACKGROUND

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires all covered entities to use only Claim Status Category Codes and Claim Status Codes approved by the National Code Maintenance Committee in the ASC X12 276/277 Health Care Claim Status Request and Response transaction standards adopted under HIPAA for electronically submitting health care claims status requests and responses. These codes explain the status of submitted claim(s). Proprietary codes may not be used in the ASC X12 276/277 transactions to report claim status. The National Code Maintenance Committee meets at the beginning of each ASC X12 trimester meeting (January/February, June, and September/October) and makes decisions about additions, modifications, and retirement of existing codes. The Committee allows the industry 6 months for implementation of newly added or changed codes.


All code changes approved during the June 2018 committee meeting shall be posted on these sites on or about July 1, 2018.

The Centers for Medicare & Medicaid Services (CMS) will issue future updates to these codes, as needed. MACs must update their claims systems to ensure that the current version of these codes is used in their claim status responses.

These code changes are used in editing of all ASC X12 276 transactions processed on or after the date of implementation and to be reflected in the ASC X12 277 transactions issued on and after the date of implementation of CR 10777.

The CMS’ Medicare contractors must comply with the requirements contained in the current standards adopted under HIPAA for electronically submitting certain health care transactions, among them the ASC X12 276/277 Health Care Claim Status Request and Response. These contractors must use valid Claim Status Category Codes and Claim Status Codes when sending ASC X12 277 Health Care Claim Status Responses. They must also use valid Claim Status Category Codes and Claim Status Codes when sending ASC X12 277 Healthcare Claim Acknowledgments. References in CR 10777 to “277 responses” and “claim status responses” encompass both the ASC X12 277 Health Care Claim Status Response and the ASC X12 277 Healthcare Claim Acknowledgment transactions.

ADDITIONAL INFORMATION

New Release of PEPPER Available for Hospices, SNFs, IRFs, IPFs, CAHs and LTCHs

- Fourth quarter FY 2017 Program for Evaluating Payment Patterns Electronic Reports (PEPPERs) are available for Hospices, Skilled Nursing Facilities (SNFs), Inpatient Rehabilitation Facilities (IRFs), Inpatient Psychiatric Facilities (IPFs), Critical Access Hospitals (CAHs) and Long-term Acute Care Hospitals (LTCHs). 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.

- Hospices, LTCHs and free-standing SNFs and IRFs: For instructions on obtaining your PEPPER, see the Secure PEPPER Access Guide.

- CAHs, IPFs, and SNF and IRF units of hospitals: PEPPER was distributed via the QualityNet secure portal.

- 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.

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.

Physicians! Your Medical Records Play a Vital Role in Ordering and Providing DMEPOS to Your Patients - Reminder

Noridian is reminding physicians for any Durable Medical Equipment, Prosthetic, Orthotic and Supply (DMEPOS) item to be covered by Medicare, the patient’s medical record must contain sufficient information. This would include the patient’s medical condition in order to substantiate the necessity for the type of equipment or supply, quantity and/or frequency of use or replacement, if applicable.

Robotic Radiosurgery Fee Revisions – Effective July 1, 2018

Effective July 1, 2018, HCPCS G0339 and G0340 fees will be revised to establish consistent fees between Noridian Part B Jurisdictions. The new fees will crosswalk to existing CPT codes for similar services.

- HCPCS G0339 crosswalk to CPT 77372
- HCPCS G0340 crosswalk to CPT 77373

Applicable GPCIs will be applied in each payment locale.
### HCPCS Description

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Description</th>
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<tbody>
<tr>
<td>G0339</td>
<td>Image-guided robotic linear accelerator-based stereotactic radiosurgery, complete course of therapy in one session or first session of fractionated treatment</td>
</tr>
<tr>
<td>G0340</td>
<td>Image-guided robotic linear accelerator-based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, second through fifth sessions, maximum five sessions per course of treatment</td>
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### Prohibition Billing Dually Eligible Individuals Enrolled in the QMB Program – Ninth Revision

**MLN Matters Number:** SE1128 Revised  
**Article Release Date:** June 26, 2018

This article was revised on June 26, 2018, to clarify the description of the QMB program. It also adds that starting July 2018 the Medicare Summary Notice (MSN) is another way for providers to verify the QMB status of beneficiaries for Medicare Fee-For-Service (FFS) claims. All other information remains the same.

#### PROVIDER TYPES AFFECTED

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

#### PROVIDER ACTION NEEDED

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

Implement key measures to ensure compliance with QMB billing requirements. Use the Medicare 270/271 HIPAA Eligibility Transaction System (HETS) (effective November 2017), CMS’ eligibility-verification system, and the provider Remittance Advice (RA) (July 2018) to identify beneficiaries’ QMB status and exemption from cost-sharing prior to billing. Starting July 2018, look for QMB alerts messages in the RA for FFS claims to verify QMB after claims processing. Work with your office staff and vendors to make sure your insurance verification and billing systems are ready to incorporate these QMB updates. Refer to the Background and Additional Information Sections 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(g)(3), 1866(a)(1)(A), and 1848(g)(3)(A) of the Social Security Act [the Act]). The QMB program provides Medicaid coverage of Medicare Part A and Part B premiums and cost sharing to low income Medicare beneficiaries. QMB is an eligibility category under the Medicare Savings Programs. In 2016, 7.5 million individuals (more than one out of eight beneficiaries) were enrolled in the QMB program.

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

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:

- Establish processes to routinely identify the QMB status of Medicare beneficiaries prior to billing for items and services. Use the Medicare 270/271 HETS data provided to Medicare providers, suppliers, and their authorized billing agents (including clearinghouses and third party vendors) (effective November 2017) to verify a beneficiary’s QMB status and exemption from cost-sharing charges. Ask your third party eligibility-verification vendors how their products reflect the new QMB information from HETS. For more information, visit the HETS website.

- In July 2018, CMS will reintroduce QMB information in the Medicare RA that Original Medicare providers and suppliers can use 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.

- Providers and suppliers may also verify beneficiaries’ QMB status through automated Medicaid eligibility-verification systems in the State in which the person is a resident or by asking beneficiaries for other proof, such as their Medicaid identification card, MSN (starting July 2018) or other documentation of their QMB status.

- Ensure that billing procedures and third-party vendors exempt individuals enrolled in the QMB program from Medicare charges and that you remedy billing problems should they occur. If you have erroneously billed individuals enrolled in the QMB program, recall the charges (including referrals to collection agencies) and refund the invalid charges they paid.

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

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

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

Important Reminders Concerning QMB Billing Requirements

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

1. All Original Medicare and MA providers and suppliers—not only those that accept Medicaid—must not charge individuals enrolled in the QMB program for Medicare cost-sharing.
2. Individuals enrolled in the QMB program keep their protection from billing when they cross State lines to receive care. Providers and suppliers cannot charge individuals enrolled in QMB even if their QMB benefit is from a different State than the State where they get care.

3. Note that individuals enrolled in QMB cannot elect to pay Medicare deductibles, coinsurance, and copays, but may have 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 11, 2018, for Part B claims and by September 12, 2018, for Part A/Durable Medical Equipment C claims.

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

For more information about dual eligibles under Medicare and Medicaid, please visit https://www.medicaid.gov/medicaid/eligibility/medicaid-enrollees/index.html and refer to Dual Eligible Beneficiaries Under Medicare and Medicaid. For general Medicaid information, please visit http://www.medicaid.gov/index.html.

**DOCUMENT HISTORY**

<table>
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<tr>
<th>Date of Change</th>
<th>Description</th>
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<tr>
<td>June 26, 2018</td>
<td>This article was revised to clarify the description of the QMB program. It also adds that starting July 2018 the Medicare Summary Notice (MSN) is another way for providers to verify the QMB status of beneficiaries for Medicare Fee-For-Service (FFS) claims. All other information remains the same.</td>
</tr>
<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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<td>Date</td>
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<tr>
<td>October 18, 2017</td>
<td>The article was revised to indicate that the Provider Remittance Advice and the Medicare Summary Notice for beneficiaries identifies the QMB status of beneficiaries and exemption from cost-sharing for Part A and B claims processed on or after October 2, 2017, and to recommend how providers can use these and other upcoming system changes to promote compliance with QMB billing requirements. All other information remains the same.</td>
</tr>
<tr>
<td>August 23, 2017</td>
<td>The article was revised to highlight upcoming system changes that identify the QMB status of beneficiaries and exemption from Medicare cost-sharing, recommend key ways to promote compliance with QMB billing rules, and remind certain types of providers that they may seek reimbursement for unpaid deductible and coinsurance amounts as a Medicare bad debt.</td>
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<tr>
<td>May 12, 2017</td>
<td>This article was revised on May 12, 2017, to modify language pertaining to billing beneficiaries enrolled in the QMB program. All other information is the same.</td>
</tr>
<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>
</tr>
<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>
</tr>
<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>
</tr>
<tr>
<td>March 28, 2014</td>
<td>The article was revised to change the name of the Coordination of Benefits Contractor (COBC) to BCRC.</td>
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Increased Ambulance Payment Reduction for Non-Emergency Basic Life Support (BLS) Transports to and from Renal Dialysis Facilities

MLN Matters Number: MM10549
Related Change Request (CR) Number: 10549
Related CR Release Date: April 6, 2018
Effective Date: October 1, 2018
Related CR Transmittal Number: R4017CP
Implementation Date: October 1, 2018

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

PROVIDER ACTION NEEDED
Change Request (CR) 10549 provides instructions regarding Section 53108 of the Bipartisan Budget Act of 2018. This section reduces the ambulance payment by 23 percent for non-emergency Basic Life Support (BLS) transports of individuals with End-Stage Renal Disease (ESRD), to and from renal dialysis treatment (at both hospital-based and freestanding renal dialysis treatment facilities). Please make sure your billing staffs are aware of these changes.

BACKGROUND
Payment for ambulance transports (including items and services furnished in association with such transports) are based on the Ambulance Fee Schedule (AFS) and include a base rate payment plus a separate payment for mileage. This raised payment reduction for non-emergency BLS transports to and from renal dialysis treatment applies to both the base rate and the mileage reimbursement.

CR8269, issued May 10, 2013, implemented Section 637 of the American Taxpayer Relief Act of 2012, which, for transports occurring on and after October 1, 2013; required a 10-percent reduction in fee schedule payments for non-emergency (BLS transports of beneficiaries with ESRD); to and from both hospital-based and freestanding renal dialysis treatment facilities, for non-emergent dialysis services. The MLN Matters article associated with this CR is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8269.pdf.

CR10549 provides instructions regarding Section 53108 of the Bipartisan Budget Act of 2018, (signed into law on February 9, 2018), which requires that, effective October 1, 2018, the reduction of fee schedule payments for BLS transports to and from renal dialysis treatments be increased to 23 percent.

Non-emergency BLS ground transports are identified by Healthcare Common Procedure Coding System (HCPCS) code A0428 (Ambulance service, basic life support, non-emergency transport, (bls)). Ambulance transports to and from renal dialysis treatment are further identified by origin/destination modifier codes “G” (hospital-based ESRD) and “J” (freestanding ESRD facility), in either the origin or destination position of an ambulance modifier.

Specific Details
• Effective for claims with dates of service on and after October 1, 2018, payment for non-emergency BLS transports to and from renal dialysis treatment facilities will be reduced by 23 percent. The reduced rate will be calculated after the normal payment rate (including any applicable add-on payments) is calculated, and will be applied to the base rate for non-emergency BLS transports (identified by HCPCS code A0428 when billed with the indicated modifier codes) and the associated, separate mileage payment (identified by HCPCS code A0425).

• Payment for emergency transports and non-emergency BLS transports to other destinations (rural and urban) will remain unchanged. The AFS will also remain unchanged.

• For ambulance services, suppliers and hospital-based ambulance providers must report an accurate origin and destination modifier for each ambulance trip provided. Origin and destination modifiers used for ambulance services are created by combining two alpha characters. Each alpha character, with the
exception of “X”, represents an origin code or a destination code. The pair of alpha codes creates a modifier. The first position alpha code equals origin; the second position alpha code equals destination.

- The reduction will be applied on claim lines containing HCPCS code A0428 with modifier code “G” or “J”, in either the first position (origin code) or second position (destination code) within the two-digit ambulance modifier code and HCPCS code A0425.

- MACs will keep in place all existing edits and logic (implemented previously via CMS CR 8269) that currently apply to the reduced AFS payment rates; however, effective for claims with dates of service on or after October 1, 2018, will increase the reduction from 10 percent to 23 percent. Additionally, they will continue to use the claim adjustment reason code, group code and Medicare Summary Notice messages that are currently used for the reduced AFS payment methodology.

**Note:** This 23-percent reduction applies to beneficiaries with ESRD that are receiving a non-emergency BLS transport to and from renal dialysis treatment. While it is possible that a beneficiary who is not diagnosed with ESRD will require routine transport to and from renal dialysis treatment, it is highly unlikely. However, MACs have the discretion to override or reverse the reduction on appeal if they deem it appropriate based on supporting documentation.

**ADDITIONAL INFORMATION**


**DOCUMENT HISTORY**

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<td>April 6, 2018</td>
<td>Initial article released.</td>
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MLN Matters Number: MM10550
Related Change Request (CR) Number: 10550
Related CR Release Date: April 13, 2018
Effective Date: July 16, 2018
Related CR Transmittal Number: R243BP and R4021CP
Implementation Date: July 16, 2018

**PROVIDER TYPES AFFECTED**

This MLN Matters Article is intended for Skilled Nursing Facilities (SNF), ambulance providers and suppliers providing ambulance services to patients and billing Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries who are not in a covered Part A stay.

**PROVIDER ACTION NEEDED**

Change Request (CR) 10550 provides clarification on coverage of an ambulance transport for a SNF resident in a stay not covered by Part A, who has Part B benefits, to the nearest supplier of medically necessary services not available at the SNF, including the return trip. These clarifications relate to Chapter 10 of the Medicare Benefit Policy Manual, and Chapter 15, of the Medicare Claims Processing Manual. The revised manual sections are attachments to CR10550. Make sure your billing staffs are aware of these clarifications.

**BACKGROUND**

In the June 17, 1997, ambulance proposed rule (62 FR 32720), the Centers for Medicare & Medicaid Services (CMS) proposed a provision under Part B that permits ambulance transportation from a SNF to the nearest supplier of medically necessary services not available at the SNF where the beneficiary is an ambulanc...
inpatient, including the return trip. CMS finalized this proposal in the January 25, 1999, final rule (64 FR 3648) at 42 CFR 410.40(e)(3).

CMS is revising the Medicare Benefit Policy Manual and Medicare Claims Processing Manual to clarify that a medically necessary ambulance transport from an SNF to the nearest supplier of medically necessary services not available at the SNF where the beneficiary is a resident (including the return trip) may be covered under Part B. This applies to beneficiaries who are in an SNF stay not covered by Part A, but who has Part B benefits.

For example, this includes ambulance transport of such residents from the SNF (modifier N) to the nearest diagnostic or therapeutic site, other than a physician’s office or hospital, such as an Independent Diagnostic Testing Facility (IDTF), cancer treatment center, radiation therapy center, or wound care center, as reported with ambulance modifier D. For SNF residents receiving Part A benefits, this type of ambulance service is subject to SNF consolidated billing.

ADDITIONAL INFORMATION


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<td>April 13, 2018</td>
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**Global Surgical Days for CAH Method II – Revised**

MLN Matters Number: MM10425 Revised  
Related Change Request (CR) Number: 10425  
Related CR Release Date: June 22, 2018  
Effective Date: July 1, 2018  
Related CR Transmittal Number: R20960TN  
Implementation Date: July 2, 2018

This article was revised on June 25, 2018, to reflect a revised CR10425 issued on June 22. In the article, we removed terminated HCPCS codes from edits for visits which are included in the global package. Also, the CR release date, transmittal number, and the Web address of the CR are revised. All other information remains the same.

**PROVIDER TYPE AFFECTED**

This MLN Matters® Article is intended for 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, 99291, 99292, 99315, 99316, and 99347-99350) 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.

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<tr>
<td>January 26, 2018</td>
<td>Initial article released.</td>
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**Telehealth Billing Requirement Revisions for Distant Site Services – Revised**

MLN Matters Number: MM10583 Revised
Related Change Request (CR) Number: 10583
Related CR Release Date: June 21, 2018
Effective Date: October 1, 2018
Related CR Transmittal Number: R2095OTN
Implementation Date: October 1, 2018

This article was revised on June 21, 2018, to reflect a revised CR10583 issued on June 20. In the article, the criteria that allows the GT modifier to be present on Method II CAH claim lines is revised. Also, the CR release date, transmittal number, and the Web address of the CR are revised. All other information remains the same.

**PROVIDER TYPE AFFECTED**
This MLN Matters® Article is intended for providers who submit claims to Medicare Administrative Contractors (MACs) for telehealth services provided to Medicare beneficiaries.
PROVIDER ACTION NEEDED

Change Request (CR) implements requirements for billing modifier GT for Telehealth Distant Site Services. As of January 1, 2018, the GT modifier is only allowed on institutional claims billed by a Critical Access Hospital (CAH) Method II. Make sure your billing staffs are aware of this requirement.

BACKGROUND

Previous guidance instructed providers to submit claims for telehealth services using the appropriate procedure code along with the telehealth modifier GT (via interactive audio and video telecommunications systems). In the Calendar Year (CY) 2017 Physician Fee Schedule (PFS) final rule, payment policies regarding Medicare’s use of a new Place of Service (POS) Code describing services furnished via telehealth (POS 02) were finalized and implemented through CR9726. The new POS code became effective January 1, 2017.

In the CY 2018 PFS final rule, the requirement to use the GT modifier was eliminated for all professional claims. CR10152, which implemented that policy, included a business requirement instructing MACs to be aware that the GT modifier is only allowed for distant site services billed when the type of bill is a Method II CAH with a revenue code 96X, 97X, or 98X or with a service line that contains HCPCS code Q3014 or the type of bill is a Method II CAH with revenue code 942 and contains G0420 or G0421. As of January 1, 2018, the GT modifier is only allowed on institutional claims billed under CAH Method II. If the GT modifier is billed under any circumstances, except as just outlined for Method II CAHs, the claim line will be rejected with the following remittance codes:

- Group Code CO - Contractual obligation
- Claim Adjustment Reason Code 4 - The procedure code is inconsistent with the modifier used or a required modifier is missing. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 07/01/2017

ADDITIONAL INFORMATION


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<tr>
<td>April 27, 2018</td>
<td>Initial article released.</td>
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CLAIM REVIEWS

Cataract Surgery Once in a Lifetime
The Recovery Auditor identified an issue associated with hospital outpatient providers billing more than one unit of cataract removal for the same eye. Cataract removal can only occur once per eye for the same date of service in a patient’s lifetime. CPT codes 66830 – 66984 are affected.

Resources:
- NCCI Policy Manual for Medicare Services – Chapter 8, Section D

CERT Errors Identified for Laboratory Standing Orders Submitted Beyond 12 Months
Recently, Noridian received notice of errors from the Comprehensive Error Rate Testing Contractor (CERT) for laboratory claims that have “Standing Orders” that are over 12 months old. In some cases, specifically for End Stage Renal Disease beneficiaries, standing orders submitted for review were over 12 months old. View the Laboratory Orders Must be Submitted Within 12 Months of Order webpage for clarification.
Direct Data Entry Claims Display Error

Claims that were originally submitted for processing with a Health Insurance Claim Number (HICN) as the beneficiary identifier are being incorrectly displayed in Direct Data Entry (DDE) with the Medicare Beneficiary Identifier (MBI). Claims should be displaying in DDE with the original identifier submitted on the claim (either the HICN or MBI). We will resolve this issue no later than May 29, 2018.

If you use the MBI returned through this display error on claims, the beneficiary will receive a Medicare Summary Notice with the MBI on it, possibly before they receive their new Medicare card containing their MBI.

To avoid confusion, please do not use a beneficiary’s MBI until one of these occur:

- They present their new Medicare card (which will contain their MBI)
- The MBI is available through your Medicare Administrative Contractor’s secure portal
- Their MBI is shared through the remittance advice starting in October 2018

For More Information

- Transition to New Medicare Numbers and Cards Medicare Learning Network® Fact Sheet
- New Medicare Card webpage

Direct Data Entry (DDE) User Guide Updated

The Direct Data Entry (DDE) User Guide has been updated on the Noridian website. Noridian has been updating the content on the webpages to better serve providers.

The items below have been updated in the DDE User Guide:

- Claims Entry
- Claims Corrections
- Reports
- Health Insurance Query Access (HIQA)

Visit the DDE User Guide [PDF] to view the updated information.

PWK Coversheet Updated

CMS Change Request (CR) 10124 revises the PWK (paperwork) Fax/Mail/esMD Coversheet to remove HICN and replace it with Medicare ID. All receipts containing the previous form received on or after April 2, 2018 will be returned for correction and resubmission.

The updated coversheets will be screened for completion of all required fields. Forms that are incomplete will also be returned for correction and resubmission.

View the CMS Medicare Learning Network (MLN) Matters (MM)10124 for complete instructions. The updated PWK Coversheet can be found on the Forms page under Medical Review Forms on the Noridian website.

Reason Code 7Z167 Webpage Now Available

Are you a provider who has received a returned claim with Reason Code 7Z167? Learn the common errors and corrections for when Intensity-Modulated Radiation Therapy (IMRT) is not allowed.

View the new Reason Code 7Z167 webpage.
Reason Code W7106 Webpage Now Available

Are you a provider who has received a returned claim with Reason Code W7106? Learn the common errors and corrections for when Intensity-Modulated Radiation Therapy (IMRT) is not allowed.

View the new Reason Code W7106 webpage.
HCPCS Drug/Biological Code Changes – July 2018 Update

MLN Matters Number: MM10624
Related Change Request (CR) Number: 10624
Related CR Release Date: April 20, 2018
Effective Date: July 1, 2018
Related CR Transmittal Number: R4025CP
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.

PROVIDER ACTION NEEDED
Change Request (CR) 10624 informs MACs of updated drug/biological HCPCS codes. The HCPCS code set is updated on a quarterly basis. The July 2018 HCPCS file includes 4 new HCPCS codes: Q9991, Q9992, Q9993 and Q9995. Please make sure your billing staffs are aware of these updates.

BACKGROUND
The July 2018 HCPCS file includes four new HCPCS codes, which are payable by Medicare, effective for claims with dates of service on or after July 1, 2018. These codes are:

Q9991
- Short Description: Buprenorph xtr 100 mg or less
- Long Description: Injection, buprenorphine extended-release (sublocade), less than or equal to 100 mg
- Type of Service (TOS) Code: 1
- Medicare Physician Fee Schedule Data Base (MPFSDB) Status Indicator: E

Q9992
- Short Description: Buprenorphine xtr over 100 mg
- Long Description: Injection, buprenorphine extended-release (sublocade), greater than 100 mg
- TOS Code: 1
- MPFSDB Status Indicator: E

Q9993
- Short Description: Inj., triamcinolone ext rel
- Long Description: Injection, triamcinolone acetonide, preservative-free, extended-release, microsphere formulation, 1 mg
- TOS Code: 1,P
- MPFSDB Status Indicator: E

Q9995
- Short Description: Inj. emicizumab-kxwh, 0.5 mg
- Long Description: Injection, emicizumab-kxwh, 0.5 mg
- TOS Code: 1
- MPFSDB Status Indicator: E

ADDITIONAL INFORMATION
Pricing for CPT Code 0449T

The service described by CPT Code 0449T (Insertion of aqueous drainage device, without extraocular reservoir, internal approach, into the subconjunctival space; initial device) will be allowed for reimbursement when reasonable and medically necessary criteria is met. A Local Coverage Determination (LCD) for Micro Invasive Glaucoma Surgery (MIGS) is in draft and will describe the reasonable and necessary conditions once completed.

In the meantime, coverage determinations are made on a case-by-case basis. CPT 0449T will be paid as a zero-day global period, so all post-operative visits after the day of surgery should be billed separately using the appropriate Evaluation and Management (E/M) codes.

Payment will be based on the relative value units (RVUs) with the appropriate geographic practice cost index (GPCI): 4.5 RVUs for physician work, 2.5 RVUs for practice expense, and 0.5 RVUs for liability insurance.
Additional Information Required for Coverage and Pricing for Category III CPT Codes – R3

The Additional Information Required for Coverage and Pricing for Category III CPT® Codes has been revised and published and for notice under contract numbers: 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601 (WY) in the CMS Medicare Coverage Database (MCD) and on our (Noridian) website.

Summary of Changes: Category III CPT® code 0398T, is being moved from Group 2 to Group 4.

Effective Date: May 24, 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
  • Once in the CMS MCD, select corresponding article title

Additional Information Required for Coverage and Pricing for Category III CPT Codes - R4

The Additional Information Required for Coverage and Pricing for Category III CPT® Codes has been revised and published and for notice under contract numbers: 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601 (WY) in the CMS Medicare Coverage Database (MCD) and on our (Noridian) website.

Summary of Changes: Category III CPT code 0254T, is being moved from Group 1 to Group 4.

Effective Date: June 21, 2018

View the locally hosted Medicare Coverage Article PDF.

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

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  • 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
**Cosmetic vs. Reconstructive Surgery Coverage Article Retirement – Effective June 25, 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:** A52729

**Article Title:** Cosmetic vs. Reconstructive Services

**Effective Date:** June 25, 2018

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

This article is retired as the Plastic Surgery LCD is present in all LOB which addresses Cosmetic vs. Reconstructive Services.

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

- Go to [Medicare Coverage Articles](#).
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
  - 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.

**Flow Cytometry Coverage Clarification**

The Flow Cytometry Coverage Clarification has been created and published for notice under contract numbers: 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601 (WY) in the CMS Medicare Coverage Database (MCD) and on our (Noridian) website.

**Article Medicare Coverage Database (MCD) Number:** A55934

**Effective Date:** October 1, 2015

**Article Summary:** LCD L36094 Flow Cytometry outlines the coverage criteria for flow cytometry testing. When covered, testing is limited to no more than 24 markers without additional medical necessity documentation and flow cytometry for the detection and/or identification or enumeration of bacteria or viruses in patients with chronic rhinosinusitis with or without polyps is investigational/experimental and is not a Medicare benefit.

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.
### High Compression Bandage System Clarification - R3

The High Compression Bandage System Clarification coverage article has been revised and published and for notice under contract numbers: 02101 (AK), 02201 (ID), 02301(OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601 (WY) in the CMS Medicare Coverage Database (MCD) and on our (Noridian) website.

**Effective Date:** January 1, 2018

**Summary of Changes:** The following procedure codes were deleted per the 2018 CPT/HCPCS codes.
- 29582 - thigh and leg, including ankle and foot, when performed
- 29583 - upper arm and forearm

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

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- Go to the Noridian Medicare Coverage Articles webpage.
- View complete list of Noridian coverage articles.
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  - Scroll to bottom of webpage
  - Select state/contract of interest from Active column (This link will redirect you to the CMS website.)
  - Once in the CMS MCD, select corresponding article title.

### Investigational Device Exemptions (IDEs) Coverage Article Retirement - Effective June 25, 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:** A52938

**Article Title:** Investigational Device Exemptions (IDEs)

**Effective Date:** June 25, 2018

**Summary:** Coverage articles may be retired due to lack of evidence of current problems or CMS may have issued guidance regarding national coverage. The Noridian guidance in the retired article may still be helpful in assessing medical necessity. Where providers have adjusted their billing and coding practices to correspond to the guidance in a coverage article, they will want to be very careful in departing from these practices just because the article is retired. Provider offices remain responsible for correct performance, billing, and medical necessity under Medicare. This responsibility for correct claims submission is unchanged whether or not there is a coverage article in place.
NOTE: With this retirement, providers can instead see the Investigational Device Exemptions (IDE) - IDE Documentation Requirements for Studies with an FDA Approval dated January 01, 2015 or later Coverage Article.

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

- Go to Medicare Coverage Articles webpage
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
  - Select the state of interest in the table under “Retired Articles.”
  - This link will redirect you to the CMS website.

On the CMS website, locate the above-listed CMS Medicare Coverage Database (MCD) number and article title and select the title of interest.

**Medical Necessity of Therapy Services - R4**

The Medical Necessity of Therapy Services coverage article has been revised and published and for notice under contract numbers: 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601 (WY) in the CMS Medicare Coverage Database (MCD) and on our (Noridian) website.

**Summary of Changes:** Corrected the hyperlinks to the Therapy Students and Aides and Therapy Evaluation and Assessment article noted in the article text.

**Effective Date:** January 1, 2017

View the locally hosted Medicare Coverage Article PDF.

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

To view complete list of Noridian coverage articles:

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

**MolDX: ENG and ACVRL1 Gene Tests Billing and Coding Guidelines – R1**

The MolDX: ENG and ACVRL1 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:** Added Part A claim filing information.

**Effective Date:** October 24, 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: FDA Approved CLL Companion Diagnostic Test Billing and Coding Guidelines Coverage Article**

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

**Summary of Article:** Article provides coverage and billing criteria for venetoclax (VENCLEXTA®/AbbVie) for patients with B-cell chronic lymphocytic leukemia (CLL) with 17p deletion and at least one prior therapy, and a new indication for Vysis CLL FISH Probe Kit, a laboratory test to detect 17p deletion, as a companion diagnostic for venetoclax.

**Effective Date:** July 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: Fragile X Billing and Coding Guidelines Update – R1**

The MolDX: Fragile X Billing and Coding Guidelines Update 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 instructions.

**Effective Date:** October 31, 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.

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

MolDX: GBA Genetic Testing Billing and Coding Guidelines – R1

The MolDX: GBA 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: Non-coverage article is revised to include Part A claim filing information.

Effective Date: October 31, 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).
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The MolDX: HBB 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) in the CMS Medicare Coverage Database (MCD) and on our (Noridian) website.

Summary of Changes: Article is revised to:

Add CPT codes:
• 81361 - Hbb (hemoglobin, subunit beta) (eg, sickle cell anemia, beta thalassemia, hemoglobinopathy); common variant(s) (eg, hbs, hbc, hbe)
• 81362 - Hbb (hemoglobin, subunit beta) (eg, sickle cell anemia, beta thalassemia, hemoglobinopathy); known familial variant(s)
• 81363 - Hbb (hemoglobin, subunit beta) (eg, sickle cell anemia, beta thalassemia, hemoglobinopathy); duplication/deletion variant(s)
• 81364 - Hbb (hemoglobin, subunit beta) (eg, sickle cell anemia, beta thalassemia, hemoglobinopathy); full gene sequence

Delete CPT codes:
• 81401 - Mopath procedure level 2
• 81403 - Mopath procedure level 4
• 81404 - Mopath procedure level 5

Effective Date: February 7, 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.

Go to the Noridian Medicare Coverage Articles webpage to:
• 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 – R4**
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 88399 Unlisted pathology procedure, 89398 Unlisted reproductive medicine laboratory procedure and revise wording to clarify the scope of the Program.

**Effective Date:** July 1, 2018

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).
**MolDX: Molecular Test Registration Requirement for Hospital Laboratories**

The MolDX: Molecular Test Registration Requirement for Hospital Laboratories coverage article has been published on the Noridian website.

**Summary of Article:** Article provides MolDX Program requirements for hospital laboratories including sharing DEX Z-Codes™ with reference laboratories.

**Effective Date:** March 31, 2017

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).

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

The MolDX: Next Generation Sequencing Billing and Coding Guidelines has been created and published for notice under contract numbers: 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601 (WY) in the CMS Medicare Coverage Database (MCD) and on our (Noridian) website.

**Summary:** Updated coverage and billing requirements for MolDX: Next Generation Sequencing

**Effective Date:** January 1, 2018

View the locally hosted Medicare Coverage Article PDF.

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

To view complete list of Noridian coverage articles:

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  - Once in the CMS MCD, select corresponding article title
**MolDX: PAX6 Gene Sequencing Billing and Coding Guidelines**

The MolDX: PAX6 Gene Sequencing Billing and Coding Guidelines has been created and published for notice under contract numbers: 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601 (WY) in the CMS Medicare Coverage Database (MCD) and on our (Noridian) website.

**Summary:** View billing and coding guidelines for MolDX: PAX6 Gene Sequencing.

**Effective Date:** October 9, 2017

View the locally hosted Medicare Coverage Article PDF.

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

To view complete list of Noridian coverage articles:

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

**MolDX: SETP9 Gene Test Billing and Coding Guidelines**

The MolDX: SETP9 Gene Sequencing Billing and Coding Guidelines has been created and published for notice under contract numbers: 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601 (WY) in the CMS Medicare Coverage Database (MCD) and on our (Noridian) website.

**Summary:** View billing and coding guidelines for MolDX: SETP9 Gene Test.

**Effective Date:** October 9, 2017

View the locally hosted Medicare Coverage Article PDF.

- Go to Noridian Medicare Coverage Articles webpage.
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
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  - Once in the CMS MCD, select corresponding article title
Molecular Diagnostic Program (MolDX) Manual
The Molecular Diagnostic Program (MolDX®) Manual has been published on the Noridian website.

Summary of Article: Removed 22 modifier information.

Effective Date: Immediately

View the locally hosted MolDX Manual 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).

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

Summary of Article: Removed NOC codes 88399 Unlisted surgical pathology procedure and 89398 Unlisted reproductive medicine laboratory procedure from CPT table.

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).

Piriformis Injections
The Piriformis Injections 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 (WY).

Article Summary: This replaces all previous articles on piriformis muscle injections and instructs providers to bill 20552-INJECTION(S); SINGLE OR MULTIPLE TRIGGER POINT(S), 1 OR 2 MUSCLE(S) when the injection focus is in the piriformis muscle or surrounding muscle groups. Per CPT Assistant December 2011, Volume 21, Issue 12 page 8; There is a significant difference in the work and procedure, as well as intent, between an injection of the piriformis muscle and the perineural injection of the sciatic nerve.

Effective Date: July 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).
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To view complete list of Noridian coverage articles:

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  - Scroll to bottom of webpage
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  - Once in the CMS MCD, select corresponding article title
Spinal Fusion Services – Documentation Requirements Article Number Changes for JFA and JFB - Effective April 12, 2018

The following JF Local Coverage Article (LCA) has been retired 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: A53973
Article Title: Spinal Fusion Services – Documentation Requirements
Effective Date: April 12, 2018

Summary of Changes: LCA number A53973 for Jurisdiction F Part A (JFA) was retired on April 12, 2018 and combined into Jurisdiction F Part B (JFB) LCA number A53975. JFA and JFB contract numbers will have the same final MCD LCA number and remain an Active Article. Coverage will remain the same.

To access the Noridian Active Local Coverage Articles from our website, follow the instructions below.

• Go to https://med.noridianmedicare.com/web/jfa/policies/coverage-articles.
  • The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
  • On the “Medicare Coverage Articles” page, locate the above listed LCA title.
  • This link will direct you to the locally hosted copy of the LCA.

Topical HBO and Physician Related Service Billing and Coding Guidelines

The Topical HBO and Physician Related Service 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 (WY).

Article Summary: Presently, the following two HCPCS codes for topical oxygen therapy are designated as DME jurisdiction and since CMS has instructed the local MACs to not allow a physician service with topical oxygen, Noridian does not expect to see any claims for this service in either Part A or Part B. This article provides billing for denial instructions of the physician services billed under 99199- UNLISTED SPECIAL SERVICE, PROCEDURE OR REPORT.

• A4575 - TOPICAL HYPERBARIC OXYGEN CHAMBER, DISPOSABLE
• E0446 - TOPICAL OXYGEN DELIVERY SYSTEM, NOT OTHERWISE SPECIFIED, INCLUDES ALL SUPPLIES AND ACCESSORIES

Effective Date: April 3, 2017

View the locally hosted Medicare Coverage Article PDF.

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

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  • Once in the CMS MCD, select corresponding article title
Wound Care & Debridement - Provided by a Therapist, Physician, NPP or as Incident-to Services - R3

The Wound Care & Debridement - Provided by a Therapist, Physician, NPP or as Incident-to Services 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) in the CMS Medicare Coverage Database (MCD) and on our (Noridian) website.

Summary of Changes: Corrected the hyperlinks to the High Compression Bandage System Clarification article noted in the article text.

Effective Date: January 1, 2017

View the locally hosted Medicare Coverage Article PDF.

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

To view complete list of Noridian coverage articles:

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

Medicare FFS Response to the 2018 California Wildfires – Second Revision

MLN Matters Number: SE17035 Revised
Article Revised Date: April 2, 2018

This article was revised on April 2, 2018, to advise providers that the public health emergency declaration and Section 1135 waiver authority expired on January 5, 2018. 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, who were affected by the 2017 wildfires in the State of California.

PROVIDER INFORMATION AVAILABLE

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


On October 17, 2017, the Administrator of the Centers for Medicare & Medicaid Services (CMS) authorized waivers under §1812(f) of the Social Security Act for the State of California retroactive to October 8, 2017 for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of wildfires. Providers can request an individual Section 1135 waiver by following the instructions available at https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Requesting-an-1135-Waiver-Updated-11-16-2016.pdf. The Public Health Emergency declaration and Social Security Act waivers including the Section 1135 waiver authority expired on January 5, 2018.

BACKGROUND

Section 1135 and Section 1812(f) Waivers

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

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

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

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

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

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

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

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

Waiver for California

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

Skilled Nursing Facilities

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

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

**Administrative Relief**

Appeal Administrative Relief for Areas Affected by California Wildfires

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

**Requesting an 1135 Waiver**


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

**Medicare Quality Reporting and Value-based Purchasing Programs**

CMS is granting exceptions under certain Medicare quality reporting and value-based purchasing programs to acute care hospitals, inpatient psychiatric facilities, skilled nursing facilities, home health agencies, hospices, inpatient rehabilitation facilities, long-term care hospitals, renal dialysis facilities, and ambulatory surgical centers located in areas affected by the devastating impacts of the Northern California wildfires since October 8, 2017, in and around counties in Northern California. For complete details of these exceptions, see the document posted at https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Memo-Requirements-Facilities-CA-Wildfires.pdf.
DISASTER CLAIMS

DOCUMENT HISTORY

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
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<tbody>
<tr>
<td>April 2, 2018</td>
<td>The article was revised to advise providers that the public health emergency declaration and Section 1135 waiver authority expired on January 5, 2018.</td>
</tr>
<tr>
<td>November 1, 2017</td>
<td>This article was revised to add information regarding the exceptions granted for certain Medicare quality reporting and value-based purchasing programs.</td>
</tr>
<tr>
<td>October 18, 2017</td>
<td>Initial article released.</td>
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</table>

Medicare FFS Response to the 2017 Southern California Wildfires - Revised

MLN Matters Number: SE17037 Revised
Article Revised Date: April 2, 2018

This article was revised on April 2, 2018, to advise providers that the public health emergency declaration and Section 1135 waiver authority expired on March 3, 2018. 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, who were affected by the December 2017 wildfires in the State of California.

PROVIDER INFORMATION AVAILABLE

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


BACKGROUND

Section 1135 and Section 1812(f) Waivers

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

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


Also referenced below are Q&As that are applicable for items and services furnished to Medicare beneficiaries within the State of California. These Q&As are displayed in two files:
One file addresses policies and procedures that are applicable without any Section 1135 or other formal waiver. These policies are always applicable in any kind of emergency or disaster, including the current emergency.

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

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

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

Waiver for California

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

Skilled Nursing Facilities

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

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

Administrative Relief

Apartment Relief for Areas Affected by California Wildfires

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

Requesting an 1135 Waiver


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

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<tr>
<td>December 18, 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](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

**Provider Enrollment – Unlicensed Residents**

MLN Matters Number: SE18008
Article Release Date: June 8, 2018

**PROVIDER TYPE AFFECTED**

This MLN Matters Article is intended for unlicensed resident physicians who need to enroll in the Medicare program through Medicare Administrative Contractors (MACs). The article is also intended for the providers for whom these residents will practice.

**WHAT YOU NEED TO KNOW**

Effective as soon as possible but no later than June 17, 2018, MACs will process CMS Form-855O provider enrollment applications submitted for unlicensed residents if the application submission includes either, 1) a Residency Contract signed and dated by both an official of the institution and the Resident Physician or, 2) a letter, on institution letterhead, confirming the applicant’s status as a Resident Physician signed and dated by an official of the institution and containing at a minimum the name of the applicant.

MACs shall approve the enrollment if the applicant passes all screening requirements and provides proof of residency as described above.

**DOCUMENT HISTORY**

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<tr>
<td>June 8, 2018</td>
<td>Initial article released.</td>
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End Stage Renal Disease (ESRD) Webpage Updated

The End Stage Renal Disease (ESRD) webpage has been updated on the Noridian website. Noridian has been updating the content on the webpages to better serve providers.

The items below have been updated on the ESRD webpage:

- Acute Kidney Injury (AKI) and ESRD Facilities
- ESRD PPS Outpatient Maintenance Billing Guide
- Ultrafiltration Coverage, Coding, and Reimbursement

Visit the End Stage Renal Disease (ESRD) webpage to view the updated information.

ESRD Facility Claim (Type of Bill 72X) to Accommodate Dialysis Furnished to Beneficiaries with AKI – Second Revision

MLN Matters® Number: MM9598 Revised
Related Change Request (CR) #: CR 9598
Related CR Release Date: December 6, 2016
Effective Date: January 1, 2017
Related CR Transmittal #: R17590TN
Implementation Date: January 3, 2017

This article was revised on May 18, 2018, to update language on page 4. The Non-ESRD HCPCS codes and ESRD modifiers were updated. All other information is unchanged.

Provider Types Affected

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

What You Need to Know

Change Request (CR) 9598 implements changes to the ESRD Facility claim (Type of Bill 72x) to accommodate dialysis furnished to beneficiaries with Acute Kidney Injury (AKI). This MLN Matters Article summarizes these changes. Make sure that your billing staffs are aware of these changes.

Background

On June 29, 2015, The Trade Preferences Extension Act of 2015 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 Section 1881(b)(14) to beneficiaries with AKI effective January 1, 2017.

Beginning January 1, 2017, ESRD facilities will be able to furnish dialysis to AKI patients. The AKI provision was signed into law on June 29, 2015. (See Sec. 808 Public Law 114-27.)

The provision provides Medicare payment beginning on dates of service January 1, 2017, and after to ESRD facilities, that is, hospital-based and freestanding, for renal dialysis services furnished to beneficiaries with AKI (both adult and pediatric). Medicare will pay ESRD facilities for the dialysis treatment using the ESRD Prospective Payment System (PPS) base rate adjusted by the applicable geographic adjustment factor, that is, wage index. In addition to the dialysis treatment, the ESRD PPS base rate pays ESRD facilities for the items and services considered to be renal dialysis services as defined in 42 CFR 413.171 and there will be no separate payment for those services.

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

Items and services furnished to beneficiaries with AKI that are not considered to be renal dialysis services as defined in 42 CFR 413.171, are separately payable. Specifically, drugs, biologicals, laboratory services,
supplies, and other services that ESRD facilities are certified to furnish and that would otherwise get furnished to a beneficiary with AKI in a hospital outpatient setting will be paid separately using the applicable Part B fee schedule. This includes vaccines. ESRD facilities may provide vaccines to beneficiaries with AKI and seek reimbursement under the applicable CMS vaccination policies discussed in Chapter 18 of the “Medicare Claims Processing Manual.”

For payment under Medicare, ESRD facilities shall report all items and services furnished to beneficiaries with AKI by submitting the 72x type of bill with condition code 84 - Dialysis for Acute Kidney Injury (AKI) on a monthly basis. Since ESRD facilities bill Medicare for renal dialysis services by submitting the 72x type of bill for ESRD beneficiaries, condition code 84 will differentiate an ESRD PPS claim from an AKI claim. AKI claims will require one of the following diagnosis codes:

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

In addition, ESRD facilities are required to include revenue code 082x, 083x, 084x, or 085x for the modality of dialysis furnished with the HCPCS code G0491 (Long descriptor – Dialysis procedure at a Medicare certified ESRD facility for Acute Kidney Injury without ESRD; Short descriptor – dialysis Acu Kidney no ESRD). Beneficiaries with AKI are able to receive either peritoneal dialysis or hemodialysis in an ESRD facility. Based on the level of care required for these beneficiaries, at this time, CMS is not extending the home dialysis benefit to beneficiaries with AKI.

AKI claims will not have limits on how many dialysis treatments can be billed for the monthly billing cycle, however, there will only be payment for one treatment per day across settings, except in the instance of uncompleted treatments. If a dialysis treatment is started, that is, a patient is connected to the machine and a dialyzer and blood lines are used, but the treatment is not completed for some unforeseen, but valid reason, the facility is paid based on the full base rate. An example includes medical emergencies such as rushing a dialysis patient to an emergency room mid-treatment. This is a rare occurrence and must be fully documented to your MAC’s satisfaction.

**Applicability of Other ESRD and CMS Adjustments**

**ESRD Network Fee**

The ESRD Network Fee reduction is not applicable to claims for beneficiaries with AKI. The operationalization of this policy occurs via CR 9814 effective April 1, 2017 and claims submitted between January 1, 2017 and March 31, 2017 will be adjusted once the CR is implemented.

**ESRD Quality Incentive Program (QIP)**

The ESRD QIP is not applicable for beneficiaries with AKI at this time.

**Sequestration Adjustments**

The 2 percent sequestration adjustment is applicable to claims for beneficiaries with AKI. This is a global CMS adjustment and as such applies to AKI claims.

**ESRD Conditions for Coverage (CfCs)**

The ESRD CfCs at 42 CFR part 494 are health and safety standards that all Medicare participating dialysis facilities must meet. These standards set baseline requirements for patient safety, infection control, care planning, staff qualifications, record keeping, and other matters to ensure that all patients, including ESRD and AKI patients, receive safe and appropriate care.
Low Volume Payment Adjustment (LVPA)

AKI dialysis treatments count toward the LVPA threshold when determining total number of treatments provided when a facility prepares the low volume attestation to determine eligibility for the LVPA, however, claims for patients with AKI will not receive the adjustment.

Home or Self-Dialysis Training Add-On Payment Adjustment

The home or self-dialysis training add-on is not applicable to claims for treatments provided to patients with AKI.

Billing for Physicians’ Services for Patients with AKI

Physicians are able to bill separately for services provided to patients with AKI. CMS expects providers to follow correct coding guidelines and use the appropriate HCPCS or CPT codes for the items and services provided to the patient.

The following CPT codes are available for ESRD facilities and physician’s offices to use when billing for physicians’ services provided in either an ESRD facility (place of service 65) or a physician’s office (place of service 11):

- 90935 - Hemodialysis procedure with single evaluation by a physician or other qualified health care professional
- 90937 - Hemodialysis procedure requiring repeated evaluation(s) with or without substantial revision of dialysis prescription
- 90945 - Dialysis procedure other than hemodialysis (eg, peritoneal dialysis, hemofiltration, or other continuous replacement therapies), with single evaluation by a physician or other qualified health care professional
- 90947 - Dialysis procedure other than hemodialysis (eg, peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies) requiring repeated evaluations by a physician or other qualified health care professional, with or without substantial revision of dialysis prescription

Please note: this is not an exhaustive list – as indicated above, CMS expects facilities and physician’s offices to bill the appropriate codes.

Payment for Erythropoietin Stimulating Agents (ESAs) and the ESA Monitoring Policy for AKI Patients

ESAs are included in the bundled payment amount for treatments administered to patients with AKI. The Non-ESRD HCPCS codes should be used (J0881, J0883, J0885, J0888 and Q0138). This policy was implemented with CR 9987.

The ESA monitoring policy has not yet been extended to AKI patients receiving treatment in an ESRD facility. Since this policy is not applicable to these treatments, the value codes used to report hemoglobin and hematocrit levels are not required when billing for ESAs.

Telehealth

Unless other criteria are met, telehealth is only available for ESRD beneficiaries at this time. Please see https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfctsht.pdf.

Modifier, Value Code, Condition Code, and Occurrence Codes

- Urea reduction ratio and vascular access modifiers are not required on ESRD facility claims for patients with AKI.
- ESRD specific modifiers, including JA, JB, and JE should not be included on AKI claims.
- ESRD facilities are not required to report the Kt/v reading value or the date of the last reading (occurrence code 51) for patients with AKI.
- ESRD facilities are not required to report a patient’s height and weight (value codes A8 and A9) for patients with AKI.
Additional Information


The official instruction, CR9987, issued to your MAC regarding this change is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9987.pdf.


42 CFR 413.171 is available at https://www.ecfr.gov/cgi-bin/retrieveECFR?gp&SID=3233ff9c843c3f74275cab5dcbcf088c&mc=true&amp;n=pt42.2.413&amp;r=PART&amp;ty=HTML&amp;se42.2.413_1171.


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<td>This article was revised to update language on page 4. The Non-ESRD HCPCS codes and ESRD modifiers were updated.</td>
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<tr>
<td>November 21, 2017</td>
<td>This article was revised to add a link to MM10281. That article updates the AKI payment policy regarding Transitional Drug Add- on Payment Adjustments (TDAPA).</td>
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<tr>
<td>June 19, 2017</td>
<td>This article was revised on June 19, 2017 to refer to code G0491 as a HCPCS code rather than a CPT code. In addition, a clarification was made on pages 3 and 4 in the paragraphs relating to the ESRD Conditions of Coverage and the Low Volume Payment Adjustment. Information regarding home or self-dialysis training add-on payment adjustments, billing for physician services, payment for erythropoietin stimulating agents, telehealth, and modifiers, value codes, condition codes, and occurrence codes is also added starting on page 4.</td>
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<tr>
<td>March 7, 2017</td>
<td>The article was revised to add a link to MLN Matters article MM9807 which implements the payment for renal dialysis services furnished to beneficiaries with AKI in ESRD Facilities for CY2017. All other information is unchanged.</td>
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<tr>
<td>December 7, 2016</td>
<td>Article Released</td>
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Comprehensive ESRD Care (CEC) Model Telehealth – Implementation – Revised

MLN Matters Number: MM10314 Revised
Related Change Request (CR) Number: 10314
Related CR Release Date: June 27, 2018
Effective Date: October 1, 2018
Related CR Transmittal Number: RI98DEMO
Implementation Date: October 1, 2018

This article was revised on June 28, 2018, to reflect a revised CR10314 issued on June 27. In the article, the CR release date, transmittal number, and the Web address of the CR are revised. All other information remains the same.

PROVIDER TYPES AFFECTED

This MLN Matters Article is intended for physicians, providers, and suppliers billing Medicare Administrative Contractors (MACs) and participating in the Comprehensive ESRD Care (CEC) Model for telehealth services provided to Medicare End-Stage Renal Disease (ESRD) beneficiaries associated with the CEC Model.

PROVIDER ACTION NEEDED

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

BACKGROUND

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

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

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

According to United States Renal Data System, in 2014, ESRD beneficiaries comprised less than 1 percent of the Medicare population, but accounted for an estimated 7.2 percent of total Medicare Fee-For-Service (FFS) spending, totaling more than $32.8 billion.

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

In the CEC Model, dialysis clinics, nephrologists and other providers collaborate to create an ESRD Seamless Care Organization (ESCO) to coordinate care for matched beneficiaries. ESCOs are accountable for clinical quality outcomes and financial outcomes measured by Medicare Part A and B spending, including all spending on dialysis services for their aligned ESRD beneficiaries. This model encourages dialysis providers to think beyond their traditional roles in care delivery and supports them as they provide patient-centered care that will address beneficiaries’ health needs, both in and outside of the dialysis clinic.
The CEC Model includes separate financial arrangements for larger and smaller dialysis organizations. Large Dialysis Organizations (LDOs), defined as having 200 or more dialysis facilities, will be eligible to receive shared savings payments. These LDOs will also be liable for shared losses and will have higher overall levels of risk compared with their smaller counterparts.

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

The CEC Model began on October 1, 2015, and will run until December 31, 2020. The CEC Model conducted a solicitation in 2016 to add more ESCOs for Performance Year 2 of the model, beginning on January 1, 2017. The CEC Model has no current plans for another round of solicitations.

The CEC Model LDO payment track and Non-LDO two-sided payment track are considered Advance Payment Models (APMs) regarding the Quality Payment Program.

The CEC Model will implement design elements with implications for the FFS system for its third performance year that includes benefit enhancements to give ACOs the tools to direct care and engage beneficiaries in their own care. The model also offers increased monitoring to account for different financial incentives and the provision of enhanced benefits. The model’s quality requirements are similar to Shared Savings Program (SSP) and Pioneer, modified as needed to take into account unique aspects of dialysis care, in keeping with the agencies initiatives to unify and streamline quality measurement and requirements.

**Telehealth Waiver**

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

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

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

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

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

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

- Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or Skilled Nursing Facilities (SNFs) - HCPCS codes G0406-G0408.
- Subsequent hospital care services, with the limitation of 1 telehealth visit every 3 days - CPT codes 99231-99233.
- Subsequent nursing facility care services, with the limitation of 1 telehealth visit every 30 days - CPT codes 99307-99310.
• Telehealth consultations, emergency department or initial inpatient - HCPCS codes G0425-G0427.
• Telehealth Consultation, Critical Care, initial - HCPCS code G0508.
• Telehealth Consultation, Critical Care, subsequent - HCPCS code G0509.
• Prolonged service in the inpatient or observation setting requiring unit/floor time beyond the usual service - CPT codes 99356-99357.

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

90785, 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90846, 90847, 90951, 90952, 90954, 90955, 90957, 90958, 90960, 90961, 90963, 90964, 90965, 90966, 90967, 90968, 90969, 90970, 96116, 96150, 96151, 96152, 96153, 96154, 96160, 96161, 97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99354, 99355, 99406, 99407, 99495, 99496, 99497, 99498, G0108, G0109, G0270, G0396, G0397, G0420, G0421, G0438, G0439, G0442, G0443, G0444, G0445, G0446, G0447, G0459, G0506, G0508, G0509, G9481, G9482, G9483, G9484, G9485, G9486, G9487, G9488, G9489

For Part A CEC claims when providers are ESCO providers and beneficiaries are aligned to the same ESCO for the Date of Service (DOS) on the claims submitted on Type of Bill (TOB) 12X, 13X, 22X, 23X, 71X, 72X, 76X, 77X, or 85X and contains the demo code 85 and one of the following CPT or HCPCS codes:

90785, 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90846, 90847, 90951, 90952, 90954, 90955, 90957, 90958, 90960, 90961, 90963, 90964, 90965, 90966, 90967, 90968, 90969, 90970, 96116, 96150, 96151, 96152, 96153, 96154, 96160, 96161, 97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99354, 99355, 99406, 99407, 99495, 99496, 99497, 99498, G0108, G0109, G0270, G0396, G0397, G0420, G0421, G0438, G0439, G0442, G0443, G0444, G0445, G0446, G0447, G0459, G0506, G0508, G0509, G9481, G9482, G9483, G9484, G9485, G9486, G9487, G9488, G9489

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

• HCPCS codes G0406 – G0408.
• CPT codes 99231 – 99233.
• CPT codes 99307 – 99310.
• HCPCS codes G0425-G0427
• HCPCS code G0508
• HCPCS code G0509
• CPT codes 99356-99357

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

Providers submitting electronic 837 claims should enter DEMO 85 in the REF segment 2300 Loop Demonstration Project Identifiers and providers will include Qualifier P4. Providers submitting a paper claim should enter demo 85 in the treatment authorization field.

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

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

In returning Part B claims, your MAC will use the following messaging:
• Claims Adjustment Reason Code (CARC) 16: (Claim/service lacks information or has submission/billing error(s) which is needed for adjudication) and
• Remittance Advice Remark Code (RARC) N763 (The demonstration code is not appropriate for this claim; resubmit without a demonstration code.)
• Group Code: CO (Contractual Obligation)

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

ADDITIONAL INFORMATION

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<td>April 27, 2018</td>
<td>Initial article released.</td>
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ESRD PPS Quarterly Update – Revised
MLN Matters Number: MM10818 Revised
Related Change Request (CR) Number: CR 10818
Related CR Release Date: June 15, 2018
Effective Date: July 1, 2018
Related CR Transmittal Number: R4073CP
Implementation Date: July 2, 2018

This article was revised on June 19, 2018, to add information on the revenue codes to be used for reporting code Q5105 on the 72x type of bill for ESRD beneficiaries. All other information remains the same.

provider type 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) 10818 provides instructions for new codes added to the Healthcare Common Procedure Coding System (HCPCS) file for anemia management that will be included in the list of items and services subject to the ESRD PPS Consolidated Billing (CB) requirements. Make sure your billing staff is aware of the changes.

Background
Section 153(b) of the Medicare Improvements for Patients and Providers Act (MIPPA) required the implementation of an End Stage Renal Disease Prospective Payment System (ESRD PPS), effective January 1, 2011.
The ESRD PPS:

- Includes consolidated billing requirements for limited Part B services included in the ESRD facility’s bundled payment
- Provides ESRD facilities a single payment that covers all of the resources used to furnish an outpatient dialysis treatment
- Provides outlier payments, if applicable, for high cost patients due to unusual variations in the type or amount of medically necessary care.

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of items and services subject to Part B CB, and are therefore no longer separately payable when provided to ESRD beneficiaries by providers other than ESRD facilities.

CR10818 provides instructions for a new code (Q5105 - Injection, epoetin alfa, biosimilar, (Retacrit) 100 units (for erd on dialysis) added to the Healthcare Common Procedure Coding System (HCPCS) file for anemia management; and which will be included in the list of items and services subject to the ESRD PPS CB requirements, effective July 1, 2018. This code will be reportable with revenue code 0634 or 0635 on the 72X type of bill for ESRD beneficiaries.

Anemia management is a functional category under the ESRD PPS, and the drugs and biologicals that fall within this category are always considered to be used for the treatment of ESRD. Further, in accordance with 42 CFR 413.237(a)(1), HCPCS Q5105 is considered to be an eligible outlier service and will be included in the outlier calculation. If the pricing data is not available on the ASP drug file, then MACs will manually price the drug using 1847A pricing methodologies. ESRD facilities will not receive separate payment for Q5105, with or without the AY modifier (Item or service furnished to an ESRD patient that is not for the treatment of ESRD), and the claims will process the line item as covered with no separate payment under the ESRD PPS.

In addition, there is a new HCPCS code - Q5106 (Injection, epoetin alfa, biosimilar, (Retacrit) (for non-erd use), 1000 units). This code will be reportable with revenue code 0636 on the 72X type of bill for individuals with Acute Kidney Injury (AKI). Q5106 is paid for through the AKI payment rate and therefore separate payment is not allowable on the 72X type of bill.

The updated list of renal dialysis services that are subject to the ESRD PPS CB requirements is available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/Consolidated_Billing.html. Also, CR10818 has an attachment that is a list of drugs always considered ESRD.

ADDITIONAL INFORMATION


DOCUMENT HISTORY

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<tr>
<td>June 19, 2018</td>
<td>This article was revised to add information on the revenue codes to be used for reporting code Q5105 on the 72x type of bill for ESRD beneficiaries. All other information remains the same.</td>
</tr>
<tr>
<td>June 15, 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

MLN Matters Number: MM10642  
Related Change Request (CR) Number: 10642  
Related CR Release Date: May 11, 2018  
Effective Date: July 1, 2018  
Related CR Transmittal Number: R4045CP  
Implementation Date: July 2, 2018

PROVIDER TYPE AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 10642 informs MACs about the changes in the July 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 clinical laboratory fee schedule.

Access to Data File

Under normal circumstances, CMS will make the updated CLFS data file available to MACs approximately 6 weeks prior to the beginning of each quarter. For example, the updated file will typically be made available for download and testing on or before approximately May 15 for the July 1 release. 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.

Other 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 CLFS. It 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 contractor priced until they are addressed at the annual Clinical Laboratory Public Meeting, which will take place in July 2018. The following “U” codes will 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, Type of Service (TOS), Short Descriptor, Long Descriptor)

The following new codes are effective April 1, 2018:

- 0035U TOS 5; Short Descriptor—Neuro csf prion prtn qual; Long Descriptor—Neurology (prion disease), cerebrospinal fluid, detection of prion protein by quaking-induced conformational conversion, qualitative
- 0036U TOS 5; Short Descriptor—Xome tum & nml spec seq alys; Long Descriptor—Exome (ie, somatic mutations), paired formalin-fixed paraffin-embedded tumor tissue and normal specimen, sequence analyses
- 0037U TOS 5; Short Descriptor—Trgt gen seq dna 324 genes; Long Descriptor—Targeted genomic sequence analysis, solid organ neoplasm, DNA analysis of 324 genes, interrogation for sequence
variants, gene copy number amplifications, gene rearrangements, microsatellite instability and tumor mutational burden

- 0038U TOS 5; Short Descriptor—Vitamin d smr microsamp quan; Long Descriptor—Vitamin D, 25 hydroxy D2 and D3, by LC-MS/MS, serum microsample, quantitative
- 0039U TOS 5; Short Descriptor—Dna antb 2strand hi avidity; Long Descriptor—Deoxyribonucleic acid (DNA) antibody, double stranded, high avidity
- 0040U TOS 5; Short Descriptor—Bcr/abl1 gene major bp quan; Long Descriptor—BCR/ABL1 (t(9;22)) (eg, chronic myelogenous leukemial translocation analysis, major breakpoint, quantitative
- 0041U TOS 5; Short Descriptor—B brdfrer antb 5 prtn igm; Long Descriptor—Borrelia burgdorferi, antibody detection of 5 recombinant protein groups, by immunoblot, IgM
- 0042U TOS 5; Short Descriptor—B brdfrer antb 12 prtn igg; Long Descriptor—Borrelia burgdorferi, antibody detection of 12 recombinant protein groups, by immunoblot, IgG
- 0043U TOS 5; Short Descriptor—Tbfr b grp antb 4 prtn igm; Long Descriptor—Tick-borne relapsing fever Borrelia group, antibody detection to 4 recombinant protein groups, by immunoblot, IgM
- 0044U TOS 5; Short Descriptor—Tbfr b grp antb 4 prtn igg; Long Descriptor—Tick-borne relapsing fever Borrelia group, antibody detection to 4 recombinant protein groups, by immunoblot, IgG0024U Glycosylated acute phase proteins (GlycA), nuclear magnetic resonance spectroscopy, quantitative
- 0012M TOS 5; Short Descriptor—Onc mrna 5 gen rsk urthl ca; Long Descriptor—Oncology (urothelial), mRNA, gene expression profiling by real-time quantitative PCR of five genes (MDK, HOXA13, CDC2 [CDK1], IGFBP5, and XCR2), utilizing urine, algorithm reported as a risk score for having urothelial carcinoma
- 0013M TOS 5; Short Descriptor—Onc mrna 5 gen recr urthl ca; Long Descriptor—Oncology (urothelial), mRNA, gene expression profiling by real-time quantitative PCR of five genes (MDK, HOXA13, CDC2 [CDK1], IGFBP5, and CXCR2), utilizing urine, algorithm reported as a risk score for having recurrent urothelial carcinoma

The following new code is effective January 1, 2018:

- 0011M TOS 5; Short Descriptor—Onc prst8 ca mrna 12 gen alg; Long Descriptor—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

Notes:

- In instances where Medicare-covered CLFS procedure codes do not yet appear on the quarterly CLFS file or the quarterly Integrated Outpatient Code Editor (I/OCE) update, MACs will locally price the codes until they appear on the CLFS file and/or, for Part A claims, the I/OCE.
- MACs will not search their files to either retract payment or retroactively pay claims; however, they should adjust claims that you bring to their attention.

ADDITIONAL INFORMATION


DOCUMENT HISTORY

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<td>May 14, 2018</td>
<td>Initial article released.</td>
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IPPS and LTCH PPS Extensions per the ACCESS Act Included in the Bipartisan Budget Act of 2018

MLN Matters Number: MM10547
Related Change Request (CR) Number: 10547
Related CR Release Date: May 10, 2018
Effective Date: October 1, 2017
Related CR Transmittal Number: R4046CP
Implementation Date: April 2, 2018

PROVIDER TYPE AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 10547 provides information and implementation instructions for Sections 50204, 50205, and 51005 of the Advancing Chronic Care, Extenders, and Social Services (ACCESS) Act of 2018. Make sure that your billing staffs are aware of these changes.

BACKGROUND

On February 9, 2018, President Trump signed into law the Bipartisan Budget Act of 2018 (see https://www.gpo.gov/fdsys/pkg/BILLS-115hr1892enr/pdf/BILLS-115hr1892enr.pdf). The new law includes the extension of certain provisions that had expired October 1, 2017. Specifically, the following Medicare Inpatient Prospective Payment System (IPPS) and LTCH Prospective Payment System (PPS) fee-for-service policies have been extended.

Section 50204 – Extension of Increased Inpatient Hospital Payment Adjustment for Certain Low-Volume Hospitals

The Affordable Care Act and subsequent legislation provided for temporary changes to the low-volume hospital adjustment for Fiscal Years (FYs) 2011 through 2017. To qualify, the hospital must have less than 1,600 Medicare discharges and be located 15 miles or more from the nearest subsection (d) hospital. Section 50204 of the Bipartisan Budget Act of 2018 extends these temporary changes through FY 2018 (and provides for modified temporary changes through FY 2022).

Section 50205 – Extension of the Medicare-Dependent Hospital (MDH) Program

The MDH program provides enhanced payment to support small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges. The Affordable Care Act and subsequent legislation had authorized the MDH program through September 30, 2017. Section 50205 of the Bipartisan Budget Act of 2018 extends the MDH program for discharges occurring on or after October 1, 2017, through FY 2022 (that is, for discharges occurring on or before September 30, 2022).

Section 51005 – Adjustments to the LTCH Site Neutral Payment Rate

Section 1206(a) of the Bipartisan Budget Act of 2013 established patient-level criteria for payments under the LTCH PPS for implementation beginning for cost reporting periods beginning on or after October 1, 2015. LTCH cases meeting specific clinical criteria are paid the LTCH PPS standard Federal rate payment and those cases not meeting specific clinical criteria are paid the site neutral rate payment. The Bipartisan Budget Act of 2013 provided for a transition period to the site neutral payment rate discharges occurring in cost reporting periods beginning in FY 2016 and FY 2017. Section 51005 of the Bipartisan Budget Act of 2018 extends the blended payment rate for LTCH site neutral payment rate discharges that occur in cost reporting periods beginning in FY 2018 and FY 2019, and adjusts the site neutral payment rate by reducing the IPPS comparable amount by 4.6 percent for FYs 2018 through 2026.

Low-Volume Hospitals – Criteria and Payment Adjustments for FY 2018

To implement the extension of the temporary change in the low-volume hospital payment policy for FY 2018, in accordance with the existing regulations at Section 412.101(b)(2)(ii) (see https://www.ecfr.
Specifically, the number of Medicare discharges for purposes of the low-volume hospital adjustment for FY 2018 is determined in a manner consistent with how it was done for FY 2011 through FY 2017. During that time, the number of Medicare discharges used to establish the discharge criterion and the applicable low-volume percentage adjustment for qualifying hospitals were determined by Table 14, a list of IPPS hospitals with fewer than 1,600 Medicare discharges and their number of Medicare discharges according to the most recent available data published in the corresponding IPPS/LTCH final rule. In the case of FY 2018, the corresponding most recent available data at the time CMS developed the FY 2018 IPPS/LTCH final rule was the March 2017 update of the FY 2016 Medicare Provider Analysis and Review (MedPAR) file. A file that lists the IPPS hospitals with fewer than 1,600 Medicare discharges based on the March 2017 update of the FY 2016 MedPAR file is available on the FY 2018 MAC Implementation Files webpage at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2018-IPPS-Final-Rule-Home-Page-Items/FY2018-IPPS-Final-Rule-MAC-Implementation.html. (CMS issued CMS-1677-N Table 1, a list of the IPPS hospitals with fewer than 1,600 Medicare discharges based on the March 2017 update of the FY 2016 MedPAR files in conjunction with the notice in the Federal Register published on April 26, 2018. In lieu of Table 14 of the FY 2018 IPPS/LTCH Final Rule, CMS-1677-N Table 1 is available on the FY 2018 Final Rule Tables webpage at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2018-IPPS-Final-Rule-Home-Page-Items/FY2018-IPPS-Final-Rule-Tables.html.)

In order to facilitate administrative implementation, consistent with historical practice, the only source that CMS and the MACs will use to determine the number of Medicare discharges for purposes of the low-volume adjustment for FY 2018 is the data from the March 2017 update of the FY 2016 MedPAR file. CMS notes that CMS-1677-N Table 1 is a list of IPPS hospitals with fewer than 1,600 Medicare discharges and is not a listing of the hospitals that qualify for the low-volume adjustment for FY 2018, since it does not reflect whether or not the hospital meets the mileage criterion (that is, generally the hospital must also be located more than 15 road miles from any other subsection (d) hospital). In order to receive the applicable low-volume hospital payment adjustment (percentage increase) for FY 2018 discharges, a hospital must meet both the discharge and mileage criteria.

In order to receive a low-volume adjustment for FY 2018, consistent with the previously established process (described in the FY 2017 IPPS/LTCH Final rule (81 FR 56941 through 56943)), CMS is continuing to require a hospital to provide written notification to its MAC. Such notification must contain sufficient documentation to establish that the hospital meets the applicable mileage and discharge criteria so that the MAC can determine if the hospital qualifies as a low-volume hospital in accordance with existing requirements set forth in the regulations at Section 412.101(b)(2)(ii) (in conjunction with Section 412.101(e) as applicable). Under this procedure, a hospital receiving the low-volume hospital payment adjustment in FY 2017 may continue to receive a low-volume hospital payment adjustment in FY 2018 without reapplying if it continues to meet both the discharge criterion and the mileage criterion applicable for FY 2018. Such a hospital must send written verification stating that it continues to meet the applicable mileage criterion applicable for FY 2018.

A hospital’s written notification must be received by its MAC no later than May 29, 2018, as stated in the notice CMS-1677-N published in the Federal Register on April 26, 2018 that announced the discharge data source (as mentioned above). If a hospital’s request for low-volume hospital status for FY 2018 is received after this date, and if the MAC determines the hospital meets the criteria to qualify as a low-volume hospital, the MAC will apply the low-volume hospital payment adjustment to determine the payment for the hospital’s FY 2018 discharges, effective prospectively within 30 days of the date of the MAC’s low-volume hospital status determination.
For discharges occurring during FY 2018, if a hospital qualifies as a low-volume hospital, the low-volume hospital indicator field on the Provider Specific File (PSF) (position 74 – temporary relief indicator) must contain a value of ‘Y’ and the low-volume payment adjustment factor field on the PSF (positions 252-258) must contain a value greater than 0 and less than or equal to 0.250000. (For hospitals that meet both the discharge criterion and the mileage criterion applicable for FY 2018, the value for the low-volume payment adjustment factor field can be found in CMS-1677-N Table 1 as described above). To implement this, the Pricer will apply the applicable low-volume hospital payment adjustment factor from the PSF for hospitals that have a value of “Y” in the low-volume hospital indicator field on the PSF. Any hospital that does not meet either the discharge or mileage criteria is not eligible to receive a low-volume payment adjustment for FY 2018, and the MAC must update the low-volume hospital indicator field on the PSF (position 74 – temporary relief indicator) to hold a value of “blank.”

The applicable low-volume hospital adjustment (percentage increase) is based on and in addition to all other IPPS per discharge payments, including capital, Disproportionate Share Hospital (DSH), uncompensated care, Indirect Medical Education (IME) and outliers. For Sole Community Hospitals (SCHs) and MDHs, the applicable low-volume percentage increase is based on and in addition to either payment based on the federal rate or the hospital-specific rate, whichever results in a greater operating IPPS payment.

Extension of the MDH Program

Under Section 3124 of the Affordable Care Act, the MDH program authorized by the Social Security Act (§1886(d)(5)(G)) was set to expire at the end of FY 2012. These amendments were extended through September 30, 2017, by subsequent legislation. Section 50205 of the Bipartisan Budget Act of 2018 extends the MDH program, through September 30, 2022. CMS implemented the extension of the MDH program provided by the Affordable Care Act and subsequent legislation in the regulations at §412.108 (see https://www.ecfr.gov/cgi-bin/text-idx?SID=4d2d4d21664431bde481af4210219ec&mnode=true&node=pt42.2.412&rgn=div5#se42.2.412_1108). (For additional information, refer to the FY 2016 Extension of the Low-Volume Hospital Payment Adjustment and MDH Program Interim Final Rule with Comment (IFC) (August 17, 2015; 80 FR 49594 through 49597)).

MDH Classification in States with No Rural Area

In addition to extending the MDH program, Section 50205 of the Bipartisan Budget Act of 2018 also provides for hospitals that are located in a state without a rural area (that is, an all-urban state) to be eligible to qualify for MDH status if it otherwise satisfies any of the statutory criteria to be reclassified as rural. Prior to the Bipartisan Budget Act of 2018, hospitals could only qualify for MDH status if they were geographically in a rural area or if they reclassified as rural under the statutory provision that is codified in the regulations at 42 CFR 412.103 (see https://www.ecfr.gov/cgi-bin/text-idx?SID=4d2d4d21664431bde481af4210219ec&mnode=true&node=pt42.2.412&rgn=div5#se42.2.412_1103). Under current regulations, hospitals located in all-urban states cannot reclassify as rural because their states do not have rural areas into which they can reclassify. This precluded hospitals in all-urban states from being classified as MDHs. The newly added provision in the Bipartisan Budget Act of 2018 allows an hospital in an all-urban state to be eligible for MDH classification if, among the other criteria, it would have qualified for rural reclassification by meeting the criteria at § 412.103(a)(1) or (3) or the criteria at § 412.103(a)(2) as of January 1, 2018, notwithstanding its location in an all-urban state. Hospitals in all-urban states looking to qualify for MDH classification should submit the following:

1. Apply to their Regional Office as per the application requirements outlined at 42 CFR 412.103(b) to determine if they meet the qualifications for rural reclassification other than being located in an all urban state.

2. Submit its request for MDH status to its MAC as per the classification procedures under 42 CFR 412.108(b) (the requirements of which are detail below).

A hospital in an all-urban state that qualifies as an MDH under the newly-added statutory provision will not be considered as having reclassified as rural but only as having satisfied one of the criteria at section 1886(d)(5)(E)(ii)(I), (II), or (III) (as of January 1, 2018 as applicable) for purposes of MDH classification.

Reinstatement of MDH Status

Consistent with implementation of previous extensions of the MDH program, generally, providers that were classified as MDHs as of the date of expiration of the MDH provision will be reinstated as MDHs effective October 1, 2017, with no need to reapply for MDH classification.
There are two exceptions:

a. MDHs that classified as SCHs on or after October 1, 2017

In anticipation of the expiration of the MDH provision, CMS allowed MDHs that applied for classification as an SCH by September 1, 2017, (that is, 30 days prior to the expiration of the MDH program), to be granted such status effective with the expiration of the MDH program. Hospitals that applied in this manner and were approved for SCH classification received SCH status as of October 1, 2017. Additionally, some hospitals that had MDH status as of the October 1, 2017, expiration of the MDH program may have missed the September 1, 2017, application deadline. These hospitals applied for SCH status in the usual manner instead and may have been approved for SCH status effective 30 days from the date of approval resulting in an effective date later than October 1, 2017.

b. MDHs that requested a cancellation of their rural classification under §412.103(b)

In order to meet the criteria to become an MDH, generally a hospital must be located in a rural area. To qualify for MDH status, some MDHs may have reclassified as rural under the regulations at §412.103. With the expiration of the MDH provision, some of these providers may have requested a cancellation of their rural classification.

Any provider that falls within either of the two exceptions listed above will not have its MDH status automatically reinstated retroactively to October 1, 2017. All other former MDHs will be automatically reinstated as MDHs effective October 1, 2017. Providers that fall within either of the two exceptions will have to reapply for MDH classification in accordance with the regulations at 42 CFR 412.108(b) and meet the classification criteria at 42 CFR 412.108(a). Specifically, the regulations at Section 412.108(b) require that:

1. The hospital submit a written request along with qualifying documentation to its contractor to be considered for MDH status (§412.108(b)(2)).
2. The contractor make its determination and notify the hospital within 90 days from the date that it receives the request for MDH classification (§412.108(b)(3)).
3. The determination of MDH status be effective 30 days after the date of the contractor’s written notification to the hospital (§412.108(b)(4)).

Cancellation of MDH Status

As required by the regulations at Section 412.108(b)(5), MACs must “evaluate on an ongoing basis” whether or not a hospital continues to qualify for MDH status. Therefore, as required by the regulations at §412.108(b)(5) and (6), the MACs will ensure that the hospital continues to meet the MDH criteria at §412.108(a) and will notify any MDH that no longer qualifies for MDH status. The cancellation of MDH status will become effective 30 days after the date the MAC provides written notification to the hospital.

It is important to note that despite the fact some providers might no longer meet the criteria necessary to be classified as MDHs, these providers could qualify for automatic reinstatement of MDH status retroactive to October 1, 2017, (unless they meet either of the two exceptions for automatic reinstatement as explained above) and would subsequently lose their MDH status prospectively.

Notification to Provider

Notification to providers is necessary only if there is a change that affects a provider’s MDH status; that is, if the provider’s MDH status is not reinstated seamlessly from October 1, 2017, because it falls within one of the two exceptions listed above or if the provider will lose its MDH status prospectively due to no longer meeting the criteria for MDH status, per the regulations at §412.108(b)(6).

Hospital Specific (HSP) Rate Update for MDHs

For the payment of FY 2018 discharges occurring on or after October 1, 2017, the Hospital Specific (HSP) amount for MDHs in the PSF will continue to be entered in FY 2012 dollars. The Pricer will apply the cumulative documentation and coding adjustment factor for FYs 2011 - 2013 of 0.9480 and apply all updates and other adjustment factors to the HSP amount for FY 2013 and beyond.

Changes to the LTCH Site Neutral Payment Rate

Section 51005(a) of the Bipartisan Budget Act of 2018 extends the blended payment rate for LTCH PPS site neutral payment rate cases provided by the Social Security Act (§1886(m)(6)(B)(i)) to discharges occurring in cost reporting periods beginning in FY 2018 and FY 2019. Section 51005(b) of the Bipartisan Budget Act of
2018 reduces the “IPPS comparable amount” component of the site neutral payment rate at §1886(m)(6)(B)(ii)(I) of the Social Security Act by 4.6 percent for FYs 2018 through 2026.

**Extension of the Blended Payment Rate for LTCH Site Neutral Payment Rate Cases**

The blended payment rate for LTCH site neutral payment rate cases is determined by the LTCH PPS Pricer according to the Federal PPS Blend Indicator variable in the PSF (data element 18, file position 75) so that providers with a value of ‘6’ or ‘7’ are paid a blend of 50 percent of the LTCH standard Federal payment rate and 50 percent of the site neutral payment rate, while providers with a value of ‘8’ in the Federal PPS Blend Indicator variable in the PSF are paid 100 percent of the site neutral payment rate.

To implement the extension of the blended payment rate provided by Section 51005(a) of the Bipartisan Budget Act of 2018, CMS is revising the description of the Federal PPS Blend Indicator variable in the PSF for a value of ‘7’ to indicate 50 percent of the site neutral payment rate and 50 percent of the LTCH standard Federal payment rate effective for all LTCH providers with cost reporting periods beginning in FY 2017, FY 2018, or FY 2019 (that is, Blend Years 2 through 4).

In order to ensure site neutral payment rate for discharges in cost reporting periods beginning in FY 2018 (beginning on or after October 1, 2017, and before October 1, 2018), MACs will update the Federal PPS Blend Indicator variable as follows:

- **6** – Blend Year 1 (represents 50 percent site neutral payment and 50 percent standard payment effective for all LTCH providers with cost reporting periods beginning in FY 2016 (on or after 10/01/2015 through 09/30/16)
- **7** – Blend Years 2 through 4 (represents 50 percent site neutral payment and 50 percent standard payment effective for all LTCH providers with cost reporting periods beginning in FY 2017, FY 2018, or FY 2019
- **8** – Transition Blend no longer applies with cost reporting periods beginning in FY 2020 (on or after 10/01/2019)

Therefore, MACs will ensure that the Federal PPS Blend Indicator variable in the PSF is updated to a value of ‘7’ for any providers with a cost reporting period beginning on or after October 1, 2017, and as such currently have a value of ‘8’ in the Federal PPS Blend Indicator variable in the PSF with an effective date of the fiscal year begin date date for the cost reporting period.

**Adjustment to the LTCH Site Neutral Payment Rate Cases**

As provided by the Social Security Act (§1886(m)(6)(B)), the site neutral payment rate is the lesser of 100 percent of the estimated cost of the case or the “IPPS comparable amount.” Section 51005 (b) of the Bipartisan Budget Act of 2018 adjusts the “IPPS comparable payment” component under the site neutral payment rate at §1886(m)(6)(B)(ii)(I) of the Social Security Act (described in Section 412.522(c)(1)(i)) (see [https://www.ecfr.gov/cgi-bin/text-idx?SID=4d2d4d21664431bde481aff4210219ec&mc=true&node=pt42.2.412&rgn=div5#se42.2.412_1522](https://www.ecfr.gov/cgi-bin/text-idx?SID=4d2d4d21664431bde481aff4210219ec&mc=true&node=pt42.2.412&rgn=div5#se42.2.412_1522)) in each of FYs 2018 through 2026. Specifically, Section 51005(b) reduces the “IPPS comparable amount” component of the site neutral payment rate by 4.6 percent. (CMS notes this 4.6 percent reduction applies to any applicable outlier payments under §412.522(c)(1)(i), as well, and is applied after the application of the site neutral payment rate high cost outlier budget neutrality factor under Section 412.522(c)(2)(i).)

In order to implement this adjustment, Pricer logic has been updated to reflect this reduction to the “IPPS comparable amount” component of the site neutral payment rate for discharges occurring in FY 2018.

**ADDITIONAL INFORMATION**


**DOCUMENT HISTORY**

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<td>May 14, 2018</td>
<td>Initial article released.</td>
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Medicare Beneficiary Identifier (MBI) Page Updated

Noridian has been diligently working to update the content of the MBI webpage to better serve our providers. Easy access to updated information will help providers with this transition. See the MBI webpage for information on the below topics.

- Transition Period
- MBI Format
- Mailing Schedule
- How to Prepare
- Implementation

Medicare Beneficiary Identifier (MBI) – New Education on Demand Tutorial

Beginning April 2018, new Medicare cards will begin being mailed to beneficiaries on a geographic basis. These cards contain a Medicare Beneficiary Identifier (MBI) that replaces the Health Insurance Claim Number (HICN). For a quick overview, view the MBI Education on Demand Tutorial (7 minutes, 35 seconds).

For additional Education on Demand Tutorials, browse the Noridian Education on Demand Tutorials webpage.

For complete details on MBI, including transition period information, system updates and more, see the Medicare Beneficiary Identifier (MBI) page.

MBI – Get It, Use It – Revised

MLN Matters Number: SE18006 Revised
Article Release Date: June 21, 2018

This article was revised on June 21, 2018, to emphasize the need to submit the MBI without hyphens or spaces to avoid rejection of your claim. All other information remains the same.

PROVIDER TYPE AFFECTED

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

PROVIDER ACTION NEEDED

The Centers for Medicare & Medicaid Services (CMS) is mailing the new Medicare cards with the MBI in phases by geographic location. There are 3 ways you and your office staff can get MBIs:

1. Ask your Medicare patients
   Ask your Medicare patients for their new Medicare card when they come for care. If they haven’t received a new card at the completion of their geographic wave, refer them to 1-800-Medicare (1-800-633-4227).

2. Use the MAC’s secure MBI look-up tool
   Once we mail the new Medicare card with the MBI to your patient, you can look up MBIs for your Medicare patients when they don’t or can’t give them. Sign up for the Portal to use the tool. You can use this tool even after the end of the transition period – it doesn’t end on December 31, 2019.

3. Check the remittance advice
   Starting in October 2018 through the end of the transition period, we’ll also return the MBI on every remittance advice when you submit claims with valid and active Health Insurance Claim Numbers (HICNs).
You can start using the MBIs even if the other health care providers and hospitals who also treat your patients haven’t. When the transition period ends on December 31, 2019, you must use the MBI for most transactions.

BACKGROUND

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS to remove Social Security Numbers from all Medicare cards by April 2019. A new, randomly generated Medicare Beneficiary Identifier, or MBI, is replacing the SSN-based HICN. The new MBI is noticeably different than the HICN. Just like with the HICN, the MBI hyphens on the card are for illustration purposes: don’t include the hyphens or spaces on transactions.

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

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

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

**FFS claims submissions with:**

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

**FFS eligibility transactions when the:**

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

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

**Protect the MBI as Personally Identifiable Information (PII); it is confidential like the HICN.**

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

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

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

Medicare Advantage and Prescription Drug plans continue to assign and use their own identifiers on their health insurance cards. For patients in these plans, continue to ask for and use the plans’ health insurance cards.

ADDITIONAL INFORMATION


DOCUMENT HISTORY

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 21, 2018</td>
<td>The article was revised to emphasize the need to submit the MBI without hyphens or spaces to avoid rejection of your claim. All other information remains the same.</td>
</tr>
<tr>
<td>June 21, 2018</td>
<td>The article was revised to emphasize the need to submit the MBI without hyphens or spaces to avoid rejection of your claim. All other information remains the same.</td>
</tr>
<tr>
<td>May 25, 2018</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>
MEDICAL POLICIES

**Allergy Testing Draft LCD Retirement – Effective May 2, 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:** DL37342

**LCD Title:** Allergy Testing

**Effective Date:** May 2, 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.

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.

**Arthroscopic Lavage and Arthroscopic Debridement for Osteoarthritic Knees – R2**

The following Noridian coverage requirements for the Arthroscopic Lavage and Arthroscopic Debridement for Osteoarthritic Knees 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:** Arthroscopic Lavage and Arthroscopic Debridement for Osteoarthritic Knees – NCD 150.9

**Summary of Changes:** Jurisdiction F Part A (JFA) Article number A54062 is retired and is combined into the Jurisdiction F Part B (JFB) Article number A54063 so that both JFA and JFB contract numbers will have the same final MCD Article number.

**Effective Date:** April 9, 2018

**View the locally hosted NCD requirements article.**

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.
Chest X-Ray Draft LCD Retirement - Effective May 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: DL34052

LCD Title: Chest X-Ray

Effective Date: May 9, 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.

Draft Policy DL34052 was replaced with Draft LCD DL37549 which finalized on 03/19/2018. LCD L37549 will be effective 06/22/2018.

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.

Chest X-Ray Policy LCD - Effective June 22, 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: L37549

LCD Title: Chest X-Ray Policy

Effective Date: June 22, 2018

Summary of LCD: To simplify this policy, make it easier for patients to receive, and for physicians to be reimbursed for chest X-rays and avoiding coding errors, we are converting this to a negative policy. Noridian is listing those diagnoses that are not reasonable and necessary based on literature from medical societies and clear community standards and for which data analysis shows are the more common reasons for denial.

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

- Go to Future LCD webpage
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
  - 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.
Chest X-Ray Policy LCD Retirement - Effective June 21, 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:** L34097

**LCD Title:** Chest X-Ray Policy

**Effective Date:** June 21, 2018

**Summary:** 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.

**NOTE:** Effective June 21, 2018, this LCD has been replaced with L37549 for JFA and JFB.

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

- Go to [Retired LCD](#) webpage.
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
- 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.

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Coenzyme Q10 (CoQ10) 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:** L37068

**LCD Title:** Coenzyme Q10 (CoQ10)

**Effective Date:** April 30, 2018

**Summary of Changes:** This LCD was revised to remove all content related to Reference number 9 in the Bibliography and Summary of Evidence sections of the LCD as this reference was withdrawn. The bibliography numbering from 10-15 was also corrected throughout the LCD.

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 on the left side of the webpage.
Controlled Substance Monitoring and Drugs of Abuse Testing LCD - R5
The following JF Local Coverage Determination (LCD) has been revised under contractor numbers: 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT), 03601 (WY).

Medicare Coverage Database (MCD) Number: L36707
LCD Title: Controlled Substance Monitoring and Drugs of Abuse Testing
Effective Date: October 1, 2017
Summary of Changes: Addition of ICD-10 Code effective October 1, 2017:
M54.12: Radiculopathy, cervical region
M25.511: Pain in right shoulder
M25.512: Pain in left shoulder
To access the Noridian Active LCDs from our website, follow the instructions below.
Go to Active LCD webpage
  • The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
Locate the above listed LCD title 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.

Electrocardiograms 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: L37283
LCD Title: Electrocardiograms
Effective Date: March 26, 2018
Summary of Changes: LCD revised to add ICD-10-CM Z51.81 - Encounter for therapeutic drug level monitoring and Z79.899 - Other long term (current) drug therapy. There is no change in the LCD coverage.
View the locally hosted Noridian Active LCD PDF.
  • Go to https://med.noridianmedicare.com/web/jfa/policies/lcd/active.
    • The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
  • Locate and select above listed LCD title.
**Flow Cytometry LCD – R9**

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:** L36094

**LCD Title:** Flow Cytometry

**Effective Date:** October 1, 2017

**Summary of Changes:** This LCD has been updated to add ICD-10 code Z85.72 - Personal history of non-Hodgkin lymphomas

View the locally hosted Noridian Active LCD PDF.

- 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).
- Locate and select above listed LCD title

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**Immune Globulin Intravenous (IVIg) LCD – R7**

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

**Medicare Coverage Database (MCD) Number:** L34074

**LCD Title:** Immune Globulin Intravenous (IVIg)

**Effective Date:** July 1, 2018

**Summary of Changes:** LCD is revised to clarify coverage for immunodeficiency, coverage for pre and post heart transplantation and pre kidney transplantation without restriction, sources are updated and the following diagnoses are added:

- T86.21 – heart transplant rejection
- T86.22 – heart transplant failure
- T86.298 – other complications of heart transplant
- Z48.21 – encounter for aftercare following heart transplant
- Z86.19 – personal history of other infectious and parasitic diseases
- Z87.01 – personal history of pneumonia (recurrent)
- Z94.1 – heart transplant status

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

- Go to Active LCD webpage
- The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
- Locate the above listed LCD title 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.

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.
**Lumbar Epidural Injections LCD - R5**

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

**Medicare Coverage Database (MCD) Number:** L34980

**LCD Title:** Lumbar Epidural Injections

**Effective Date:** October 1, 2017

**Summary of Changes:**

- Addition of M48.061 ICD-10 Code effective 10/01/2017. This code was not added per the ICD 9 to ICD 10 Coding Translation for Spinal Stenosis.

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.

**Lumbar MRI Final LCD - Effective August 27, 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:** L37281

**LCD Title:** Lumbar MRI

**Effective Date:** August 27, 2018

**Summary of LCD:** Circumstances for which MRI of the lumbar spine is covered, as well as circumstances for which it is covered imminently vs after therapeutic trials of conservative therapy.

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

- Go to Future LCDs webpage
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
  - Select the coordinating state and locate the above listed CMS MCD number or LCD title.
  - This link will redirect you to the state specific Future Effective LCD on the CMS website.
MolDX: APC and MUTYH Gene 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: L36884

LCD Title: MolDX: APC and MUTYH Gene Testing

Effective Date: May 15, 2017

Summary of Changes: LCD is revised to add CPT 81401. CPT 81401 was inadvertently left out of the draft and final LCDs.

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

- Go to Active LCD webpage
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
  - Locate the above listed LCD title 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.
  - 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: ConfirmMDx Epigenetic Molecular Assay LCD – R4

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: L36329

LCD Title: MolDX: ConfirmMDx Epigenetic Molecular Assay

Effective Date: May 21, 2018

Summary of Changes: LCD is updated to remove CDD from the title and remove the Pascual trial requirement, delete #8 under the conditions in which ConfirmMDx is covered, revise indications and limitations, update for 21st Century Cures Act required fields and add sources 17. Partin and 18. Van Neste.

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

- Go to Active LCD webpage
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
  - Locate the above listed LCD title 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.
  - 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: Decipher Prostate Cancer Classifier Assay LCD – R5
The following JF Local Coverage Determination (LCD) has been revised under contractor numbers 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT), 03601 (WY).

**Medicare Coverage Database (MCD) Number:** L36345

**LCD Title:** MolDX: Decipher® Prostate Cancer Classifier Assay

**Effective Date:** December 21, 2017

**Summary of Changes:** LCD is revised to delete CDD from the title and under Analysis of Evidence, the following sentence is revised: “Patient must have achieved initial PSA nadir (defined as undetectable PSA at or below 0.2 ng/ml) within 120 days of RP surgery, and...”

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: DecisionDx-Melanoma 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: DecisionDx-Melanoma

**Medicare Coverage Database Number:** DL37748

**Comment period:** June 7 – August 14, 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 JF Part A
  Attention: Draft LCD Comments
  PO Box 6781
  Fargo, ND 58103-6781
MEDICAL POLICIES

MolDX: Oncotype DX Genomic Prostate Score for Men with Favorable Intermediate Risk Prostate Cancer 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: L37321

LCD Title: MolDX: Oncotype DX® Genomic Prostate Score for Men with Favorable Intermediate Risk Prostate Cancer

Effective Date: March 18, 2018

Summary of Changes: Removed bibliography entry #7 and all content related to it.

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 AR-V7 Nucleus Detect for Men with Metastatic Castrate Resistant Prostate Cancer (MCRPC) 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: Oncotype DX AR-V7 Nucleus Detect for Men with Metastatic Castrate Resistant Prostate Cancer (MCRPC)

Medicare Coverage Database Number: DL37744

Comment period: June 7 – August 14, 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 JF Part A
Attention: Draft LCD Comments
PO Box 6781
Fargo, ND 58103-6781
MolDX: Pigmented Lesion Assay (PLA) Draft LCD Published for Review and Comments

The following draft Local Coverage Determination (LCD) has 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:** Pigmented Lesion Assay (PLA)

**Medicare Coverage Database Number:** DL37740

**Comment period:** June 7 – August 14, 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 JF Part A
Attention: Draft LCD Comments
PO Box 6781
Fargo, ND 58103-6781

MolDX: Prolaris Prostate Cancer Genomic Assay LCD – R4

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:** L36350

**LCD Title:** MolDX: Prolaris™ Prostate Cancer Genomic Assay

**Effective Date:** January 1, 2018

**Summary of Changes:** Removed CDD from the title and added 21st Century Cures Act information.

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: Prolaris Prostate Cancer Genomic Assay LCD – R5
The following JF Local Coverage Determination (LCD) has been revised under contractor numbers 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT), 03601 (WY).

**Medicare Coverage Database (MCD) Number:** L36350

**LCD Title:** MolDX: Prolaris™ Prostate Cancer Genomic Assay

**Effective Date:** January 1, 2018

**Summary of Changes:** Replaced CPT code 81479 Unlisted molecular pathology procedure with 81541 Oncology (prostate), mrna gene expression profiling by real-time rt-pcr of 46 genes (31 content and 15 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a disease-specific mortality risk score.

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

- Go to Active LCDs
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
  - On the “Active LCDs” page, locate the above listed LCD title.

This link will direct you to the locally hosted copy of the Active LCD. You may also view the LCD on the CMS MCD by selecting the appropriate state link at the top of the page and locating the LCD title.

MolDX: Prometheus IBD sgi Diagnostic Policy 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:** L37313

**LCD Title:** MolDX: Prometheus IBD sgi Diagnostic Policy

**Effective Date:** January 30, 2018

**Summary of Changes:** The 5th biomarker, CRP, is added to the listing of biomarkers in the following sentence under Coverage Indications, Limitations and/or Medical Necessity: “…and five inflammatory biomarkers: ICAM-1, VCAM-1, VEGF, CRP and SSA.”

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.
Non-Coverage of 0075T Article Retirement - Effective April 9, 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: A54698

Article Title: Non-Coverage of 0075T

Effective Date: April 9, 2018

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

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

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

Non-Covered Services LCD – R25

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: April 6, 2018

Summary of Changes: This LCD has been updated to remove CPT codes 84145.

- Deleted CPT code 84145 – Procalcitonin (PCT)

View the locally hosted Noridian Active LCD PDF.

- Go to Active LCDs
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
  - Locate and select above listed LCD title
Non-Covered Services LCD – R26

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: May 24, 2018

Summary of Changes: This LCD has been updated to remove CPT code 0398T.

- Deleted CPT code 0398T – Magnetic Resonance Image Guided High Intensity Focused Ultrasound (MRGFUS), stereotactic ablation lesion, intracranial for movement disorder including stereotactic navigation and frame placement when performed.

View the locally hosted Noridian Active LCD PDF.

- Go to Active LCDs
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
- Locate and select above listed LCD title

Non-Covered Services LCD - R27

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: June 21, 2018

Summary of Changes: This LCD has been updated to remove CPT code 0254T from Group 1.

- Deleted CPT 0254T: Endovascular repair of iliac artery bifurcation (eg, aneurysm, pseudoaneurysm, arteriovenous malformation, trauma, dissection) using bifurcated endograft from the common iliac artery into both the external and internal iliac artery, including all selective and/or nonselective catheterization(s) required for device placement and all associated radiological supervision and interpretation, unilateral.

View the locally hosted Noridian Active LCD PDF.

- Go to Active LCD 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 LCD title
Respiratory Care (Respiratory Therapy) Final LCD – Effective July 9, 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: L37293

LCD Title: Respiratory Care (Respiratory Therapy)

Effective Date: July 9, 2018

Summary of LCD: LCD is updated to clarify the ordering of Respiratory Therapy services and the medical necessity in the article text. Added and deleted the following CPT® codes new for 2018 because they are within the coverage indications of this LCD effective DOS October 1, 2017:

- Added:
  - 96417 - Exercise test for spasm, including pre- and post-spirometry, electrographic recording(s), and pulse oximetry and
  - 96418 - Pulmonary stress testing (e.g., 6-minute walk test), including measurement of heart rate, oximetry and oxygen titration, when performed

- Deleted:
  - 96420 - Pulmonary stress test/simple

Added the following ICD-10 codes new for 2018 because they are within the coverage indications of this LCD:

- E85.81 - Light chain (AL) amyloidosis,
- E85.82 - Wild-type transthyretin-related (ATTR) amyloidosis,
- R85.89 - Other amyloidosis,
- 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,
- I27.9 - Other secondary pulmonary hypertension,
- I27.83 - Eisenmenger’s syndrome and
- R06.03 - Acute respiratory distress.

The following ICD-10 codes were deleted with the 2018 ICD-10 code updates:

- E85.8 - Other amyloidosis and
- I27.2 - Other secondary pulmonary hypertension

Also, the description for the following ICD-10 codes changed effective for DOS 01/01/2018:

- I50.1 - Left ventricular failure, unspecified,
- M33.01 - Juvenile dermatomyositis with respiratory involvement and
- M33.11 - Other dermatomyositis with respiratory involvement

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.

Respiratory Care (Respiratory Therapy) Final LCD - Effective July 9, 2018 - Revised

The following has been revised on June 12, 2018 to correct the CPT codes added and deleted from the finalized Respiratory Care (Respiratory Therapy) LCD L34149.

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: L37293

LCD Title: Respiratory Care (Respiratory Therapy)

Effective Date: July 9, 2018

Summary of LCD: LCD is updated to clarify the ordering of Respiratory Therapy services and the medical necessity in the article text. Added and deleted the following CPT® codes new for 2018 because they are within the coverage indications of this LCD effective date of service (DOS) October 1, 2017:

- Added:
  - 94617 - Exercise test for spasm, including pre- and post-spirometry, electrographic recording(s), and pulse oximetry and
  - 94618 - Pulmonary stress testing (e.g., 6-minute walk test), including measurement of heart rate, oximetry and oxygen titration, when performed

- Deleted:
  - 94620 - Pulmonary stress test/simple

Added the following ICD-10 codes new for 2018 because they are within the coverage indications of this LCD:

- E85.81 - Light chain (AL) amyloidosis,
- E85.82 - Wild-type transthyretin-related (ATTR) amyloidosis,
- R85.89 - Other amyloidosis,
- 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,
- I27.9 - Other secondary pulmonary hypertension,
- I27.83 - Eisenmenger’s syndrome and
- R06.03 - Acute respiratory distress.

The following ICD-10 codes were deleted with the 2018 ICD-10 code updates:

- E85.8 - Other amyloidosis and
- I27.2 - Other secondary pulmonary hypertension

Also, the description for the following ICD-10 codes changed effective for DOS 01/01/2018:

- I50.1 - Left ventricular failure, unspecified,
MEDICAL POLICIES

- M33.01 - Juvenile dermatomyositis with respiratory involvement and
- M33.11 - Other dermatomyositis with respiratory involvement

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

- Go to Future LCD webpage
  - 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.

**Single Chamber and Dual Chamber Permanent Cardiac Pacemakers – Coding and Billing – R4**

The following Noridian coverage requirements for the Single Chamber and Dual Chamber Permanent Cardiac Pacemakers 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:** Single Chamber and Dual Chamber Permanent Cardiac Pacemakers (NCD 20.8.3)

**Effective Date:** May 1, 2016

**Summary of Changes:** Article is updated to indicate the KX modifier must be used when the appropriate diagnosis for doing the procedure is listed in Group I or Group II in the Covered ICD-10 Codes section. Added clarification for inserting a pacemaker prior to a medically necessary and reasonable cardiac ablation procedure.

View the locally hosted National Coverage Determination (NCD) requirements article.

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

- View the locally hosted NCD article PDF

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.

**Therapeutic Apheresis for Familial Hypercholesterolemia Coverage Article Number Changes for JFA and JFB - Effective April 12, 2018**

The following JF Local Coverage Article (LCA) has been retired 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:** A54544

**Article Title:** Therapeutic Apheresis for Familial Hypercholesterolemia

**Effective Date:** April 12, 2018

**Summary of Changes:** LCA number A54544 for Jurisdiction F Part A (JFA) was retired on April 12, 2018 and combined into Jurisdiction F Part B (JFB) LCA number A54545. JFA and JFB contract numbers will have the same final MCD LCA number and remain an Active Article. Coverage will remain the same.

To access the Noridian Active Local Coverage Articles from our website, follow the instructions below.

- Go to https://med.noridianmedicare.com/web/jfa/policies/coverage-articles.
• The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).

• On the “Medicare Coverage Articles” page, locate the above listed LCA title.

• This link will direct you to the locally hosted copy of the LCA.
MLN Connects – April 5, 2018
MLN Connects® for Thursday, April 5, 2018
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News & Announcements

• New Medicare Card Project – Important Updates
• Bipartisan Budget Act: CMS Reprocessing Impacted Claims
• Reducing Provider Burden: Send us Your Feedback
• MIPS Group Web Interface and CAHPS Survey: Register by June 30
• MIPS APM: Resources for Performance Year 2018
• Medicare Diabetes Prevention Program: New Resources
• Administrative Simplification: Electronic Transactions
• Opioids: CDC Online Training Series
• Opioid Overdoses Treated in Emergency Departments: CDC Vital Signs Report
• Help Prevent Alcohol Misuse or Abuse
• Reduce the Risk of Falls in Elderly Patients

Provider Compliance

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

Claims, Pricers & Codes

• HCPCS Code Set Modifications

Upcoming Events

• Cultural Competence: Meeting LTSS Needs of Beneficiaries Webinar — April 12
• Safe and Effective Use of Medications in Older Adults Webinar — April 18
• Managing Older Adults with Substance Use Disorders Webinar — May 16

Medicare Learning Network® Publications & Multimedia

• Institutional Billing for No Cost Items MLN Matters Article — New
• Proper Coding for Specimen Validity Testing Billed in Combination with Drug Testing MLN Matters Article — New
• SNF ABN MLN Matters Article — New
• SNF Value-Based Purchasing Program Updated MLN Matters Article — New
• Dementia Care Call: Audio Recording and Transcript — New
• Medicare FFS Response to the 2017 California Wildfires MLN Matters Article — Updated
• Medicare FFS Response to the 2017 Southern California Wildfires MLN Matters Article — Updated
• Inpatient Psychiatric Facility PPS Booklet — Revised
• Medicare Enrollment for Providers Who Solely Order, Certify, or Prescribe Booklet — Revised
• 2018 Medicare Part C and Part D Reporting Requirements and Data Validation Web-Based Training Course — Revised
• Medicare Parts A & B Appeals Process Booklet — Reminder
• Looking for Educational Materials?
MLN Connects – April 12, 2018

MLN Connects® for Thursday, April 12, 2018
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News & Announcements
• Help Your Medicare Patients Avoid and Report Scams
• 2018 MIPS Eligibility Tool
• Draft 2019 QRDA Category I Schematron: Submit Comments by April 20
• Home Health Utilization and Payment Data
• National Health Care Decisions Day is April 16

Provider Compliance
• Provider Compliance Tips for Oral Anticancer Drugs and Antiemetic Drugs Used in Conjunction

Upcoming Events
• Opioids Forum: Strategies and Solutions for Minority Communities — April 25
• Medicare Cost Report e-Filing System Webcast — May 1

Medicare Learning Network® Publications & Multimedia
• Increased Ambulance Payment Reduction for Non-Emergency BLS Transports to and from Renal Dialysis Facilities MLN Matters Article — New
• New Waived Tests MLN Matters Article — New
• Supervised Exercise Therapy for Symptomatic PAD MLN Matters Article — Revised
• Modifications to the Implementation of the PWK Segment of the esMD System MLN Matters Article — Revised
• Claims Processing Actions to Implement Certain Provisions of the Bipartisan Budget Act of 2018 MLN Matters Article — Revised
• Revised and New Modifiers for Oxygen Flow Rate MLN Matters Article — Revised
• April 2018 MLN Catalog – Revised
• Medicare Home Health Benefit Booklet — Revised
MLN Connects – April 19, 2018

MLN Connects® for Thursday, April 19, 2018

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News & Announcements

• New Medicare Card: New Numbers Are Confidential
• Market Saturation and Utilization Data Tool
• MIPS Study on Burdens Associated with Reporting Quality Measures: Apply by April 30
• IMPACT Act Transfer of Health Measures: Public Comment Period Ends May 3
• PEPPERs Available for Hospices, SNFs, IRFs, IPFs, CAHs, LTCHs
• National Minority Health Month: Partnering for Health Equity

Provider Compliance

• Ophthalmology Services: Questionable Billing and Improper Payments

Claims, Pricers & Codes

• April 2018 OPPS Pricer File

Upcoming Events

• Medicare Cost Report e-Filing System Webcast — May 1
• 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

• Quarterly Update to the NCCI PTP Edits, Version 24.2 MLN Matters Article — New
• Change in Type of Service for CPT Code 77067 MLN Matters Article — New
• Ambulance Transportation for SNF Resident in Stay Not Covered by Part A MLN Matters Article — New
• Supervised Exercise Therapy for Symptomatic PAD MLN Matters Article — Revised
• Guidelines for Teaching Physicians, Interns, and Residents Booklet — Revised
• Billing Information for Rural Providers and Suppliers Booklet — Revised
• ICD-10-CM/PCS: The Next Generation of Coding Booklet — Reminder
• General Equivalence Mappings FAQs Booklet — Reminder
• Critical Access Hospital Booklet — Reminder
• Learn About Medicare Policy
CMS Proposes Changes to Empower Patients and Reduce Administrative Burden

Changes in IPPS and LTCH PPS would advance price transparency and interoperability

On April 24, CMS proposed changes to empower patients through better access to hospital price information, improve patients’ access to their electronic health records, and make it easier for providers to spend time with their patients. The proposed rule proposes updates to Medicare payment policies and rates under the Inpatient Prospective Payment System (IPPS) and the Long-Term Care Hospital (LTCH) Prospective Payment System (PPS).

“We seek to ensure the health care system puts patients first,” said Administrator Seema Verma. “Today’s proposed rule demonstrates our commitment to patient access to high quality care while removing outdated and redundant regulations on providers. We envision a system that rewards value over volume and where patients reap the benefits through more choices and better health outcomes. Secretary Azar has made such a value-based transformation in our health care system a top priority for HHS, and CMS is taking important, concrete steps toward achieving it.”

The policies in the IPPS and LTCH PPS proposed rule would further advance the agency’s priority of creating a patient-driven health care system by achieving greater price transparency and interoperability – essential components of value-based care – while also significantly reducing the burden for hospitals so they can operate with better flexibility and patients have the information they need to become active health care consumers.

While hospitals are already required under guidelines developed by CMS to either make publicly available a list of their standard charges, or their policies for allowing the public to view a list of those charges upon request, CMS is updating its guidelines to specifically require that hospitals post this information. The agency is also seeking comment on what price transparency information stakeholders would find most useful and how best to help hospitals create patient-friendly interfaces to make it easier for consumers to access relevant health care data so they can more readily compare providers.

The proposed policies begin implementing core pieces of the government-wide MyHealthEData initiative through steps to strengthen interoperability or the sharing of health care data between providers. Specifically, CMS is proposing to overhaul the Medicare and Medicaid Electronic Health Record Incentive Programs (also known as the “Meaningful Use” program) to:

- Make the program more flexible and less burdensome
- Emphasize measures that require the exchange of health information between providers and patients
- Incentivize providers to make it easier for patients to obtain their medical records electronically

To better reflect this new focus, we are renaming the Meaningful Use program “Promoting Interoperability.” In addition, the proposed rule reiterates the requirement for providers to use the 2015 Edition of certified electronic health record technology in 2019 as part of demonstrating meaningful use to qualify for incentive payments and avoid reductions to Medicare payments. This updated technology includes the use of application programming interfaces, which have the potential to improve the flow of information between providers and patients. In the proposed rule, CMS is requesting stakeholder feedback through a Request for Information on the possibility of revising Conditions of Participation to revive interoperability as a way to increase electronic sharing of data by hospitals.

As part of its commitment to burden reduction, CMS is proposing in the FY 2019 IPPS/LTCH PPS proposed rule to remove unnecessary, redundant, and process-driven quality measures from a number of quality reporting and pay-for-performance programs. The proposed rule would eliminate a significant number of measures acute care hospitals are currently required to report and remove duplicative measures across the 5 hospital quality and value-based purchasing programs. This would remove 19 measures from the programs and de-duplicate another 21 measures while still maintaining meaningful measures of hospital quality and patient safety. Additionally, CMS is proposing a variety of other changes to reduce the number of hours providers spend on paperwork. CMS is proposing this new flexibility so that hospitals can spend more time providing care to their patients thereby improving the quality of care their patients receive.

In sum, this results in the elimination of 25 measures across the 5 programs with well over 2 million burden hours reduced for hospital providers impacted by the IPPS proposed rule, saving them $75 million.
For More Information:
- Proposed Rule
- Fact Sheet
See the full text of this excerpted CMS Press Release (issued April 24).

**MLN Connects – April 26, 2018**

**MLN Connects® for Thursday, April 26, 2018**

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**News & Announcements**
- New Medicare Card: Help Your Patients
- CMS Changes Name of the EHR Incentive Programs and Advancing Care Information to “Promoting Interoperability”
- Protect Medicare and Medicaid: Report Fraud, Waste, and Abuse
- Hospital Inpatient Quality Reporting Program: Submission Deadline May 15
- IRF, LTCH, and SNF Quality Reporting Programs: Submission Deadline May 15
- Open Payments Review and Dispute Data by May 15
- MACRA Funding Opportunity: Deadline Extended to May 30
- STD Awareness Month: Talk, Test, Treat

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

**Upcoming Events**
- Medicare Cost Report e-Filing System Webcast — May 1
- CMS Quality Measures: How They Are Used and How You Can Be Involved Webinar — May 2
- Quality Payment Program: Answering Your Frequently Asked Questions Call — May 16
- Settlement Conference Facilitation Expansion Call — May 22

**Medicare Learning Network® Publications & Multimedia**
- Quarterly HCPCS Drug/Biological Code Changes: July 2018 Update MLN Matters Article — New
Skilled Nursing Facility: Proposed FY 2019 Payment and Policy Changes

CMS issued a proposed rule outlining proposed FY 2019 Medicare payment updates and proposed quality program changes for Skilled Nursing Facilities (SNFs).

Proposed Rule Details:
- Advancing My HealthEData: Request for Information from stakeholders
- Modernizing the SNF Prospective Payment System (PPS) Case-mix Classification System
- SNF Quality Reporting Program (QRP)
- SNF Value-Based Purchasing Program (VBP)
- Payment rate changes under SNF PPS

For More Information:
- Proposed Rule: CMS will accept comments until June 26
- Press Release
- SNF PPS website
- SNF QRP website
- IMPACT Act of 2014 Data Standardization & Cross Setting Measures webpage
- SNF VBP Program website

See the full text of this excerpted CMS Fact Sheet (issued April 27).

Inpatient Rehabilitation Facility: Prospective Payment System FY 2019 Proposed Rule

On April 27, CMS proposed changes on how Medicare pays Inpatient Rehabilitation Facilities (IRFs) to make it easier for providers to spend more time with their patients and improve the use of electronic health records.

Proposed Rule Details:
- Advancing My HealthEData: Request for Information from stakeholders
- Burden reduction / Patients over Paperwork
- Meaningful Measures
- Proposed updates to IRF payment rates
- Solicitation of comments regarding additional changes to the physician supervision requirement

For More Information:
- Proposed Rule: CMS will accept comments until June 26
- Press Release

See the full text of this excerpted CMS Fact Sheet (issued April 27).

Inpatient Psychiatric Facility: FY 2019 Payment and Quality Reporting Updates

On April 27, CMS issued a rule proposing updates for FY 2019 to Medicare payment policies and rates for the Inpatient Psychiatric Facility (IPF) Prospective Payment System (PPS) and the IPF Quality Reporting Program.
Proposed Rule Details:

- Advancing My HealthEData: Request for Information from stakeholders
- Meaningful Measures
- Proposed payment updates
- Proposed technical corrections to IPF regulations
- IPF PPS refinements comment solicitation

For More Information:

- **Proposed Rule**: CMS will accept comments until June 26
- **Press Release**

See the full text of this excerpted [CMS Fact Sheet](#) (issued April 27).

Hospice: Proposed Updates to the Wage Index and Payment Rates for FY 2019

On April 27, CMS issued a proposed rule that would update FY 2019 Medicare payment rates and the wage index for hospices serving Medicare beneficiaries. This rule also proposes changes to the Hospice Quality Reporting Program.

Proposed Rule Details:

- Advancing My HealthEData: Request for Information from stakeholders
- Burden reduction
- Meaningful Measures
- Routine annual rate setting changes
- Hospice regulations text changes due to the Bipartisan Budget Act of 2018
- Improving transparency for patients

For More Information:

- **Proposed Rule**: CMS will accept comments until June 26
- **Press Release**

See the full text of this excerpted [CMS Fact Sheet](#) (issued April 27).
MLN Connects – May 3, 2018

MLN Connects® for Thursday, May 3, 2018

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News & Announcements

- New Medicare Cards: You Can Use MBIs Right Away
- New Strategy to Fuel Data-driven Patient Care, Transparency
- CMS Encourages Eligible Suppliers to Participate in Expanded Medicare Diabetes Prevention Program Model
- Patients Over Paperwork April Newsletter
- Hospital Quality Reporting Center Spring 2018 Newsletter
- Administrative Simplification: Transactions
- Can’t Find An Answer To Your Question?
- Hand Hygiene Day is May 5

Provider Compliance

- Provider Compliance Tips for Ordering Lower Limb Orthoses

Upcoming Events

- Quality Payment Program: Participation Criteria for Year 2 Webinar — May 9
- eCQI Resource Center Demonstration and Annual Update Webinar — May 10
- Quality Payment Program: Answering Your Frequently Asked Questions Call — May 16
- Settlement Conference Facilitation Expansion Call — May 22
- Comparative Billing Report on Critical Care Services Webinar — June 6

Medicare Learning Network® Publications & Multimedia

- New Physician Specialty Code for Medical Genetics and Genomics MLN Matters® Article — New
- Processing Instructions to Update the Identification Code Qualifier Being Used in the NM108 Data Element MLN Matters Article — New
- Revisions to the Telehealth Billing Requirements for Distant Site Services MLN Matters Article — New
- Enhancements to Processing of Hospice Routine Home Care Payments MLN Matters Article — New
- Comprehensive ESRD Care Model Telehealth - Implementation MLN Matters Article — New
- Removal of KH Modifier from Capped Rental Items MLN Matters Article — New
- Acute Care Hospital IPPS Booklet — Revised
MLN Connects – May 10, 2018

MLN Connects® for Thursday, May 10, 2018
View this edition as a PDF

News & Announcements

- First CMS Rural Health Strategy
- Direct Provider Contracting RFI — Submit Comments by May 25
- Provider Documentation Manual: Home Use of Oxygen — Submit Comments on Draft by May 31
- Hospital Compare Preview Reports Available through June 2
- eCQM Annual Update
- Hospital Quality Reporting: 2019 QRDA I Implementation Guide, Schematron, and Sample Files
- 2018 Measure Development Plan Annual Report
- National Women’s Health Week Kicks off on Mother’s Day

Provider Compliance

- Reporting Changes in Ownership — Reminder

Upcoming Events

- Quality Payment Program: Answering Your Frequently Asked Questions Call — May 16
- Managing Older Adults with Substance Use Disorders Webinar — May 16
- FY 2019 IPPS Proposed Rule: eCQM Reporting Webinar — May 16
- Settlement Conference Facilitation Expansion Call — May 22
- Qualified Medicare Beneficiary Program Billing Requirements Call — June 6

Medicare Learning Network® Publications & Multimedia

- Inexpensive or Routinely Purchased DME Payment Classification for SGD and Accessories MLN Matters Article — New
- Medicare Cost Report E-Filing MLN Matters Article — New
- MCRF System Webcast: Audio Recording and Transcript — New
MLN Connects – May 17, 2018

MLN Connects® for Thursday, May 17, 2018

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News & Announcements

• New Medicare Card: MBI Look-up Tool Clarification and RRB Mailing
• Enhanced “Drug Dashboards” to Increase Transparency on Drug Prices
• CMS Safeguards Patient Access to Certain Medical Equipment and Services in Rural and Other Non-contiguous Communities
• Quality Payment Program: Check 2018 MIPS Clinician Eligibility at the Group Level
• Medicare Diabetes Prevention Program Resources
• Hospital Outpatient Quality Reporting Spring 2018 Newsletter
• Talk to Your Patients about Mental Health

Provider Compliance

• Cochlear Devices Replaced Without Cost: Bill Correctly — Reminder

Upcoming Events

• Settlement Conference Facilitation Expansion Call — May 22
• Qualified Medicare Beneficiary Program Billing Requirements Call — June 6

Medicare Learning Network® Publications & Multimedia

• ICD-10 and Other Coding Revisions to National Coverage Determinations MLN Matters Article — New
• Quarterly Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment MLN Matters Article — New
• Updates to Publication 100-04 to Replace RARC MA61 with N382 MLN Matters Article — New
• IPPS and LTCH PPS Extensions per the ACCESS Act MLN Matters Article — New
• Supervised Exercise Therapy for Symptomatic PAD MLN Matters Article — Revised
• Quarterly HCPCS Drug/Biological Code Changes – July 2018 Update MLN Matters Article — Revised
• Medicare Preventive Services National Educational Products — Revised
• Power Mobility Devices Booklet — Reminder
• Advance Beneficiary Notice of Noncoverage Interactive Tutorial Educational Tool — Reminder
• Medicare Advance Written Notices of Noncoverage Booklet — Reminder
• Long-Term Care Hospital Prospective Payment System Booklet — Reminder
• Medicare Disproportionate Share Hospital Fact Sheet — Reminder
• Hospital-Acquired Conditions and Present on Admission Indicator Reporting Provision Fact Sheet — Reminder
MLN Connects – May 24, 2018
MLN Connects® for Thursday, May 24, 2018
View this edition as a PDF

News & Announcements

• MIPS Promoting Interoperability Performance Category
• Provider Documentation Manual on Home Use of Oxygen: Submit Comments on Draft by May 31
• Proposals for New Measures for Promoting Interoperability Program: Deadline June 29
• Targeted Probe and Educate Video
• Hospice Compare Quarterly Refresh
• CQM Annual Update
• Break Free from Osteoporosis

Provider Compliance

• Medicare Hospital Claims: Avoid Coding Errors — Reminder

Claims, Pricers & Codes

• FY 2019 ICD-10-PCS Procedure Codes

Upcoming Events

• Hospice Quality Reporting Program Data Submission and Reporting Webinar — May 30
• DMEPOS Dietary Related Items, Templates and CDEs Special Open Door Forum — May 31
• Qualified Medicare Beneficiary Program Billing Requirements Call — June 6
• MIPS Promoting Interoperability Performance Category Webinar — June 12

Medicare Learning Network® Publications & Multimedia

• RARC, CARC, MREP, and PC Print Update MLN Matters Article — New
• Implement Operating Rules - Phase III ERA EFT: CORE 360 Uniform Use of CARC, RARC and CAGC Rule - Update from CAQH CORE MLN Matters Article — New
• Removal of KH Modifier from Capped Rental Items MLN Matters Article — Revised
• Changes to the ESRD Claim to Accommodate Dialysis Furnished to Beneficiaries with AKI MLN Matters Article — Revised
• World of Medicare Web-Based Training Course — Revised
• Your Office in the World of Medicare Web-Based Training Course — Revised
• Your Institution in the World of Medicare Web-Based Training Course — Revised
MLN Connects – May 31, 2018
MLN Connects® for Thursday, May 31, 2018
View this edition as a PDF

News & Announcements

• New Medicare Card Project — Card Mailing Update
• MIPS: Submit Quality Measures for Consideration by June 1
• 2016 Physician and Other Supplier PUF
• 2016 Referring Provider DMEPOS PUF

Provider Compliance

• Provider Minute Video: The Importance of Proper Documentation

Upcoming Events

• Qualified Medicare Beneficiary Program Billing Requirements Call — June 6
• Medicare Diabetes Prevention Program: Supplier Enrollment Call — June 20
• IMPACT Act: Frequently Asked Questions Call — June 21

Medicare Learning Network® Publications & Multimedia

• New Medicare Beneficiary Identifier: Get It, Use It MLN Matters Article — New
• Quarterly Update to the Medicare Physician Fee Schedule Database MLN Matters Article — New
• Quarterly Update for the DMEPOS CBP MLN Matters Article — New
• Quarterly ASP Part B Drug Pricing Files and Revisions to Prior Files MLN Matters Article — New
• MCReF System Webcast: Video Presentation — New
• Quality Payment Program Call: Audio Recording and Transcript — New
• Diagnosis Code Update for Add-on Payments for Blood Clotting Factor Administered to Hemophilia Inpatients MLN Matters Article — Revised
MLN Connects – June 7, 2018
MLN Connects® for Thursday, June 7, 2018
View this edition as a PDF

News & Announcements

• New Medicare Card: MBI Look-up Tool Available through your MAC
• Declines in Hospital-Acquired Conditions Save 8,000 Lives and $2.9 Billion
• 2017 Quality Payment Program Year 1 Submission Results
• DMEPOS Prior Authorization List Additions
• Draft QRDA III Implementation Guide: Submit Comments by June 20
• IRF and LTCH Provider Preview Reports: Review Your Data by June 30
• SNF Provider Preview Report: Review Your Data by June 30
• Hospice Provider Preview Reports: Review Your Data by June 30
• Eligible Hospitals: Submit a Hardship Exception Application by July 1
• PEPER for Short-term Acute Care Hospitals
• View Your MIPS Preliminary Performance Feedback Data
• Physician Compare downloadable Database: 2016 Performance Scores

Provider Compliance

• Bill Correctly for Device Replacement Procedures — Reminder

Claims, Pricers & Codes

• July 2018 Average Sales Price Files

Upcoming Events

• MIPS Promoting Interoperability Performance Category Webinar — June 12
• CMS Quality Measures: Development, Implementation, and You Webinar — June 13 or 14
• Medicare Diabetes Prevention Program: Supplier Enrollment Call — June 20
• IMPACT Act: Frequently Asked Questions Call — June 21
• Home Health Agencies: Quality of Patient Care Star Ratings Algorithm Call — June 27
• Ground Ambulance Providers and Suppliers: Data Collection System Listening Session — June 28
• Comparative Billing Report on Knee Orthoses Referring Providers Webinar — July 11

Medicare Learning Network® Publications & Multimedia

• New Q Code for In-Line Cartridge Containing Digestive Enzyme(s) MLN Matters Article — New
• July 2018 Update of the Ambulatory Surgical Center Payment System MLN Matters Article — New
• Claim Status Category and Claim Status Codes Update MLN Matters Article — New
• Settlement Conference Facilitation Call: Audio Recording and Transcript — New
• E/M Service Documentation Provided by Students MLN Matters Article — Revised
MLN Connects – June 14, 2018

News & Announcements

- CMS Opioids Roadmap
- LTCH and IRF Compare Refresh
- Antipsychotic Drug Use in Nursing Homes: Trend Update
- Men’s Health Week Ends on Father’s Day

Provider Compliance

- Billing for Stem Cell Transplants — Reminder

Claims, Pricers & Codes

- FY 2019 ICD-10-CM Diagnosis Codes

Upcoming Events

- Medicare Diabetes Prevention Program: Supplier Enrollment Call — June 20
- IMPACT Act: Frequently Asked Questions Call — June 21
- Home Health Agencies: Quality of Patient Care Star Ratings Algorithm Call — June 27
- Ground Ambulance Providers and Suppliers: Data Collection System Listening Session — June 28

Medicare Learning Network® Publications & Multimedia

- Improvements in Hospice Billing and Claims Processing MLN Matters Article — New
- Provider Enrollment: Unlicensed Residents MLN Matters Article — New
- Update of the Hospital OPPS: July 2018 MLN Matters Article — New
- Quarterly Update for the DMEPOS CBP: October 2018 MLN Matters Article — New
- Medicare Claims Processing Manual Update, Chapters 18 and 35: IDTF MLN Matters Article — New
- Provider/Supplier Reporting of Adverse Legal Actions MLN Matters Article — New
- Transition to New Medicare Numbers and Cards Fact Sheet — Revised
- CMS Web Wheel Educational Tool — Revised
- Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians Web-based Training — Reminder
- Remittance Advice Resources and FAQs Booklet — Reminder
MLN Connects – June 21, 2018

MLN Connects® for Thursday, June 21, 2018

View this edition as a PDF

News &Announcements

• New Medicare Cards May Have QR Codes
• Continuous Glucose Monitors: Changes Impacting Medicare Coverage
• Quality Payment Program Look-Up Tool Updated
• Quality Payment Program Website Includes 2018 MIPS Measures and Activities
• Hospice Provider Preview Reports: Review Your Data by June 30
• IRF and LTCH Provider Preview Reports: Review Your Data by July 1
• SNF Provider Preview Report: Review Your Data by July 1
• CMS Leverages Medicaid Program to Combat the Opioid Crisis

Provider Compliance

• Payment for Outpatient Services Provided to Beneficiaries Who Are Inpatients of Other Facilities — Reminder

Upcoming Events

• Home Health Agencies: Quality of Patient Care Star Ratings Algorithm Call — June 27
• Ground Ambulance Providers and Suppliers: Data Collection System Listening Session — June 28

Medicare Learning Network® Publications & Multimedia

• July Quarterly Update for 2018 DMEPOS Fee Schedule MLN Matters Article — New
• Qualified Medicare Beneficiary Call: Audio Recording and Transcript — New

MLN Connects Special Edition – June 25, 2018

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

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

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

• Print and give them the “Still Waiting for Your New Card?” handout (in English or Spanish).
• Or tell them to call 1-800-Medicare (1-800-633-4227). There might be something that needs to be corrected, such as updating their mailing address.

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

To ensure people with Medicare continue to get health care services, continue to use the Health Insurance Claim Number (HICN) through December 31, 2019 or until your patient brings in their new card with the new number.
Check this [website](#) as the mailings progress. Continue to direct people with Medicare to [Medicare.gov/NewCard](http://Medicare.gov/NewCard) for information about the mailings and to sign up to get email about the status of card mailings in their state.

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

Information on the transition to the new Medicare Beneficiary identifier:

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

**MLN Connects – June 28, 2018**

**MLN Connects® for Thursday, June 28, 2018**

**View this edition as a PDF**

**News & Announcements**

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

**Provider Compliance**

- Comprehensive Error Rate Testing: Arthroscopic Rotator Cuff Repair

**Claims, Pricers & Codes**

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

**Upcoming Events**

- Provider Compliance Focus Group — July 13

**Medicare Learning Network® Publications & Multimedia**

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

Effective June 18, 2018, per guidance in CMS Change Request (CR)10611, the cost report submission feature through Noridian Medicare Portal (NMP) has been disabled. As an alternative, providers may use the CMS Medicare Cost Report Electronic Filing (MCReF) portal. For additional information, view the resources below.

Resources
- CR10611
- CMS Medicare Cost Report e-Filing System Webcast
- MCReF Login

MBI Look-Up Tool Available on the Noridian Medicare Portal

The Medicare Beneficiary Identifier (MBI) Look-Up Tool is now available on the Noridian Medicare Portal (NMP). This tool is an option for providers/suppliers to use if they are not able to obtain the MBI number from the patient. The new portal feature will only return the MBI if the patient’s new Medicare card has been mailed. The new cards are being mailed in phases following a geographic location strategy.

The MBI Lookup requires users to enter first and last name, Date of Birth (DOB) and Social Security Number (SSN). Users will also need to complete the “I am not a robot” verification for every five transactions.

Note: The SSN may be different than the Health Insurance Claim Number (HICN) if the patient receives benefits under a spouse or family member.

To begin using the MBI Look-Up Tool, log onto the Noridian Medicare Portal. For step-by-step instructions, view the NMP User Manual and self-paced tutorial.

More information regarding MBI efforts and educational resources are available on the CMS New Medicare Cards website.
MLN Matters Number: MM10699 Revised
Related Change Request (CR) Number: 10699
Related CR Release Date: June 15, 2018
Effective Date: July 1, 2018
Related CR Transmittal Number: R4074CP
Implementation Date: July 2, 2018

This article was revised on June 18, 2018, to reflect an updated Change Request (CR) that made revisions to the Summary of Changes and Summary of Modifications documents. In the article “Service Not Paid by Medicare (edit 13)” was added in the table on page 3. All other information remains the same.

PROVIDER TYPE AFFECTED
This MLN Matters Article is intended for 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 10699 provides the I/OCE instructions and specifications for the I/OCE that will be utilized under the Outpatient Prospective Payment System (OPPS) and non-OPPS for hospital outpatient departments, community mental health centers, all non-OPPS providers, and for limited services when provided in a home health agency not under the Home Health PPS (HH PPS) or to a hospice payment for the treatment of a non-terminal illness. Please make sure your billing staffs are aware of these updates.

BACKGROUND
CR10699 informs the Part A/B MACs Part A, the A/B MACs Part Home Health and Hospice (HHH) and the Fiscal Intermediary Shared System (FISS) that the I/OCE is being updated for July 1, 2018. The I/OCE routes all institutional outpatient claims (which includes non-OPPS hospital claims) through a single I/OCE.

The I/OCE is used under the OPPS and non-OPPS for hospital outpatient departments, community mental health centers, all non-OPPS providers, and for limited services when provided in a home health agency not under HH PPS or to a hospice patient for the treatment of a non-terminal illness.

The modifications of the I/OCE for the July 2018 V19.2 release are summarized in the table below. Readers should also read through the entire specifications document and note the highlighted sections, which also indicate changes from the prior release of the software. The I/OCE specifications will be posted on the Centers for Medicare & Medicaid Services (CMS) website at http://www.cms.gov/OutpatientCodeEdit/.

Table 1: July 2018 I/OCE Modifications

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Edits Affected</th>
<th>Modification</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/1/2018</td>
<td>18</td>
<td>Implement new program logic retroactively (1/1/18) to allow Anesthesia code 01402 (Status Indicator (SI) = C) reported with procedure code 27447 to package by changing its SI from C to N. If 01402 is reported with any other procedure the SI remains a C and will process as usual.</td>
</tr>
<tr>
<td>1/1/2016</td>
<td>38</td>
<td>Update program logic retroactively (1/1/16) to exclude procedures with SI=J2 from satisfying edit 38.</td>
</tr>
<tr>
<td>4/1/2018</td>
<td>106,107,108</td>
<td>Update logic for Add-on Code Editing to apply the applicable edits on both add-on procedure line items, if reporting multiple add-on codes without one or both primary procedures.</td>
</tr>
<tr>
<td>7/1/2018</td>
<td>6,20,22,40,106,107,108</td>
<td>Update the program logic to include edits (6, 20, 22, 40, 106, 107, and 108) to applicable bill types retroactively to the edits activation date. This includes the documentation update to the edits applied by bill type tables, see table for updates.</td>
</tr>
<tr>
<td>Date</td>
<td>Action</td>
<td></td>
</tr>
<tr>
<td>------------</td>
<td>------------------------------</td>
<td></td>
</tr>
<tr>
<td>7/1/2018</td>
<td>Implement logic to include a condition in which lines submitted on a 32x bill type (HHA) with revenue code 0023 do not have edit 6 or 22 applied.</td>
<td></td>
</tr>
<tr>
<td>7/1/2018</td>
<td>Add the following new modifier to the valid modifier list QO – Qualified cdm consulted</td>
<td></td>
</tr>
<tr>
<td>7/1/2018</td>
<td>Update the Add-on Code Editing section to include additional conditions for editing. This includes an update to the Edit Descriptions and Reason for Edit Generation table.</td>
<td></td>
</tr>
<tr>
<td>7/1/2018</td>
<td>Update the I/OCE Execution and Processing Flowchart to include Rural Health Clinic (RHC) in the Federally Qualified Health Center (FQHC) objects mentioned in processing.</td>
<td></td>
</tr>
<tr>
<td>7/1/2018</td>
<td>Update to Hospice Processing section to note the logic that is discontinued by edit 61 and 72 being removed from bill type 81x and 82x (1/1/14).</td>
<td></td>
</tr>
<tr>
<td>7/1/2018</td>
<td>Update the Pass-through Device Processing section to change language from device-intensive procedure pairing to procedure and pass-through device pairings.</td>
<td></td>
</tr>
<tr>
<td>7/1/2018</td>
<td>Make all HCPCS/APC/SI changes as specified by CMS (quarterly data files).</td>
<td></td>
</tr>
<tr>
<td>7/1/2018</td>
<td>Update the following lists for the release (see quarterly data files): Add on Type I (edit 106) Add on Type II (edit 107) Add on Type III (edit 108) Comprehensive Ambulatory Payment Classification (APC) Ranking Comprehensive APC Exclusions Procedure and Sex Conflict (edit 8) RHC CG Modifier not Payable Skin Substitute Product (edit 86) Non-covered service (edit 9) Service Not Paid by Medicare (edit 13)</td>
<td></td>
</tr>
<tr>
<td>7/1/2018</td>
<td>Implement version 24.2 of the National Correct Coding Initiative (NCCI) (as modified for applicable outpatient institutional providers).</td>
<td></td>
</tr>
</tbody>
</table>

**ADDITIONAL INFORMATION**


**DOCUMENT HISTORY**

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 18, 2018</td>
<td>This article was revised to reflect an updated CR that made revisions to the Summary of Changes and Summary of Modifications documents. In the article “Service Not Paid by Medicare (edit 13)” was added in the table on page 3.</td>
</tr>
<tr>
<td>June 1, 2018</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>
Hospital OPSS – July 2018 Update – Revised

MLN Matters Number: MM10781 Revised
Related Change Request (CR) #: 10781
Related CR Release Date: June 15, 2018
Effective Date: July 1, 2018
Related CR Transmittal Number: R4075CP
Implementation Date: July 2, 2018

This article was revised on June 19, 2018, to reflect an updated Change Request (CR). That update added new Retacrit codes Q5105 and Q5106 and new PLA codes 0045U - 0061U. Code Q9994 was also added for In-Line Cartridge Containing Digestive Enzyme(s). These codes are effective July 1, 2018. CMS is also changing status indicators for two drug codes, The status indicator for J9216 and Q2049 were also changed from SI “K” to SI “E2” effective July 1, 2018. The CR release date, transmittal number and link to the transmittal also changed. All other information remains the same.

PROVIDERS TYPE AFFECTED

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

PROVIDER ACTION NEEDED

CR10781 describes changes to and billing instructions for various payment policies implemented in the July 2018 OPSS update. Make sure your billing staffs are aware of these changes.

BACKGROUND

This recurring update notification describes changes to billing instructions for various payment policies implemented in the July 2018 OPSS update. The July 2018 I/OCE will reflect the HCPCS, APC, HCPCS modifier, and revenue code additions, changes, and deletions identified in this CR.

Key Changes in CR 10781

Key changes and billing instructions for various payment policies implemented in July 2018 OPSS updates are as follows:

Multianalyte Assays with Algorithmic Analyses (MAAA) CPT Coding Changes Effective April 1, 2018

The American Medical Association (AMA) Current Procedural Terminology (CPT) Editorial Panel established two new MAAA codes, specifically, 0012M and 0013M, effective April 1, 2018. Because the codes were released on March 1, 2018, it was too late to include them in the April 2018 OPSS update. Instead, the codes are being included in the July 2018 update with an effective date of April 1, 2018. Because the codes were released on March 1, 2018, it was too late to include them in the April 2018 OPSS update. Instead, the codes are being included in the July 2018 update with an effective date of April 1, 2018. Because the codes were released on March 1, 2018, it was too late to include them in the April 2018 OPSS update. Instead, the codes are being included in the July 2018 update with an effective date of April 1, 2018. Table 1 lists the long descriptor and status indicator (SI) for CPT codes 0012M and 0013M.

Table 1 - Multianalyte Assays with Algorithmic Analyses (MAAA) CPT Coding Changes Effective April 1, 2018

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Long Descriptor</th>
<th>OPPS Status Indicator(SI)</th>
<th>OPPS Ambulatory Payment Classification (APC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0012M</td>
<td>Oncology (urothelial), mRNA, gene expression profiling by real-time quantitative</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>PCR of five genes (MDK, HOXA13, CDC2 [CDK1], IGFBP5, and XCR2), utilizing urine,</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Proprietary Laboratory Analyses (PLA) CPT Coding Changes Effective April 1, 2018

The AMA CPT Editorial Panel established 10 new PLA CPT codes, specifically, CPT codes 0035U through 0044U effective April 1, 2018. Because the codes were released on February 22, 2018, it was too late to include them in the January 2018 OPPS update. Instead, they are being included in the July 2018 update with an effective date of April 1, 2018.

Table 2 lists the long descriptors and status indicators for CPT codes 0035U through 0044U. For more information on OPPS status indicators “A” and “Q4”, refer to OPPS Addendum D1 of the Calendar Year (CY) 2018 OPPS/Ambulatory Surgical Center (ASC) final rule. CPT codes 0035U through 0044U have been added to the July 2018 I/OCE, with an effective date of April 1, 2018. These codes, along with their short descriptors and status indicators, are also listed in the July 2018 OPPS Addendum B.

**Table 2 - Proprietary Laboratory Analyses (PLA) CPT Coding Changes Effective April 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>0035U</td>
<td>Neurology (prion disease), cerebrospinal fluid, detection of prion protein by quaking-induced conformational conversion, qualitative</td>
<td>Q4</td>
<td>N/A</td>
</tr>
<tr>
<td>0036U</td>
<td>Exome (i.e., somatic mutations), paired formalin-fixed paraffin-embedded tumor tissue and normal specimen, sequence analyses</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>0037U</td>
<td>Targeted genomic sequence analysis, solid organ neoplasm, DNA analysis of 324 genes, interrogation for sequence variants, gene copy number amplifications, gene rearrangements, microsatellite instability and tumor mutational burden</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>0038U</td>
<td>Vitamin D, 25 hydroxy D2 and D3, by LC-MS/MS, serum microsample, quantitative</td>
<td>Q4</td>
<td>N/A</td>
</tr>
<tr>
<td>0039U</td>
<td>Deoxyribonucleic acid (DNA) antibody, double stranded, high avidity</td>
<td>Q4</td>
<td>N/A</td>
</tr>
<tr>
<td>0040U</td>
<td>BCR/ABL1 (t (9;22)) (e.g., chronic myelogenous leukemia) translocation analysis, major breakpoint, quantitative</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>0041U</td>
<td>Borrelia burgdorferi, antibody detection of 5 recombinant protein groups, by immunoblot, IgM</td>
<td>Q4</td>
<td>N/A</td>
</tr>
<tr>
<td>0042U</td>
<td>Borrelia burgdorferi, antibody detection of 12 recombinant protein groups, by immunoblot, IgG</td>
<td>Q4</td>
<td>N/A</td>
</tr>
<tr>
<td>0043U</td>
<td>Tick-borne relapsing fever Borrelia group, antibody detection to 4 recombinant protein groups, by immunoblot, IgM</td>
<td>Q4</td>
<td>N/A</td>
</tr>
<tr>
<td>0044U</td>
<td>Tick-borne relapsing fever Borrelia group, antibody detection to 4 recombinant protein groups, by immunoblot, IgG</td>
<td>Q4</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Proprietary Laboratory Analysis (PLA) CPT Coding Changes Effective July 1, 2018

Effective July 1, 2018, the AMA CPT Editorial Panel established 17 new PLA codes, specifically, CPT codes 0045U through 0061U. Table 3 lists the long descriptors and status indicators for these codes. For more information on OPPS status indicators “A” and “Q4”, refer to OPPS Addendum D1 of the Calendar Year (CY) 2018 OPPS/Ambulatory Surgical Center (ASC) final rule. These codes, along with their short descriptors and status indicators, are also listed in the July 2018 OPPS Addendum B.

**Table 3 - PLA CPT Coding Changes Effective July 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>0045U</td>
<td>Oncology (urothelial), mRNA, gene expression profiling by real-time quantitative PCR of five genes (MDK, HOXA13, CDC2 [DK1], IGFBP5, and CXCR2), utilizing urine, algorithm reported as a risk score for having recurrent urothelial carcinoma</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>0046U</td>
<td>Oncology (urothelial), mRNA, gene expression profiling by real-time quantitative PCR of five genes (MDK, HOXA13, CDC2 [DK1], IGFBP5, and CXCR2), utilizing urine, algorithm reported as a risk score for having recurrent urothelial carcinoma</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>0047U</td>
<td>Oncology (urothelial), mRNA, gene expression profiling by real-time quantitative PCR of five genes (MDK, HOXA13, CDC2 [DK1], IGFBP5, and CXCR2), utilizing urine, algorithm reported as a risk score for having recurrent urothelial carcinoma</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>0048U</td>
<td>Oncology (urothelial), mRNA, gene expression profiling by real-time quantitative PCR of five genes (MDK, HOXA13, CDC2 [DK1], IGFBP5, and CXCR2), utilizing urine, algorithm reported as a risk score for having recurrent urothelial carcinoma</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>0049U</td>
<td>Oncology (urothelial), mRNA, gene expression profiling by real-time quantitative PCR of five genes (MDK, HOXA13, CDC2 [DK1], IGFBP5, and CXCR2), utilizing urine, algorithm reported as a risk score for having recurrent urothelial carcinoma</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>0050U</td>
<td>Oncology (urothelial), mRNA, gene expression profiling by real-time quantitative PCR of five genes (MDK, HOXA13, CDC2 [DK1], IGFBP5, and CXCR2), utilizing urine, algorithm reported as a risk score for having recurrent urothelial carcinoma</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>0051U</td>
<td>Oncology (urothelial), mRNA, gene expression profiling by real-time quantitative PCR of five genes (MDK, HOXA13, CDC2 [DK1], IGFBP5, and CXCR2), utilizing urine, algorithm reported as a risk score for having recurrent urothelial carcinoma</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>0052U</td>
<td>Oncology (urothelial), mRNA, gene expression profiling by real-time quantitative PCR of five genes (MDK, HOXA13, CDC2 [DK1], IGFBP5, and CXCR2), utilizing urine, algorithm reported as a risk score for having recurrent urothelial carcinoma</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>0053U</td>
<td>Oncology (urothelial), mRNA, gene expression profiling by real-time quantitative PCR of five genes (MDK, HOXA13, CDC2 [DK1], IGFBP5, and CXCR2), utilizing urine, algorithm reported as a risk score for having recurrent urothelial carcinoma</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>0054U</td>
<td>Oncology (urothelial), mRNA, gene expression profiling by real-time quantitative PCR of five genes (MDK, HOXA13, CDC2 [DK1], IGFBP5, and CXCR2), utilizing urine, algorithm reported as a risk score for having recurrent urothelial carcinoma</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>0055U</td>
<td>Oncology (urothelial), mRNA, gene expression profiling by real-time quantitative PCR of five genes (MDK, HOXA13, CDC2 [DK1], IGFBP5, and CXCR2), utilizing urine, algorithm reported as a risk score for having recurrent urothelial carcinoma</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>0056U</td>
<td>Oncology (urothelial), mRNA, gene expression profiling by real-time quantitative PCR of five genes (MDK, HOXA13, CDC2 [DK1], IGFBP5, and CXCR2), utilizing urine, algorithm reported as a risk score for having recurrent urothelial carcinoma</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>0057U</td>
<td>Oncology (urothelial), mRNA, gene expression profiling by real-time quantitative PCR of five genes (MDK, HOXA13, CDC2 [DK1], IGFBP5, and CXCR2), utilizing urine, algorithm reported as a risk score for having recurrent urothelial carcinoma</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>0058U</td>
<td>Oncology (urothelial), mRNA, gene expression profiling by real-time quantitative PCR of five genes (MDK, HOXA13, CDC2 [DK1], IGFBP5, and CXCR2), utilizing urine, algorithm reported as a risk score for having recurrent urothelial carcinoma</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>0059U</td>
<td>Oncology (urothelial), mRNA, gene expression profiling by real-time quantitative PCR of five genes (MDK, HOXA13, CDC2 [DK1], IGFBP5, and CXCR2), utilizing urine, algorithm reported as a risk score for having recurrent urothelial carcinoma</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>0060U</td>
<td>Oncology (urothelial), mRNA, gene expression profiling by real-time quantitative PCR of five genes (MDK, HOXA13, CDC2 [DK1], IGFBP5, and CXCR2), utilizing urine, algorithm reported as a risk score for having recurrent urothelial carcinoma</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>0061U</td>
<td>Oncology (urothelial), mRNA, gene expression profiling by real-time quantitative PCR of five genes (MDK, HOXA13, CDC2 [DK1], IGFBP5, and CXCR2), utilizing urine, algorithm reported as a risk score for having recurrent urothelial carcinoma</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>CPT Code</td>
<td>Long Descriptor</td>
<td>OPPS SI</td>
<td>OPPS APC</td>
</tr>
<tr>
<td>---------</td>
<td>----------------</td>
<td>---------</td>
<td>----------</td>
</tr>
<tr>
<td>0045U</td>
<td>Oncology (breast ductal carcinoma in situ), mRNA, gene expression profiling by real-time RT-PCR of 12 genes (7 content and 5 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as recurrence score</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>0046U</td>
<td>FLT3 (fms-related tyrosine kinase 3) (eg, acute myeloid leukemia) internal tandem duplication (ITD) variants, quantitative</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>0047U</td>
<td>Oncology (prostate), mRNA, gene expression profiling by real-time RT-PCR of 17 genes (12 content and 5 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a risk score</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>0048U</td>
<td>Oncology (solid organ neoplasia), DNA, targeted sequencing of protein-coding exons of 468 cancer-associated genes, including interrogation for somatic mutations and microsatellite instability, matched with normal specimens, utilizing formalin-fixed paraffin-embedded tumor tissue, report of clinically significant mutation(s)</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>0049U</td>
<td>NPM1 (nucleophosmin) (eg, acute myeloid leukemia) gene analysis, quantitative</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>0050U</td>
<td>Targeted genomic sequence analysis panel, acute myelogenous leukemia, DNA analysis, 194 genes, interrogation for sequence variants, copy number variants or rearrangements</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>0051U</td>
<td>Prescription drug monitoring, evaluation of drugs present by LC-MS/MS, urine, 31 drug panel, reported as quantitative results, detected or not detected, per date of service</td>
<td>Q4</td>
<td>N/A</td>
</tr>
<tr>
<td>0052U</td>
<td>Lipoprotein, blood, high resolution fractionation and quantitation of lipoproteins, including all five major lipoprotein classes and subclasses of HDL, LDL, and VLDL by vertical auto profile ultracentrifugation</td>
<td>Q4</td>
<td>N/A</td>
</tr>
<tr>
<td>0053U</td>
<td>Oncology (prostate cancer), FISH analysis of 4 genes (ASAP1, HDAC9, CHD1 and PTEN), needle biopsy specimen, algorithm reported as probability of higher tumor grade</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>0054U</td>
<td>Prescription drug monitoring, 14 or more classes of drugs and substances, definitive tandem mass spectrometry with chromatography, capillary blood, quantitative report with therapeutic and toxic ranges, including steady-state range for the prescribed dose when detected, per date of service</td>
<td>Q4</td>
<td>N/A</td>
</tr>
<tr>
<td>0055U</td>
<td>Cardiology (heart transplant), cell-free DNA, PCR assay of 96 DNA target sequences (94 single nucleotide polymorphism targets and two control targets), plasma</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>0056U</td>
<td>Hematology (acute myelogenous leukemia), DNA, whole genome next-generation sequencing to detect gene rearrangement(s), blood or bone marrow, report of specific gene rearrangement(s)</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>0057U</td>
<td>Oncology (solid organ neoplasia), mRNA, gene expression profiling by massively parallel sequencing for analysis of 51 genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a normalized percentile rank</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>0058U</td>
<td>Oncology (Merkel cell carcinoma), detection of antibodies to the Merkel cell polyoma virus oncoprotein (small T antigen), serum, quantitative</td>
<td>Q4</td>
<td>N/A</td>
</tr>
<tr>
<td>0059U</td>
<td>Oncology (Merkel cell carcinoma), detection of antibodies to the Merkel cell polyoma virus capsid protein (VP1), serum, reported as positive or negative</td>
<td>Q4</td>
<td>N/A</td>
</tr>
<tr>
<td>0060U</td>
<td>Twin zygosity, genomic targeted sequence analysis of chromosome 2, using circulating cell-free fetal DNA in maternal blood</td>
<td>A</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Transcutaneous measurement of five biomarkers (tissue oxygenation \([\text{StO}_2]\), oxyhemoglobin \([\text{ctHbO}_2]\), deoxyhemoglobin \([\text{ctHbR}]\), papillary and reticular dermal hemoglobin concentrations \([\text{ctHb1} \text{ and ctHb2}]\)), using spatial frequency domain imaging (SFDI) and multi-spectral analysis

Category III CPT Codes Effective July 1, 2018

The AMA releases Category III CPT codes twice per year: in January, for implementation beginning the following July, and in July, for implementation beginning the following January.

For the July 2018 update, CMS is implementing four Category III CPT codes that the AMA released in January 2018 for implementation on July 1, 2018. The status indicators and APC assignments for these codes are shown in Table 4. Payment rates for these services can be found in Addendum B of the July 2018 OPPS Update.

Table 4 - Category III CPT Codes Effective July 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>0505T</td>
<td>Endovenous femoral-popliteal arterial revascularization, with transcatheter placement of intravascular stent graft(s) and closure by any method, including percutaneous or open vascular access, ultrasound guidance for vascular access when performed, all catheterization(s) and intraprocedural road mapping and imaging guidance necessary to complete the intervention, all associated radiological supervision and interpretation, when performed, with crossing of the occlusive lesion in an extraluminal fashion</td>
<td>J1</td>
<td>5193</td>
</tr>
<tr>
<td>0506T</td>
<td>Macular pigment optical density measurement by heterochromatic flicker photometry, unilateral or bilateral, with interpretation and report</td>
<td>Q1</td>
<td>5733</td>
</tr>
<tr>
<td>0507T</td>
<td>Near-infrared dual imaging (i.e., simultaneous reflective and trans-illuminated light) of meibomian glands, unilateral or bilateral, with interpretation and report</td>
<td>Q1</td>
<td>5733</td>
</tr>
<tr>
<td>0508T</td>
<td>Pulse-echo ultrasound bone density measurement resulting in indicator of axial bone mineral density, tibia</td>
<td>S</td>
<td>5522</td>
</tr>
</tbody>
</table>

Bilateral Indicator for HCPCS Code C9749

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

Packaging of CPT code 01402 when reported with Total Knee Arthroplasty (CPT code 27447)

CPT code 01402 describes anesthesia for open or surgical arthroscopic procedures on knee joint; total knee arthroplasty. For CY 2018, the status indicator assigned to this code is “C”, which indicates that this is an inpatient procedure that is not paid for under the OPPS.

For the July 2018 update, when CPT code 01402 is reported with CPT code 27447, Arthroplasty, knee, condyle and plateau; medical and lateral compartments with or without patella resurfacing (total knee arthroplasty), this code is paid under the OPPS and payment for this service is packaged into the payment for CPT code 27447. If the code is not reported with CPT code 27447, the code is treated as an inpatient procedure that is not paid for under the OPPS. This change is retroactive to January 1, 2018.

Drugs, Biologicals, and Radiopharmaceuticals
A. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective July 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 July 1, 2018, and drug price restatements can be found in the July 2018 update of the OPPS Addendum A and Addendum B.

B. Drugs and Biologicals with OPPS Pass-Through Status Effective July 1, 2018

Six drugs and biologicals have been granted OPPS pass-through status, effective July 1, 2018. These items, along with their descriptors and APC assignments, are identified in Table 5.

Table 5 - Drugs and Biologicals with OPPS Pass-Through Status Effective July 1, 2018

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
<th>OPPS Status Indicator</th>
<th>OPPS APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9030</td>
<td>Injection, copanlisib, 1 mg</td>
<td>G</td>
<td>9030</td>
</tr>
<tr>
<td>C9031</td>
<td>Lutetium Lu 177, dotatate, therapeutic, 1 mCi</td>
<td>G</td>
<td>9067</td>
</tr>
<tr>
<td>C9032</td>
<td>Injection, voretigene neparvovec-rzyl, 1 billion vector genome</td>
<td>G</td>
<td>9070</td>
</tr>
<tr>
<td>Q9991</td>
<td>Injection, buprenorphine extended-release (Sublocade), less than or equal to 100 mg</td>
<td>G</td>
<td>9073</td>
</tr>
<tr>
<td>Q9992</td>
<td>Injection, buprenorphine extended-release (Sublocade), greater than 100 mg</td>
<td>G</td>
<td>9239</td>
</tr>
<tr>
<td>Q9995</td>
<td>Injection, emicizumab-kxwh, 0.5 mg</td>
<td>G</td>
<td>9257</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 CMS website on the first date of the quarter at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/OPPS-Restated-Payment-Rates.html.

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

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

Effective July 1, 2018, HCPCS code Q9993 (Injection, triamcinolone acetonide, preservative-free, extended-release, microsphere formulation, 1 mg) will replace HCPCS code C9469 (Injection, triamcinolone acetonide, preservative-free, extended-release, microsphere formulation, 1 mg). The status indicator will remain G, “Pass-Through Drugs and Biologicals”. Table 6 describes the HCPCS code change and effective date.

Table 6 - Other Changes to CY 2018 HCPCS Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
<th>OPPS SI</th>
<th>OPPS APC</th>
<th>Effective Date</th>
<th>Termination Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9469</td>
<td>Injection, triamcinolone acetonide, preservative-free, extended-release, microsphere formulation, 1 mg</td>
<td>G</td>
<td>9469</td>
<td>04/01/2018</td>
<td>06/30/2018</td>
</tr>
</tbody>
</table>
Note: HCPCS code Q9994 (In-line cartridge containing digestive enzyme(s) for enteral feeding, each) will also be added and is listed in the upcoming July 2018 I/OCE CR, effective July 1, 2018.

E. Change to Status Indicator for CPT Code 90739

Hepatitis B vaccine associated with CPT code 90739 (Hepatitis b vaccine (hepb), adult dosage, 2 dose schedule, for intramuscular use) was approved by the Food and Drug Administration (FDA) on November 09, 2017. Therefore, CMS is changing the status indicator for 90739 from SI=E1 (Not paid by Medicare when submitted on outpatient claims (any outpatient bill type) to SI=F (Not paid under OPPS. Paid at reasonable cost.), effective April 1, 2018, in the July 2018 I/OCE update. Table 7 describes the status indicator change and effective date.

Table 7 - Change to Status Indicator for CPT Code 90739

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Long Descriptor</th>
<th>OPPS SI</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>90739</td>
<td>Hepatitis b vaccine (hepb), adult dosage, 2 dose schedule, for intramuscular use</td>
<td>E1</td>
<td>January 1, 2013 – March 31, 2018</td>
</tr>
<tr>
<td>90739</td>
<td>Hepatitis b vaccine (hepb), adult dosage, 2 dose schedule, for intramuscular use</td>
<td>F</td>
<td>April 1, 2018</td>
</tr>
</tbody>
</table>

F. Drugs and Biologicals with a change in Status Indicator

Two drugs, specifically, HCPCS codes J9216 and Q2049, listed in Table 8 have a change in status indicator from “K” to “E2” effective July 1, 2018, to indicate that CMS has no pricing information for both drug codes.

Table 8 - Drugs and Biologicals with a Change in Status Indicator

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
<th>Old SI</th>
<th>New SI</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>J9216</td>
<td>Injection, interferon, gamma 1-b, 3 million units</td>
<td>K</td>
<td>E2</td>
<td>07/01/2018</td>
</tr>
<tr>
<td>Q2049</td>
<td>Injection, doxorubicin hydrochloride, liposomal, imported lipodox, 10 mg</td>
<td>K</td>
<td>E2</td>
<td>07/01/2018</td>
</tr>
</tbody>
</table>

G. New Biosimilar Biological Products Effective July 1, 2018

Two new HCPCS codes will be created for reporting Retacrit, (epoetin alfa-epbx) as a biosimilar to Epogen/Procrit (epoetin alfa) for the treatment of anemia caused by chronic kidney disease, chemotherapy, or use of zidovudine in patients with HIV infection. Retacrit is also approved for use before and after surgery to reduce the chance that red blood cell transfusions will be needed because of blood loss during surgery. Both codes are assigned to status indicator “K”. These codes are listed in Table 9 and are effective for services furnished on or after July 1, 2018. Payment for each of these codes may be found in the July 2018 update of the OPPS Addendum B at http://www.cms.gov/HospitalOutpatientPPS/.

Table 9 - New HCPCS Drug Codes for Retacrit Effective July 1, 2018

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>OPPS SI</th>
<th>OPPS APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5105</td>
<td>Inj Retacrit esrd on dialysi</td>
<td>Injection, epoetin alfa, biosimilar, (Retacrit) (for esrd on dialysis), 100 units</td>
<td>K</td>
<td>9096</td>
</tr>
<tr>
<td>Q5106</td>
<td>Inj Retacrit non-esrd use</td>
<td>Injection, epoetin alfa, biosimilar, (Retacrit) (for non-esrd use), 1000 units</td>
<td>K</td>
<td>9097</td>
</tr>
</tbody>
</table>

Reassignment of Skin Substitute Product from the Low Cost Group to the High Cost Group

One skin substitute product, HCPCS code Q4178, 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 Table 10.

Table 10 - Reassignment of Skin Substitute Product from the Low Cost Group to the High Cost Group Effective July 1, 2018

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>OPPS SI</th>
<th>Low/High Cost Skin Substitute</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q4178</td>
<td>Floweramniopatch, per sq cm</td>
<td>N</td>
<td>High</td>
</tr>
</tbody>
</table>

Allow HCPCS Code Q4116 (Alloderm, per square centimeter) to Be Billed with Either Revenue Code 0278 (Other implants) or Revenue Code 0636 (Drugs requiring detailed coding)

HCPCS code Q4116 (Alloderm, per square centimeter) may be billed with either revenue code 0278 (Other implants) or revenue code 0636 (Drugs requiring detailed coding). HCPCS code Q4116 is used both as an applied skin substitute and as an implanted biologic used in breast reconstruction, and these procedures are reported with two different revenue codes. This request is described in Table 11.

Table 11 - Allow HCPCS Code Q4116 (Alloderm, per square centimeter) to Be Billed with Either Revenue Code 0278 (Other implants) or Revenue Code 0636 (Drugs requiring detailed coding)

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>OPPS SI</th>
<th>Allowed Revenue Codes for Billing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q4116</td>
<td>Alloderm, per square centimeter</td>
<td>N</td>
<td>0278, 0636</td>
</tr>
</tbody>
</table>

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. Medicare Administrative Contractors (MACs) determine whether a drug, device, procedure, or other service meets all program requirements for coverage. For example, MACs determine that it is reasonable and necessary to treat the beneficiary’s condition and whether it is excluded from payment.

ADDITIONAL INFORMATION


DOCUMENT HISTORY

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 19, 2018</td>
<td>This article was revised to reflect an updated Change Request (CR). That update added new Retacrit codes Q5105 and Q5106 and new PLAcodes 0045U - 0061U. Code Q9994 was also added for In-Line Cartridge Containing Digestive Enzyme(s). These codes are effective July 1, 2018. CMS is also changing status indicators for two drug codes, The status indicator for J9216 and Q2049 were also changed from SI “K” to SI “E2” effective July 1, 2018. The CR release date, transmittal number and link to the transmittal also changed.</td>
</tr>
<tr>
<td>June 5, 2018</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>
PREVENTIVE SERVICES

Men’s Health Month

The month of June has been recognized as Men’s Health Month. Men’s Health Month is recognized around the country with screenings, health fairs, and other health education and outreach activities. During the month of June, we need to heighten awareness for preventable health problems and encourage early detection and treatment of disease among men.

During the month of June, we recommend that physicians encourage men to seek screening services for early treatment for Men’s Health disease prevention and early treatment. There are many screening services that Medicare allows for conditions that men may be eligible to pursue. Colorectal Cancer Screening and Prostate Cancer Screening are two that are front and center for each man. Please check out the Medicare Preventive Services Chart. This chart will help providers understand the preventive services available for Medicare coverage, along with the billing and coverage requirements for each service.

Preventive Testing for Human Immunodeficiency Virus (HIV)

The Centers for Disease Control and Prevention (CDC) recognize June 27 as National HIV Screening Day (NHTD). Medicare allows HIV Screening services for beneficiaries. This benefit and testing are significant as statistics from the CDC indicate there are approximately 1.1 million people living with HIV and 15% of them do not know they have the disease. Most new HIV infections (92%) are transmitted by persons not aware they are infected or not receiving treatment.

Medicare policy indicates that coverage is offered to certain Medicare beneficiaries without regard to perceived risk or those at increased risk, and pregnant women. National Coverage Determination (NCD) for Screening for the Human Immunodeficiency Virus (HIV) Infection (210.7) explains the coverage criteria for this critical test available to beneficiaries. You may also refer to the Medicare Preventive Services Quick Reference Chart for the appropriate diagnosis coding for this service along with the frequency parameters. Where Medicare covers this screening, the copayment and deductible are waived.

This document was developed through the A/B Medicare Administrative Contractor (MAC) Provider Outreach & Education (POE) Collaboration Team. This joint effort ensures consistent communication and education throughout the nation on a variety of topics and will assist the provider and physician community with information necessary to submit claims appropriately and receive proper payment in a timely manner.
Identification Code Qualifier Being Used in NM108 Data Element at the 2100 Loop, NM1- Patient Name Segment in the 835 Guide – Processing Instructions Update

MLN Matters Number: MM10565
Related Change Request (CR) Number: 10565
Related CR Release Date: April 27, 2018
Effective Date: October 1, 2018 – Not based on Date of Service
Related CR Transmittal Number: R2063OTN
Implementation Date: October 1, 2018

PROVIDER TYPE AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 10565 provides instructions to the MACs to update the Identification Code Qualifier in Data Element NM108 currently being used in the 2100 Loop, NM1- Patient Name Segment of the 835 guide. This will synchronize the usage of the same qualifier as used/submitted on the claim. Make sure your billing staffs are aware of these instructions.

BACKGROUND

With the removal of the Social Security Number (SSN)-based Health Insurance Claim Number (HICN) from Medicare cards and in an effort to synchronize the usage of the same Identification Code Qualifier in the Health Care Claim Payment/Advice (835) and the Professional and Institutional (837) Health Care Claim as required by the 835 guide, CR10565 modifies the Identification Code Qualifier being used in the 835 Electronic Remit from HN to MI.

ADDITIONAL INFORMATION


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Implement Operating Rules - Phase III Electronic Remittance Advice (ERA) Electronic Funds Transfer (EFT): CORE 360 Uniform Use of CARC, RARC and CAGC Rule – Update from CAQH CORE

MLN Matters Number: MM10566
Related Change Request (CR) Number: 10566
Related CR Release Date: May 18, 2018
Effective Date: October 1, 2018
Related CR Transmittal Number: R4054CP
Implementation Date: October 1, 2018

PROVIDER TYPES AFFECTED

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

Change Request (CR) 10566 informs MACs to update their systems based on the CORE 360 Uniform use of Claims Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC) and Claim Adjustment Group Code (CAGC) rule publication. These system updates are based on the Committee on Operating Rules for Information Exchange (CORE) Code Combination List to be published on or about June 4, 2018. CR10566 applies to the Medicare Claims Processing Manual, Chapter 22, Section 80.2. Make sure that your billing staffs are aware of these changes.

BACKGROUND

The Department of Health and Human Services (DHHS) adopted the Phase III Council for Affordable Quality Healthcare (CAQH) CORE, Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) Operating Rule Set that was implemented on January 1, 2014, under the Affordable Care Act. The Health Insurance Portability and Accountability Act (HIPAA) amended the Act by adding Part C—Administrative Simplification—to Title XI of the Social Security Act, requiring the Secretary of DHHS (the Secretary) to adopt standards for certain transactions to enable health information to be exchanged more efficiently and to achieve greater uniformity in the transmission of health information. Through the Affordable Care Act, Congress sought to promote implementation of electronic transactions and achieve cost reduction and efficiency improvements by creating more uniformity in the implementation of standard transactions. This was done by mandating the adoption of a set of operating rules for each of the HIPAA transactions.

CR10566 deals with the regular update in CAQH CORE defined code combinations per Operating Rule 360 - Uniform Use of CARC and RARC (835) Rule.

CAQH CORE will publish the next version of the Code Combination List on or about June 4, 2018. This update is based on the CARC and RARC updates as posted at the Washington Publishing Company (WPC) website on or about March 1, 2018. This will also include updates based on market based review that CAQH CORE conducts once a year to accommodate code combinations that are currently being used by health plans including Medicare, as the industry needs them.


NOTE: As the Affordable Care Act requires, all health plans including Medicare must comply with CORE 360 Uniform Use of CARCs and RARCs (835) rule or CORE developed maximum set of CARC/RARC and CAGC combinations for a minimum set of four (4) business scenarios. Medicare can use any code combination if the business scenario is not one of the four (4) CORE defined business scenarios. With the four (4) CORE defined business scenarios, Medicare must use the code combinations from the lists published by CAQH CORE.

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Medicare Cost Report E-Filing

MLN Matters Number: MM10611
Related Change Request (CR) Number: 10611
Related CR Release Date: April 30, 2018
Effective Date: June 12, 2018
Related CR Transmittal Number: R20750TN
Implementation Date: June 12, 2018

PROVIDER TYPES AFFECTED

This MLN Matters Article is intended for cost report staff submitting annual Medicare Cost Reports (MCRs) to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

Change Request (CR) 10611 informs MACs and providers of the new MCR e-filing (MCReF) system available for electronic transmission of cost reports. Medicare Part A providers file an annual MCR with the Centers for Medicare & Medicaid Services (CMS). The reports are filed with a MAC assigned to each provider. The MCR is used to determine the providers’ Medicare reimbursable costs. MACs may suspend payments to providers that fail to file their MCR on the due date. Make sure your cost report staffs are aware of the new MCReF System.

BACKGROUND

In accordance with Chapter 1, Section 104 of the Provider Reimbursement Manual, Part II (PRM-II), providers that continue to participate in the Medicare Program are required to submit a cost report within 5 months of their cost reporting fiscal year end. For cost reports ending on a day other than the last day of the month, cost reports are due 150 days after the last day of the cost reporting period. Exceptions to this due date for “no Medicare utilization” cost reports are addressed in PRM-II, Section 110.A. MACs are required to suspend payments to providers that fail to file their MCR by the due date.

Current Medicare Cost Report (MCR) Filing and Receipt Process:

Generally, each provider must perform the following steps to properly submit an MCR to their MAC:

- Generate an MCR consisting of a machine-readable file (ECR) and a human-readable file (PDF or equivalent, also referred to as the Print Image), using CMS-approved MCR vendor software.
- Submit the Worksheet S (Certification Page) signed by an officer or administrator of the provider. A “wet” signature is required for cost reports ending before December 31, 2017; an electronic signature is allowed for cost reports ending on or after December 31, 2017.
- Provide supporting cost report documentation including, but not limited to, the working trial balance, financial statements, Medicare Bad Debt Listing, Interns and Residents Information System data, and so on.
- Submit the MCR package to their MAC via mail (or hand delivery), which account for 91 percent of all MCR submissions, or a hybrid of mail and electronic submissions which account for 9 percent of total submissions. The signed worksheet S must be mailed to the MAC.

Streamlined the MCR Filing Process:

To streamline the MCR filing process, the 2018 Inpatient Prospective Payment System (IPPS) Final Rule allows for an electronic signature on the MCR Worksheet S (Certification Page) for cost reports ending on or after December 31, 2017. Additionally, beginning May 1, 2018, CMS will make the MCReF system available to Part A providers for electronic transmission (e-Filing) of an MCR package directly to a MAC. A CMS Enterprise Identity Management (EIDM) account is required to use MCReF, which is the same account providers use to order copies of their Provider Statistical and Reimbursement Reports (PS&R).

Upon login, providers will be able to select the Fiscal Year End for which they are filing, upload all corresponding MCR materials as attachments, and submit the documents directly to their MAC. The system will perform a basic review of the attached materials to determine if the MCR is “receivable” (See Attachment A of CR10611. The Web address of CR10611 is in the Additional Information section

REIMBURSEMENT

Medicare Cost Report E-Filing
of this article.). If issues are identified, the provider will immediately receive an error/warning message. If no issues are identified, the provider will receive a confirmation number, as well as an electronic postmark date, which can be used in correspondence regarding the submission. Once the cost report is deemed “receivable,” the MAC will perform the acceptability review within 30 days. The MAC will issue a rejection letter if the cost report is rejected.

Medicare Cost Report e-Filing (MCReF) System Access:

MCReF will be hosted at the following URL: https://mcref.cms.gov. System access to MCReF will be controlled by the EIDM system, as previously noted. Part A Provider Security Officials (SOs) and their backups (BSOs), already registered in EIDM for access to CMS PS&R, will inherit access to MCReF by default through their existing account.

Providers that are not registered in EIDM, but wish to gain access to MCReF, must register in EIDM and assign an SO for their organization. New user registration is available at https://portal.cms.gov/wps/portal/unauthportal/eidm/newuserregistration.

Note: It is important for providers to keep their EIDM credentials in good standing to avoid problems using MCReF to e-file cost reports and obtaining PS&R. This includes password updates per CMS policy and the timely replacement of SOs due to staffing changes. Issues with maintaining EIDM credentials will not constitute a valid reason for filing a cost report past its due date.

Starting July 2, 2018, providers that wish to e-file their MCR must use MCReF. MAC portals will no longer be an acceptable means of submission. Providers that wish to mail or hand deliver MCRs to MACs, may continue to do so.

Benefits of Streamlined MCR Processes:

- Increases CMS access to MCR data as submitted by providers to assist with responding to inquiries and remove additional administrative burdens on MACs and CMS.
- Eliminates MAC processes for populating the CMS Healthcare Cost Reporting Information System (HCRIS) – including the submission of 100,000 cost reports to HCRIS and subsequent resubmission.
- Eliminates the need for MACs to enter MCR Postmarked Date, Received Date, and HCRIS Sent Date.
- Enables direct receipt/promotion of IRIS data to its required end-state in STAR (eliminates manually upload IRIS data).
- Large provider chain organizations will electronically submit MCRs to one system instead of transmitting their MCRs to their assigned MAC jurisdiction’s portals or physical mailing addresses.
- An MCR submitted through MCReF will be directed automatically to the correct MAC eliminating the risk of submitting the MCR to an incorrect MAC.
- Providers will receive immediate feedback on whether the MCR is received.
- Providers will save time compiling the paperwork (files) needed to create electronic media and mail the MCR package;
- Providers will have until 11:59 p.m. eastern time on the due date to submit the MCR through MCReF.
- MCReF has a simple, straightforward user interface with just one screen.
- Reduces provider confusion due to conflicting MAC “receivability” rules.

ADDITIONAL INFORMATION

The official instruction, CR10611, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R2075OTN.pdf. A detailed MCReF System Overview is attached to the CR. CMS encourages cost report staff to review this overview.

Publication 100-04, Chapters 1 and 27, to Replace RARC MA61 with N382 Update

MLN Matters Number: MM10619  
Related Change Request (CR) Number: 10619  
Related CR Release Date: May 11, 2018  
Effective Date: August 13, 2018  
Related CR Transmittal Number: R4047CP  
Implementation Date: August 13, 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) 10619 initiates both Medicare manual changes and operational changes related to the New Medicare Card. Medicare will replace the use of Remittance Advice Remark Code (RARC) MA61, referenced in the Medicare Claims Processing Manual, Chapters 1 and 27, with RARC N382 - missing/incomplete/invalid patient identifier (HICN or MBI). Effective for claims processed on or after the effective date of CR10619, MACs will use N382 in place of MA61 to communicate reject/denials for patient identifiers (HICN or MBI) in all remittance advices and 835 transactions. However, MACs will continue to use RARC MA61 only when/if communicating rejections/denials related to a missing/incomplete/invalid social security number. Make sure your billing staffs are aware of these updates.

**BACKGROUND**

With the implementation of the Medicare Beneficiary Identifier (MBI), references to the Health Insurance Claim Number (HICN) will be replaced with a more generic reference (Patient Identifier). CR 16019 initiates the manual changes and operational changes to accomplish this task.

**ADDITIONAL INFORMATION**

RARC, CARC, MREP and PC Print Update

MLN Matters Number: MM10620
Related Change Request (CR) Number: 10620
Related CR Release Date: May 18, 2018
Effective Date: October 1, 2018
Related CR Transmittal Number: R4057CP
Implementation Date: October 1, 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.

PROVIDER ACTION NEEDED
Change Request (CR) 10620 updates the Remittance Advice Remark Code (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 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 occurs three times per year – around March 1, July 1, and November 1. CMS provides CR10620 as a code update notification indicating when updates to CARC and RARC lists are made available on the Washington Publishing Company (WPC) website. Medicare’s 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 WPC website. If any new or modified code has an effective date past the implementation date specified in CR 10620, MACs must implement on the date specified on the WPC website available at http://wpc-edi.com/Reference/.

A discrepancy between the dates may arise because the WPC website is only updated three times per year and may not match the CMS release schedule. For CR 10620, MACs and 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 referenced in CR10489.

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Qualified Medicare Beneficiary Information on RAs and MSNs

Medicare providers may not bill beneficiaries enrolled in the Qualified Medicare Beneficiary (QMB) program for Medicare Parts A and B deductibles, coinsurance, or copays, but state Medicaid programs may pay for those costs. To make it easier to identify the QMB status of your patients, CMS will reintroduce QMB information in provider Remittance Advices (RAs) and Medicare Summary Notices (MSNs) for claims processed on or after July 2, 2018. You can also verify QMB enrollment by using Medicare eligibility information returned by the CMS Health Insurance Portability and Accountability Act (HIPAA) Eligibility Transaction System (HETS) 270/271 application.

For more information:
- Reinstating the QMB Indicator MLN Matters Article
- Prohibition on Billing Dually Eligible Individuals Enrolled in the QMB Program MLN Matters Article
- QMB Program webpage
- Materials from June 6 Medicare Learning Network call, including presentation and FAQs

This is a national CMS article published within the CMS MLN Connects dated June 28, 2018.
Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage

MLN Matters Number: MM10567
Related Change Request (CR) Number: 10567
Related CR Release Date: March 30, 2018
Effective Date: April 30, 2018
Related CR Transmittal Number: R4011CP
Implementation Date: April 30, 2018

PROVIDER TYPE AFFECTED

This MLN Matters Article is intended for Skilled Nursing Facilities (SNFs) billing Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

This article informs you about Change Request (CR) 10567, which advises you that the Centers for Medicare & Medicaid Services (CMS) has revised the Skilled Nursing Facility Notice of Non-coverage (SNF ABN), Form CMS-10055. With this revision, CMS is discontinuing the five Skilled Nursing Facility (SNF) Denial Letters (namely, the Intermediary Determination of Noncoverage, the UR Committee Determination of Admission, the UR Committee Determination on Continued Stay, the SNF Determination on Admission and the SNF Determination on Continued Stay), and the Notice of Exclusion from Medicare Benefits (NEMB-SNF), Form CMS-20014. Please ensure that your billing staffs are aware of these changes.

Please note that the Notice of Medicare Non-Coverage (NOMNC), Form CMS-10123 is not being discontinued with this revised SNF ABN. More information on the NOMNC is available at https://www.cms.gov/Medicare/Medicare-General-Information/BNI/FFS-Expedited-Determination-Notices.html.

BACKGROUND

The authorization for these requirements are Section 1879 of the Social Security Act and 42 Code of Federal Regulations (CFR) 411.404(b) and (c), which specify written notice requirements. These requirements are fulfilled by the SNF ABN.

In order for SNFs to transfer liability to an Original Medicare beneficiary for items or services paid under Medicare Part A (SNF Prospective Payment System (PPS)), the SNF must issue a SNF ABN for:

- An item or service that is usually paid for by Medicare, but may not be paid for in this particular instance because it is not medically reasonable and necessary, or
- Custodial care.

Attached to CR10567 is a revised Chapter 30 of the Medicare Claims Processing Manual. This revised manual chapter provides details on SNF ABN standards and also provides information about:

- Situations in which a SNF ABN should be given
- Situations in which a SNF ABN Is not needed to transfer financial liability to the beneficiary
- SNF ABN specific delivery issues
- Special rules for SNF ABNs
- Establishing when beneficiary is on Notice of Non-coverage

Note: Further details are available at https://www.cms.gov/Medicare/Medicare-General-Information/BNI/FFS-SNFABN-.html. You may download the revised Form CMS-10055 in the Downloads section of that webpage.

SNFs will continue to use the Advance Beneficiary Notice of Non-coverage (ABN, Form CMS-R-131) for items or services that Medicare may be deny under Medicare Part B.

Please note that SNFs may start to implement this new notice any time up to the implementation date of CR10567. Upon the CR10567 implementation on April 30, 2018, the use of the new notice is mandatory.
The revised notice incorporates suggestions for changes made by users of the ABN and by beneficiary advocates based on experience with the current form, refinements made to similar liability notices through consumer testing and other means, as well as related Medicare policy changes and clarifications.

ADDITIONAL INFORMATION


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SNF Value-Based Purchasing Program Updated

MLN Matters Number: SE18003
Article Release Date: March 28, 2018

PROVIDER TYPE AFFECTED

This MLN Matters Article is intended for physicians, clinical staff, and administrators of Skilled Nursing Facilities (SNFs) submitting claims under the SNF Prospective Payment System (PPS) to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries during an SNF stay.

PROVIDER ACTION NEEDED

Special Edition article SE18003 informs providers about the SNF Value-Based Purchasing (VBP) Program. The VBP Program is one of many VBP programs that aim to reward quality and improve health care. Beginning October 1, 2018, SNFs will have an opportunity to receive incentive payments based on their performance in the program.

BACKGROUND

On August 4, 2017, the Centers for Medicare & Medicaid Services (CMS) issued a final rule (CMS-1679-F) outlining Fiscal Year (FY) 2018 Medicare payment rates for SNFs. This final rule finalized SNF VBP Program scoring and operational policies, including an exchange function approach to implement incentive payment adjustments beginning October 1, 2018.

Scoring and Operational Updates

The SNF VBP Program’s scoring and operational policies affecting payment determination in FY 2019 include:

- The adjusted Federal per diem rate applicable to each SNF in an FY will be reduced by 2 percent to fund incentive payments for that FY.
- The total amount of incentive payments distributed to SNFs will be 60 percent of the total amount withheld from SNFs’ Medicare payments for that FY. Facilities with SNF VBP
- performance scores ranked in the lowest 40 percent nationally will receive a payment rate lower than they would otherwise receive without the SNF VBP Program.
- SNF 30-Day All-Cause Readmission Measure (SNFRM) rates from the baseline year (Calendar Year 2015) affecting FY 2019 payment determinations are now publicly available on the Nursing Home Compare and SNF VBP Program websites.

Payment Exchange Function

CMS finalized a logistic exchange function to translate SNF performance scores into value-based incentive payments beginning in the FY 2019 SNF VBP Program. The logistic function maximizes the number of SNF with positive payment adjustment at a 60-percent payback percentage, while balancing Medicare’s long-term sustainability. For more information about the logistic exchange function, refer to the FY 2018 SNF PPS Final Rule at https://www.gpo.gov/fdsys/pkg/FR-2017-08-04/pdf/2017-16256.pdf.
Review and Corrections Process

CMS clarified the Review and Corrections process for SNFs’ performance data that will be made publicly available on Nursing Home Compare. During the annual Review and Corrections 30-day period, the review scope is limited to correction requests regarding SNFs’ performance score and ranking information.

FY 2020 Performance and Baseline Periods

CMS adopted FY 2018 as the performance period and FY 2016 as the baseline period for the FY 2020 SNF VBP Program. The transition from measuring SNFs’ performance during a CY period to a Federal FY period allows for a 12-month performance period and baseline period for both program years.

Table 1 provides details on the performance periods and baseline periods for the FY 2019 and FY 2020 program years.

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Public Reporting

CMS will rank SNFs for the FY 2019 program year and publish the rankings after the Review and Corrections process has completed. The published file will include, but may not be limited to, the following data elements to provide consumers and other stakeholders the necessary information to evaluate SNFs’ performance in the Program:

- Rank
- Provider ID
- Facility name
- Address
- Each SNF’s baseline period (CY 2015) and performance period (CY 2017) Risk Standardized Readmission Rate (RSRR)
- National average baseline period (CY 2015) and performance period (CY 2017) RSRR
- Achievement score
- Improvement score
- Performance score
- The range of performance scores
- The number of SNFs receiving value-based payments
- The range and total amount of value-based payments

ADDITIONAL INFORMATION


If you have additional questions, please email them to: SNFVBPinquiries@cms.hhs.gov.

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