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</thead>
<tbody>
<tr>
<td>877-908-8431</td>
<td>Claim Specific</td>
<td>Monday – Friday 8 a.m. – 6 p.m.</td>
</tr>
</tbody>
</table>

- 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

**Sources:** Transmittal 50, CR 3247 dated July 30, 2004; Internet Only Manual (IOM) *Medicare Financial Management Manual*, Publication 100-06, Chapter 5, Section 410
2018 JF Part A Quarterly Ask-the-Contractor Teleconferences

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

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

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

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

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

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

By completing and submitting the Noridian “Ask the Contractor Teleconference Question Submission Form,” providers may ask question(s), up to five (5) days prior, to be answered during the next ACT. Questions submitted with this form will be answered first. Lines will then be opened for additional questions, as time permits. **Do not include any Personal Health Information (PHI) or claim specific inquiries on this form. If you have claim specific questions, contact the Provider Contact Center.** Providers will need to have Version 7 or higher of Adobe Reader to use this form.

We look forward to your participation in these important calls.

<table>
<thead>
<tr>
<th>Medicare Part A ACTs do not address Medicare Part B or Durable Medical Equipment (DME) inquiries. If you are interested in attending a Part B or a DME ACT, select the appropriate link below for more information.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>JF Part B</strong></td>
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<tr>
<td><strong>JD DME</strong></td>
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<tr>
<td><strong>JA DME</strong></td>
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</table>
Clarification of Policies Related to Reasonable Cost Payment for Nursing and Allied Health Education Programs

SUBJECT: Clarification of Policies Related to Reasonable Cost Payment for Nursing and Allied Health Education Programs

• SUMMARY OF CHANGES: This CR clarifies policies related to payment for approved provider-operated and certain non-provider-operated nursing and allied health education programs.

EFFECTIVE DATE: August 17, 2018

*Unless otherwise specified, the effective date is the date of service.

IMPLEMENTATION DATE: November 19, 2018

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

• CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED-Only One Per Row.

<table>
<thead>
<tr>
<th>R/N/D</th>
<th>CHAPTER / SECTION / SUBSECTION / TITLE</th>
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</thead>
<tbody>
<tr>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

• FUNDING:

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

• ATTACHMENTS:

One Time Notification

Attachment - One-Time Notification

SUBJECT: Clarification of Policies Related to Reasonable Cost Payment for Nursing and Allied Health Education Programs

EFFECTIVE DATE: August 17, 2018

*Unless otherwise specified, the effective date is the date of service.

IMPLEMENTATION DATE: November 19, 2018

GENERAL INFORMATION

• Background: Under section 1861(v) of the Social Security Act, Medicare has historically paid providers for the program’s share of the costs that providers incur in connection with approved educational
activities. Approved nursing and allied health (NAH) education programs are those that are, in part, operated by a provider, and meet State licensure requirements, or is recognized by a national accrediting body. The costs of these programs are excluded from the definition of inpatient hospital operating costs and are not included in the calculation of payment rates for hospitals or hospital units paid under the Inpatient Prospective Payment System (IPPS), Inpatient Rehabilitation Facility (IRF) PPS, or Inpatient Psychiatric Facility (IPF) PPS, and are excluded from the rate-of-increase ceiling for certain facilities not paid on a PPS. These costs are separately identified and “passed through” (that is, paid separately on a reasonable cost basis). Existing regulations on NAH education program costs are located at § 413.85. The most recent rulemaking on these regulations was in the January 12, 2001 final rule (66 FR 3358) and in the August 1, 2003 final rule (68 FR 45423—45434).

Payment for Provider-operated Programs

A program is considered to be provider-operated if the hospital meets the criteria specified in § 413.85(f), which means the hospital directly incurs the training costs, controls the curriculum and the administration of the program, employs the teaching staff, and provides and controls both classroom and clinical training (where applicable) of the NAH education program.

Payment for Certain Non-provider-operated Programs

Section 4004(b)(1) of Pub. L. 101-508 provides an exception to the requirement that programs be provider-operated to receive pass-through payments. This section provides that, if certain conditions are met, the costs incurred by a hospital (or by an educational institution related to the hospital by common ownership or control) for clinical training conducted on the premises of the hospital under an approved NAH education program that is not provider-operated by the hospital are treated as pass-through costs and paid on the basis of reasonable cost. Section 4004(b)(2) of Pub. L. 101-508 sets for the conditions that a hospital must meet to receive payment on a reasonable cost basis under section 4004(b)(1). These provisions are codified in the regulations at § 413.85(g).

Policy: I. Clarification Regarding Provider-Operated Programs

The regulations regarding provider-operated programs at § 413.85 are as follows:

(f) Criteria for identifying programs operated by a provider.

- Except as provided in paragraph (f)(2) of this section, for cost reporting periods beginning on or after October 1, 1983, in order to be considered the operator of an approved nursing or allied health education program, a provider must meet all of the following requirements:

  Directly incur the training costs.

  Have direct control of the program curriculum. (A provider may enter into an agreement with an educational institution to furnish basic academic courses required for completion of the program, but the provider must provide all of the courses relating to the theory and practice of the nursing or allied health profession involved that are required for the degree, diploma, or certificate awarded at the completion of the program.)

  Control the administration of the program, including collection of tuition (where applicable), control the maintenance of payroll records of teaching staff or students, or both (where applicable), and be responsible for day-to-day program operation. (A provider may contract with another entity to perform some administrative functions, but the provider must maintain control over all aspects of the contracted functions.)

  Employ the teaching staff.

  Provide and control both classroom instruction and clinical training (where classroom instruction is a requirement for program completion), subject to the parenthetical sentence in paragraph (f)(1)(ii) of this section.

- Absent evidence to the contrary, the provider that issues the degree, diploma, or other certificate upon successful completion of an approved education program is assumed to meet all of the criteria set forth in paragraph (f)(1) of this section and to be the operator of the program.

We have received questions about §413.85(f)(2), which states, “Absent evidence to the contrary, the provider that issues the degree, diploma, or other certificate upon successful completion of an approved education program is assumed to meet all of the criteria set forth in paragraph (f)(1) of this section and to be
the operator of the program.” We are clarifying our existing policy below; we are not changing policy on this matter.

As the accreditation requirements have evolved and the trend in nursing and allied health education has grown toward degree-issuing programs from colleges or universities, hospitals have tried to restructure their programs and make arrangements with colleges or universities in order to simultaneously provide a degree to their graduates, and meet the provider-operated criteria. However, successfully satisfying the provider-operated criteria in order to qualify for Medicare pass-through payment while simultaneously meeting current accreditation requirements has become extremely difficult, if not impossible, in certain circumstances. It is a reality that many previously provider-operated programs are no longer compliant with all provider-operated criteria at §413.85(f)(1), and should not be receiving Medicare pass-through payments. We stress that in all cases, the burden of proof is on the hospital to demonstrate that its program is meeting the 5 criteria listed at §413.85(f)(1) for provider-operated status. The MAC shall not assume that because the hospital issues the degree, diploma, or certificate of completion, either individually, or jointly with a college/university, that that is sufficient to meet the provider-operated criteria. It is not sufficient. As §413.85(f)(2) states, “Absent evidence to the contrary, the provider that issues the degree, diploma, or other certificate upon successful completion of an approved education program is assumed to meet all of the criteria set forth in paragraph (f)(1) of this section and to be the operator of the program” (emphasis added). This bolded language, “absent evidence to the contrary,” indicates that the hospital must first demonstrate that there is no evidence showing that the program is not provider-operated. The MAC shall review the evidence provided, and be satisfied that all provider-operated criteria at §413.85(f)(1) are met first, and only then shall the MAC approve pass-through payment to the hospital for the program. MACs shall not rely on a degree/diploma/certificate issued by the hospital as evidence that a program is provider-operated.

We have also received questions about the meaning of the parenthetical statement at §413.85(f)(1)(iii), which states “(A provider may enter into an agreement with an educational institution to furnish basic academic courses required for completion of the program, but the provider must provide all of the courses relating to the theory and practice of the nursing or allied health profession involved that are required for the degree, diploma, or certificate awarded at the completion of the program.)” We are clarifying our existing policy below; we are not changing policy on this matter.

Regarding arrangements between hospitals and colleges or universities that could be acceptable, the January 12, 2001 Federal Register (66 FR 3363-4) states:

“…sequential operation of a nursing and allied health education program involves providers that enter into agreements with a college or university in which instruction in general academic requirements leading to a degree is provided by the educational institution, and subsequent specialized didactic and clinical training is given by the provider. The provider may receive pass-through payment for the costs of the program that the provider incurs if the provider meets all of the criteria for operating the program, including the requirement at . . . (§413.85(f)(1)(iii) of this final rule) that the provider must directly control the curriculum. We note that under this section of the regulations, there is a provision (also cited at § 413.85(f)(1)(v) of this final rule) which states that a provider may enter into an agreement with an educational institution to furnish basic academic courses required for completion of the program, but the provider must provide all of the courses related to the theory and practice of the nursing or allied health profession involved that are required for the degree, diploma, or certificate awarded at the completion of the program. No costs incurred by the college or university may be claimed as provider costs (emphasis added).”

That is, the hospital is always responsible for meeting the provider-operated criteria; hospital staff, not staff from an educational institution, must be responsible for controlling, managing, and operating the program financially and administratively on a daily basis, such as, but not limited to, enrollment, collection of tuition, human resources matters, and payroll. While §413.85(f)(1)(iii) states that a provider may contract with another entity to perform some administrative functions of day to day operations, the provider must maintain control over all aspects of the contracted functions. The hospital cannot have an arrangement with an educational institution where there are certain functions for which the hospital has no involvement and no oversight. If educational institution personnel are involved, hospital staff must have final decision making authority. In addition, the hospital may contract with an educational institution to provide basic courses required for a degree (e.g., English 101), but the hospital must teach all the courses related to the theory and practice of the particular nursing or allied health specialty.
The January 12, 2001 final rule provides additional guidance on what “direct control” of the curriculum means. Although the accrediting agency often dictates which courses and the order of the courses that must be completed by each student, to the extent where there is some flexibility provided by the accrediting body, it must be the hospital, not another educational institution deciding upon the order of the coursework, and the manner its students will accomplish the coursework that will allow the program to be accredited. In addition, there may be certain courses that are unique to the hospital, and the hospital decides what those courses are and when they are taught. Furthermore, control of the curriculum means the hospital actually provides all of the courses, or, with respect to the basic courses required for completion of the program (e.g., English 101), the hospital arranges for an outside organization to provide those academic courses necessary to complete the course work. (See 66 FR 3364).

Clarifications Regarding Payment for Certain Non-provider-Operated Programs

Sections 413.85(g)(1) and (2) specify that pass-through payment for the clinical costs (not classroom costs) of certain nonprovider-operated programs may be made to a hospital if, in part, the hospital claimed and was paid for clinical training costs on a reasonable cost basis during its most recent cost reporting period that ended on or before October 1, 1989. We note that section 4004(b) of Pub. L. 101-508 was intended to apply only to NAH programs which were not provider-operated in 1989, but for which hospitals erroneously claimed and received pass-through payment from Medicare in 1989. We emphasize that this provision allows the hospitals to receive pass-through payment after 1989 for the clinical costs of only those programs that were already not provider-operated in 1989; this provision is not intended to allow for the payment of the clinical costs of programs that became non-provider-operated after 1989. That is, after 1989, hospitals cannot receive pass-through payments under this provision for any other non-provider operated NAH program if the hospital did not receive pass-through payment in 1989. Clinical training costs are defined at §413.85(c) as “costs of training for the acquisition and use of the skills of a nursing or allied health profession or trade in the actual environment in which these skills will be used by the student upon graduation. Clinical training may involve occasional or periodic meetings to discuss or analyze cases, critique performance, or discuss specific skills or techniques; it involves no classroom instruction.”

We have received questions about the proper way to determine the allowable clinical costs to be paid for the applicable nonprovider-operated programs. We are providing instructions to implement our existing policy below; we are not changing policy on this matter.

§413.85(g)(2)(iii) states:

In any cost reporting period, the percentage of total allowable provider cost attributable to allowable clinical training cost does not exceed the percentage of total cost for clinical training in the provider’s most recent cost reporting period ending on or before October 1, 1989.

To determine whether the limit described in § 413.85(g)(2)(iii) applies to any non-provider operated program claimed in the current cost report and, if so, to compute the appropriate payment for such program or programs, the MAC shall:

Obtain the hospital’s most recent cost report ending on or before October 1, 1989 (for ease of reference, we will refer to this cost report as the “1989” cost report).

For each current year’s non-provider operated program, determine whether this same program was reported in the 1989 cost report (i.e., Form HCFA-2552-89), Worksheet A, Line 20 and subscripts (nursing schools) and lines 23 and 24 and subscripts (Allied Health programs), Column 7). It is important to ensure in this step that the 1989 NAH non-provider operated program is the same as the non-provider program in the current year. For example, the programs would not be the same in 1989 and the current year if the hospital reported a Radiology Technologist non-provider operated program and no other Radiology-type programs in the 1989 cost report but in the current year’s cost report the provider reported only a Nuclear Medicine Technology non-provider operated program. As mentioned in the first paragraph of this section, the hospital is not entitled to receive pass-through payment in the current year for the Nuclear Medicine Technology program because this program does not meet the requirements of § 413.85(g)(2).

For each non-provider operated program found to have been reported in both the current and the 1989 cost reports in Step 2, determine whether the program was not operated by the hospital in 1989 but the hospital received pass-through payment for it in that year. (See § 413.85(g)(2)(iii)).

Only for each non-provider operated NAH program reported on Worksheet A, Line 20 and subscripts and Line 23 and subscripts of the current cost report for which the hospital received pass-through payment in
1989 (as determined in Step 3), compute the “1989 percentage” using steps 5 through 7 and the “Current Year Percentage” using steps 8 through 10. Do not complete Steps 5 through 11 for any current year’s non-provider operated NAH programs if the hospital did not receive pass-through payments for the program(s) in 1989 (see Step 3). 1989 Percentage Computation if Required by Step 4

Numerator - For each program individually, from Form HCFA-2552-89, determine the sum of the costs on lines 20 and 23, 24 and subscripts as applicable, column 7, of Worksheet A.

Denominator - determine total allowable hospital costs from the amount on Form HCFA-2552-89, Worksheet A, line 95 Subtotals, column 7. (We note that Worksheet A, Line 95 of the 1989 cost report contains only the “allowable” total provider cost since the non-reimbursable cost centers’ costs are not included on this line. Per § 413.85(g)2(iii), the “percentage” is “the percentage of total allowable cost…”)

Percentage from 1989 - For each program individually, divide the NAH cost amount from Step 5 by the total allowable hospital cost from Step 6. In accordance with Provider Reimbursement Manual–2 (PRM–2), Section 4000.1, percentages are rounded to 2 decimal places. Current Year Percentage

Using the current year cost report under review, only for programs that were nonprovider-operated in 1989 and are still nonprovider-operated in step 3, refer to Form CMS-2552-10, Worksheet A, line 20 (Nursing School) and line 23 and subscripts (paramedical education programs as applicable), column 7. Numerator – For each program individually, use the amounts from Worksheet A, lines 20 and subscripts and 23 and subscripts, Column 7. For each program individually, verify that the amount on Worksheet A, line 20 or its subscripts and/or Line 23 or its subscripts, Column 7 relate only to the “clinical costs” of the NAH program. If so, use the amount from this specific line. If the amount in Column 7 for any of the programs contains “clinical training cost and classroom costs”, subtract the “classroom costs” and use the net amount. (We note that for cost reporting periods beginning on or after October 1, 1990, PRM–2, Section 3610 (Form CMSA-2552-96) and Section 4013 (Form CMS-2552-10), specify that “classroom costs” related to non-provider operated NAH programs under § 413.85(g)2 are not to be reported on Lines 20, 24 (Form CMS-2552-96) and 23 (Form CMS-2552-10).)

Denominator - determine total allowable hospital costs from the amount on Form CMS-2552-10, Worksheet A, line 118 Subtotals, column 7. (We note that Worksheet A, Line 118 of the current cost report contains only the “allowable” total provider cost since the non-reimbursable cost centers’ costs are not included on this line. Per § 413.85(g)2(iii), the “percentage” is “the percentage of total allowable cost…”).

Clinical Percentage from the Current Cost Report – For each program individually, divide the NAH clinical cost amount from step 8 by the total allowable hospital cost from step 9. In accordance with PRM–2, Section 4000.1, percentages are rounded to 2 decimal places.

For each program individually, compare the 1989 Percentage (step 7) to the Clinical Percentage from the Current Cost Report (step 10). If for any program, the current year percentage is greater than the 1989 year percentage, do not use the current year percentage; compute the current year’s allowable clinical pass-through payment for the program by using the 1989 percentage. Proceed to pay the Medicare pass-through to the hospital in the current year for the clinical costs. For example, if the 1989 clinical percent was 30 percent, and the current year percent is 40 percent, only 30 percent of the hospital’s current year clinical costs are allowable for Medicare pass-through payment. If for any program, the current year percentage is equal to or less than the 1989 percentage, then 100 percent of the hospital’s current year clinical costs are allowable for Medicare pass-through payment; use the current year percentage.

**BUSINESS REQUIREMENTS TABLE**

“Shall” denotes a mandatory requirement, and “should” denotes an optional requirement.

<table>
<thead>
<tr>
<th>Number</th>
<th>Requirement</th>
<th>Responsibility</th>
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<tbody>
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<td>A/B MAC</td>
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<td></td>
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<td>A</td>
</tr>
</tbody>
</table>
The MACs shall note that the policies contained in this notice are clarifications; no changes in policy are being made. These clarified policies shall be applied by hospitals as they file the cost reports and by the MACs during the normal desk review/audit process.

The MAC shall not assume that because the hospital issues the degree, diploma, or certificate of completion, either individually, or jointly with a college/university, that that is sufficient to meet the provider-operated criteria.

MACs shall not rely on a degree/diploma/certificate issued by the hospital as evidence that a program is provider-operated.

The MAC shall review the evidence provided, request additional documentation as necessary, and be satisfied that all provider-operated criteria at §413.85(f)(1) are met first, and only then may the MAC approve pass-through payment to the hospital for the program.

The MAC shall follow the 11 steps under section II of this CR to determine whether the limit described in § 413.85(g)(2)(iii) applies to any non-provider operated program claimed in the current cost report and to compute the appropriate payment for such program or programs.
PROVIDER EDUCATION TABLE

<table>
<thead>
<tr>
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<td>A/B MAC D M E M A C C ED I</td>
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<tr>
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<td>A B H H H</td>
</tr>
<tr>
<td>10552.6</td>
<td>CR as Provider Education: Contractors shall post this entire instruction, or a direct link to this instruction, on their Web sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the availability of the article. In addition, the entire instruction must be included in the contractor’s next regularly scheduled bulletin. Contractors are free to supplement it with localized information that would benefit their provider community in billing and administering the Medicare program correctly.</td>
<td>X</td>
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</table>

SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

“Should” denotes a recommendation.

<table>
<thead>
<tr>
<th>Requirement Number</th>
<th>Recommendations or other supporting information:</th>
</tr>
</thead>
</table>

Section B: All other recommendations and supporting information: N/A

CONTACTS

Pre-Implementation Contact(s): Renate Dombrowski, renate-rockwell.dombrowski@cms.hhs.gov , Miechal Kriger, 646-842-2766 or miechal.kriger@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer’s Representative (COR).

FUNDING

Section A: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0
Provider Contact Center Friday Training Closure Changes - Effective September 14, 2018

CMS approves training for Customer Service Representatives (CSRs) for up to eight hours per month. The goal of the training is to improve the consistency and accuracy of answers to provider questions, to increase understanding of issues, and to facilitate CSRs retention of knowledge to provide the best customer service to the provider community.

Effective September 14, the Provider Contact Center Friday training closure time will be 12:15 p.m.-2:45 p.m. CT.

View the Provider Contact Center Training Closures webpage for the remaining 2018 training closures.

Provider-Issued Beneficiary Forms Webpage Now Available

Noridian receives several inquiries regarding the appropriate beneficiary form to issue and in what timeframe providers need to issue them. To review the different original Medicare forms that are issued by providers, the reasons why they are given, and when they need to be issued, visit the Provider-Issued Beneficiary Forms webpage.

New Release of PEPPER Available for Home Health Agencies, Partial Hospitalization Programs

Fourth quarter calendar year (CY) 2017 Program for Evaluating Payment Patterns Electronic Reports (PEPPERs) are available for Home Health Agencies (HHAs) and Partial Hospitalization Programs (PHPs). 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.

HHAs and Community Mental Health Center PHPs: For instructions on obtaining your PEPPER, see the Secure PEPPER Access Guide.

PHPs operated by short-term acute care hospitals or inpatient psychiatric facilities: PEPPER was distributed via the QualityNet secure portal.

WebEx training sessions are scheduled on July 25 for HHAs and August 2 for PHPs. Visit the applicable “Training and Resources” page at PEPPERresources.org for details. For more information, including user’s guides, recorded training sessions, information about QualityNet accounts, frequently asked questions, and examples of how other providers 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.

QMB CMS Audio Recording and Transcript Available

An audio recording and transcript are available for the June 6 CMS call on Qualified Medicare Beneficiary (QMB) Program Billing Requirements. Find out about the July 2018 re-launch of changes to the remittance advice and November 2017 changes to the HIPAA Eligibility Transaction System (HETS) to identify the QMB status of your patients and exemption from cost-sharing. Also, learn key steps to promote compliance.

This is a national CMS educational resource advertised via the CMS MLN Connects dated June 21, 2018.
CMS Awards Funding for Quality Measure Development

CMS NEWS

FOR IMMEDIATE RELEASE
September 21, 2018

Contact: CMS Media Relations
(202) 690-6145 | CMS Media Inquiries

Agency funds new partnerships to develop meaningful measures for the Medicare Quality Payment Program

The CMS today awarded seven organizations new cooperative agreements to partner with the agency in developing, improving, updating, or expanding quality measures for Medicare’s Quality Payment Program (QPP). These cooperative agreements, authorized under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), represent the first funding initiative supporting public-private efforts to develop measures for the Quality Payment Program. Through these partnerships, CMS will work closely with external organizations—such as clinical professional organizations and specialty societies, patient advocacy groups, educational institutions, independent research institutions, and health systems—to develop and implement measures that offer the most promise for improving patient care.

“CMS looks forward to collaborating with these clinicians, patients, and other key stakeholders to identify quality measures that will meaningfully impact patient care,” said Administrator Seema Verma. “Through our Meaningful Measures initiative, CMS is committed to advancing measures that minimize burden on clinicians, improve outcomes for patients, and drive high-quality care. We need the expertise and firsthand experience of those on the front lines to develop measures that achieve these goals.”

This funding program aligns with CMS’s Meaningful Measures framework, which identifies high priorities for quality measurement and improvement. As outlined in the CMS Quality Measure Development Plan, the work announced today is intended to fill gaps in the QPP measure set. This could involve removing measures with limited value and adding others that are more clinically appropriate, increase value, reduce provider burden, and enhance patient care. Program partners will work to establish more appropriate measures for clinical specialties underrepresented in the current measure set with the goal of improving patient care, and focus on outcome measures, including patient-reported and functional-status measures, to better reflect what matters most to patients.

The measures developed through this initiative will help shape Medicare’s Quality Payment Program, which CMS established to implement certain provisions of MACRA. Heading into its third year in 2019, the Quality Payment Program consists of two participation pathways for doctors and other clinicians—the Merit-based Incentive Payment System or MIPS, which measures performance in four categories to determine an adjustment to Medicare payment, and Advanced Alternative Payment Models or Advanced APMs, in which clinicians may earn an incentive payment through sufficient participation in risk-based payment models.

This year, CMS has removed or proposed to eliminate reporting requirements for 105 measures across the agency’s programs, saving healthcare providers $178 million over the next three years. More than 400 measures remain across these programs, and CMS remains committed to patient safety and quality.

The next phase of Meaningful Measures is identifying a set of measures that minimizes provider time spent collecting and submitting data to CMS, while assessing those core issues that are the most critical to providing high-quality care.

For more information on today’s funding awards to support Medicare quality measure development, please visit: https://go.cms.gov/1Gb6GDL

Source
• CMSLISTS Email Update dated September 21, 2018
FYI

IOM, Publication 100-02, Chapter 11 – End Stage Renal Disease (ESRD), Section 100 Update

MLN Matters Number: MM10809
Related Change Request (CR) Number: CR 10809
Related CR Release Date: July 20, 2018
Effective Date: October 23, 2018
Related CR Transmittal Number: R244BP
Implementation Date: October 23, 2018

PROVIDER TYPE AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 10809 which informs MACs about an update to the Medicare Benefit Policy Manual, Chapter 11, Section 100, extending renal dialysis services paid under Section 1881(b)(14) of the Social Security Act to beneficiaries with Acute Kidney Injury (AKI), effective January 1, 2017. This revision does not represent a policy change. Specifically, the manual has been updated to state that Erythropoietin Stimulating Agents (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, Q0138). The revenue codes for reporting Epoetin Alfa are 0634 and 0635. All other ESAs are reported using revenue code 0636.

Make sure your billing staffs area 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 to beneficiaries with Acute Kidney Injury (AKI), effective January 1, 2017. This revision does not represent a policy change. Specifically, the manual has been updated to state that Erythropoietin Stimulating Agents (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, Q0138). The revenue codes for reporting Epoetin Alfa are 0634 and 0635. All other ESAs are reported using revenue code 0636.

ADDITIONAL INFORMATION


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Next Generation ACO Model 2019 Benefit Enhancement – Revised

MLN Matters Number: MM10824 Revised
Related Change Request (CR) Number: 10824
Related CR Release Date: August 28, 2018
Effective Date: January 1, 2019
Related CR Transmittal Number: R205DEMO
Implementation Date: January 7, 2019

This article was revised on August 29, 2018, to reflect a revised CR10824 issued on August 28. The CR was revised to show this is year four of the NGACO model. The article was revised accordingly. In the article, the CR release date, transmittal number, and the Web address of the CR are also revised. All other information remains the same.
PROVIDER TYPE AFFECTED

This MLN Matters® Article is intended for providers who are participating in Next Generation Accountable Care Organizations (NGACOs) and submitting claims to Medicare Administrative Contractors (MACs) for certain care management home visit services to Medicare beneficiaries that would not otherwise be covered by Original Fee-For-Service (FFS) Medicare.

PROVIDER ACTION NEEDED

Change Request (CR) 10824 provides instruction on implementing one new Benefit Enhancement for program year four of the NGACO Model.

BACKGROUND

The goal of the NGACO Model is to improve the quality of care, population health outcomes, and patient experience for the beneficiaries who choose traditional FFS Medicare. The Model provides greater alignment of financial incentives and greater access to tools that may aid beneficiaries and providers in achieving better health at lower costs. Some of the tools that are available to beneficiaries and providers are conditional waivers of certain Medicare payment requirements, called Benefit Enhancements. These Benefit Enhancements currently include the Three-Day Skilled Nursing Facility Rule Waiver, the Post-Discharge Home Visits Waiver, and the Telehealth Expansion Waiver. There are Medicare Learning Network articles available describing each of these and the links for them are available in the Additional Information section.

New Benefit Enhancement for 2019

Care Management Home Visits

Building upon the NGACOs’ experience in offering the Post-Discharge Home Visits Benefit Enhancement, the Model will offer a new Care Management Home Visits Benefit Enhancement to equip the NGACOs with a new tool to provide home visits proactively and in advance of a potential hospitalization. Next Generation Participants and Preferred Providers who have initiated a care treatment plan for aligned beneficiaries will be eligible to receive up to two Care Management Home Visits within 90 days of seeing that Next Generation Participant or Preferred Provider.

CMS will extend the conditional Medicare payment rule waiver issued under the Post-Discharge Home Visits Benefit Enhancement to establish the Care Management Home Visits Benefit Enhancement. Specifically, the scope of covered items and services under this Benefit Enhancement include those services and supplies that would be covered under Medicare Part B and are furnished “incident to” the professional services of a physician or other practitioner.

With the exception that CMS will waive the direct supervision requirement such that the services and supplies may be furnished by auxiliary personnel under the billing physician’s or other billing practitioner’s general supervision, this new Care Management Home Visits Benefit Enhancement will provide NGACO Participants and Preferred Providers greater flexibility to furnish these services within a beneficiary’s home or place of residence.

The items and services provided as part of these care management home visits are intended to supplement, rather than substitute for, visits to a primary care provider or specialist in a traditional health care setting. As such, these home visits are not intended to be performed on an ongoing basis, nor to serve as a substitute for the Medicare home health benefit, nor as the primary mechanism to meet beneficiaries’ care needs. Also, note that this is not a home health benefit, and beneficiaries eligible to receive home health services will not be eligible for this Benefit Enhancement.

The Healthcare Common Procedure Coding System (HCPCS) codes for the Care Management Home Visit services are:

- G0076: Brief (20 minutes) care management home visit for a new patient. For use only in a Medicare-approved Center for Medicare & Medicaid Innovation (CMMI) model. (Services must be furnished within a beneficiary’s home, domiciliary, rest home, assisted living and/or nursing facility.)
- G0077: Limited (30 minutes) care management home visit for a new patient. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary’s home, domiciliary, rest home, assisted living and/or nursing facility.)
FYI

- **G0078**: Moderate (45 minutes) care management home visit for a new patient. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary’s home, domiciliary, rest home, assisted living and/or nursing facility.)
- **G0079**: Comprehensive (60 minutes) care management home visit for a new patient. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary’s home, domiciliary, rest home, assisted living and/or nursing facility.)
- **G0080**: Extensive (75 minutes) care management home visit for a new patient. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary’s home, domiciliary, rest home, assisted living and/or nursing facility.)
- **G0081**: Brief (20 minutes) care management home visit for an existing patient. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary’s home, domiciliary, rest home, assisted living and/or nursing facility.)
- **G0082**: Limited (30 minutes) care management home visit for an existing patient. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary’s home, domiciliary, rest home, assisted living and/or nursing facility.)
- **G0083**: Moderate (45 minutes) care management home visit for an existing patient. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary’s home, domiciliary, rest home, assisted living and/or nursing facility.)
- **G0084**: Comprehensive (60 minutes) care management home visit for an existing patient. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary’s home, domiciliary, rest home, assisted living and/or nursing facility.)
- **G0085**: Extensive (75 minutes) care management home visit for an existing patient. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary’s home, domiciliary, rest home, assisted living and/or nursing facility.)
- **G0086**: Limited (30 minutes) care management home care plan oversight. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary’s home, domiciliary, rest home, assisted living and/or nursing facility.)
- **G0087**: Comprehensive (60 minutes) care management home care plan oversight. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary’s home, domiciliary, rest home, assisted living and/or nursing facility.)

These codes should be submitted on Type of Bill: 85X, with Revenue Codes 96X, 97X, or 98X. The payment rates will be in the Medicare Physician Fee Schedule (MPFS). However, Medicare will reimburse the lesser of the billed charge or MPFS rate for Critical Access Hospital Method II providers billing on Type of Bill 85X, with Revenue Codes 96X, 97X, or 98X.

**ADDITIONAL INFORMATION**


Information on the CRs previously implemented for the Next Generation ACO Model are available at:

**Medicare Claims Processing Manual, Chapter 24, ASCA Waiver Review Form of Letters, Exhibits A-H Updates**

**MLN Matters Number:** MM10858  
**Related Change Request (CR) Number:** CR 10858  
**Related CR Release Date:** August 3, 2018  
**Effective Date:** January 1, 2019  
**Related CR Transmittal Number:** R4102CP  
**Implementation Date:** January 7, 2019

**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) 10858 provides an update to the language contained in the Form Letters the MACs use to inform certain providers of Administrative Simplification Compliance Act (ASCA) waiver reviews. The CR gives you clear directions for communicating with your MACs regarding ASCA waiver review-related questions when you receive a review Form Letter. Make sure your billing staffs are aware of these directions.

**BACKGROUND**  
Section 3 of the ASCA, PL107-105, and the implementing regulation at 42 CFR 424.32, requires that you, on or after October 16, 2003, submit electronically (with limited exceptions); all of your initial claims for reimbursement under Medicare. You should be aware that Medicare cannot pay for claims: 1) That do not meet the limited exception criteria; and 2) Which you submit non-electronically. The issuance of waivers under this limited exception criteria to providers has been delegated to the MACs by the Centers for Medicare & Medicaid Services (CMS). Refer to [https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm3440.pdf](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm3440.pdf) or additional information about this requirement, including a list of these exception criteria.

Based on discussions with MACs to streamline the communication process with your MACs, CMS has made minor modifications to the ASCA waiver review letters that will improve this communication. CR10858 provides these modifications; specifically, the addition of the statement: “If you have questions, please contact your MAC Customer Service.”

You will find the updated claims Processing Manual, Chapter 24 (General EDI and EDI Support Requirements, Electronic Claims, and Mandatory Electronic Filing of Medicare Claims), as an attachment to CR10858. It documents the changes mentioned above for the waiver review Exhibits of Form Letters (A-H).

**ADDITIONAL INFORMATION**  
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Updating Language to Clarify for Providers Chapter 3, Section 20 and Chapter 5, Section 70 of the Medicare Secondary Payer Manual

MLN Matters Number: MM10863
Related Change Request (CR) Number: CR 10863
Related CR Release Date: August 17, 2018
Effective Date: November 20, 2018
Related CR Transmittal Number: R123MSP
Implementation Date: November 20, 2018

PROVIDER TYPE AFFECTED
This MLN Matters article is intended for provider and hospital-affiliated services billing Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED
Change Request (CR) 10863 furnishes providers and hospitals with additional clarification regarding when and where to obtain information from Medicare beneficiaries, or authorized representatives, for inpatient admissions or outpatient encounters. Make your staff aware of this clarification.

BACKGROUND
Prior to submitting a bill to Medicare, you must determine whether Medicare is the primary or secondary payer for each beneficiary’s inpatient admission or outpatient encounter by asking the beneficiary about any other insurance coverage that may be primary to Medicare.

Specifically, Section 1862(b)(6) of the Social Security Act (The Act), (https://www.ssa.gov/OP_Home/ssact/title18/1862.htm, (42 USC 1395y(b)(6)), https://www.gpo.gov/fdsys/pkg/USCODE-2010-title42/pdf/USCODE-2010-title42-chap7-subchapXVIII-partE-sec1395y.pdf) requires all entities seeking payment for any item or service furnished under Medicare Part B to complete (based on information obtained from the individual to whom the item or service is furnished) that portion of the claim form related to the availability of other health insurance.

Additionally, 42 CFR 489.20(g) (https://www.govregs.com/regulations/expand/title42.chapterIV_part489_subpartB_section489.20#title42.chapterIV_part489_subpartB_section489.20) requires all providers agree to bill other primary payers before billing Medicare.

CR10863 provides clarification to this process:
1. The Medicare Secondary Payer (MSP) Manual, Chapter 3 (MSP Provider, Physician, and Other Supplier Billing Requirements), Section 20.2.1(Model Admission Questions to Ask Medicare Beneficiaries) provides a model questionnaire listing the type of questions hospitals may use to determine the correct primary payers of claims for all beneficiary services that you furnish. This updated manual is an attachment to CR10863.

2. If you have access to the Common Working File (CWF), your admission staff may ask the beneficiary if any insurance information it contains has changed. If there are no changes to the beneficiary’s insurance, then there is no need to ask the questions. However, if insurance information has changed, you must ask the MSP questions. Further, you need to notate (for auditing purposes) that all the questions were not asked upon admission based on the beneficiary’s statement that their insurance information has not changed. Notations may be cited on the CWF screen print verifying the MSP information in the system is correct or the notations may be attached to the CWF print out. Your MAC may request this notation and confirmation during its hospital review.
3. The HIPAA Eligibility Transaction System (HETS) Health Care Eligibility Benefit Inquiry and Response (270/271) Transaction Set is used to transmit Health Care Eligibility Benefit Inquiries from health care providers, insurers, clearinghouses and other health care adjudication processors. You can use the HETS 270/271 transaction set to make an inquiry about the Medicare eligibility of an individual and to identify insurance that is primary or secondary to Medicare.

Similar to the CWF process, if you have the ability to submit and receive a HETS 270/271 transaction set and, upon review, there are no changes to the beneficiary’s insurance then there is no need to ask the questions. However, if there are changes, you must ask the MSP questions. Further, you need to note (for auditing purposes) that all the questions were not asked upon admission based on the beneficiary’s statement that their insurance information has not changed as your MAC may request this notation and confirmation during its hospital review. Notations may be cited on the 270/271 screen print verifying the MSP information in the system is correct or the notations may be attached to the HETS 270/271 print out.

4. Some hospitals offer provider-based services, such as a provider affiliated transfer ambulance service. The affiliated hospital-based service does not need to ask the MSP questions if the hospital admission staff has already asked the questions or verified the beneficiary’s insurance information. The admissions staff would then bill the appropriate insurer for the ambulance service.

However, if the ambulance service is not affiliated with the hospital, then the ambulance service is responsible for collecting and/or verifying the correct insurance information prior to billing for services.

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Ambulance Zip Code Definition Lookup Tool Now Available

Are you an ambulance provider/supplier looking to determine if a billed zip code is considered urban, rural, or super rural?

View our new Ambulance Zip Code Definition Lookup to stay informed of the most current geographical area designations. Knowing this will also help clarify transport reimbursement.
Chemotherapy Administration Denials
The Noridian Redeterminations Department has determined that 54% of chemotherapy administration denials occur because providers are not billing the associated chemotherapy drug with the administration code. Noridian’s claims processing system logic is currently set to deny a chemotherapy administration code when the claim does not also contain an approved chemotherapy drug code.

To avoid this denial, and having to request an appeal with supporting documentation, bill the approved administered chemotherapy drug along with the administration code. If the drug is provided at no cost, bill with a token charge of $0.01 or $1.00.

Effective October 15, 2018, the Noridian claims processing system logic will be updated to return provider (RTP) claims when a chemotherapy administration code is billed without a corresponding approved chemotherapy drug. This will help eliminate the need for providers to submit a redetermination request for payment.

Learn more by viewing the Chemotherapy Administration Billing webpage.

Liability Modifier Appeal Rights Webpage Now Available
What appeal rights are available when adding or removing a liability modifier (GA, GX, GY, and GZ)?

View the newly added Liability Modifier Appeal Rights webpage to determine what remedial claims action is available when requesting a liability modifier be added or removed.
2019 Eligible Hospital eCQM Flows are Available Now

The CMS developed and published the 2019 reporting period electronic clinical quality measure (eCQM) flows for eligible hospitals and critical access hospitals (CAH) to the eCQI Resource Center. This is a new resource for eligible hospital and CAH eCQMs for the 2019 reporting period, developed in response to stakeholder feedback.

The eCQM flows are designed to assist in interpretation of the eCQM logic and calculation methodology for reporting rates. These flows provide an overview of each of the population criteria components and associated data elements that lead to the inclusion or exclusions into the eCQM’s quality action (numerator).

The eCQM flows supplement eCQM specifications for eligible hospitals and CAHs for the following programs:

- Medicare and Medicaid Promoting Interoperability (PI)
- Hospital Inpatient Quality Reporting (IQR)

These flows are intended to be used as an additional resource when implementing eCQMs and should not be used in place of the eCQM specification or for reporting purposes. A “Read Me First” guide to understanding the flows is also available to assist users as they navigate this new resource. The guide can be found on the eCQI Resource Center website within the eCQM flows zip file.

Questions on the eCQM flows should be directed to the ONC eCQM Issue Tracker available at https://oncprojecttracking.healthit.gov/support/secure/Dashboard.jspa.

Source

- CMSLISTS Email Update dated September 25, 2018
CERT Contractor’s New Provider Mailing Address Process - Effective August 14, 2018

Effective August 14, 2018, the Comprehensive Error Rate Testing (CERT) Review Contractor is sending initial additional documentation requests (ADRs) to the Correspondence Address in Provider Enrollment Chain and Ownership System (PECOS).

Learn more on the Provider Mailing Addresses and Points of Contact for CERT Requests webpage.

CERT Late/Additional Documentation Deadline - August 30, 2018

The Comprehensive Error Rate Testing (CERT) Review Contractor must receive late/additional documentation for claims in the 2018 report by Thursday, August 30, 2018.

For additional questions or support, access the Noridian CERT team phone and email address from the Contact Noridian with CERT Related Inquiries webpage.
OIG Report: Medicare Inappropriately Paid Acute-Care Hospitals for Outpatient Services They Provided to Beneficiaries Who Were Inpatients of Other Facilities

The Office of Inspector General (OIG) determined that Medicare inappropriately paid acute-care hospitals for outpatient services provided to beneficiaries who were inpatients of other facilities, including long term care hospitals, inpatient rehabilitation facilities, inpatient psychiatric facilities, and critical access hospitals. As a result, beneficiaries were unnecessarily charged outpatient deductibles and coinsurance payments. In the report, the OIG recommended that CMS instruct the Medicare Administrative Contractors (MACs) to more effectively educate acute-care hospitals not to bill Medicare for outpatient services provided to beneficiaries who were inpatients of other facilities, but rather to provide those services under arrangements and look to the inpatient facilities for payment. Read the full OIG report.

Medical Review of E/M Documentation

MLN Matters Number: MM10627
Related Change Request (CR) Number: 10627
Related CR Release Date: July 13, 2018
Effective Date: August 14, 2018
Related CR Transmittal Number: R808PI
Implementation Date: August 14, 2018

PROVIDER TYPE AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 10627 establishes a new Section (6.8) in Chapter 6 of the “Medicare Program Integrity Manual” (Pub. 100-08), titled, “Medical Review of Evaluation and Management (E/M) Documentation.” Please make sure your billing staffs are aware of this new content.

BACKGROUND

CR10627 establishes Section 6.8 (Medical Review of Evaluation and Management (E/M) Documentation) with subsection 6.8.1 (Medical Review of E/M Documentation Provided by Student). These sections provide direction to Medicare’s medical review contractors on how to review claims where a medical student documented the E/M service. This is a follow-up instruction to CR10412 (published in February 2018), which allowed teaching physicians to verify a student’s E/M visit notes rather than re-documenting them.


The new section of the “Medicare Program Integrity Manual” states the following:

The “Medicare Claims Processing Manual”, Chapter 12, Section 100.1.1 (B) states 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. If the teaching physician chooses to rely on the medical student documentation and chooses not to re-document the E/M services, contractors shall consider this requirement met if the teaching physician signs and dates the medical student’s entry in the medical record.”

ADDITIONAL INFORMATION

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CLAIM SUBMISSION

Chemotherapy Administration Billing Webpage Now Available

Due to the high volume of chemotherapy related redetermination requests submitted and processed, a new webpage has been created for all providers to review administration hierarchies, bundled/packaged services, billing guidance, and redeterminations examples.

View the new Chemotherapy Administration Billing webpage.

FISS Adding Additional Search Features to Provider DDE Screen – User CR

MLN Matters Number: MM10542
Related Change Request (CR) Number: 10542
Related CR Release Date: August 10, 2018
Effective Date: January 1, 2019
Related CR Transmittal Number: R2112OTN
Implementation Date: January 7, 2019

PROVIDER TYPE AFFECTED

MLN Matters® Article 10542 is a one-time notice that highlights the improved claim search capability in Fiscal Intermediary Shared System (FISS) for providers who use Direct Data Entry (DDE) and submit claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

Change Request (CR) 10542 allows providers who use DDE to look up the claims associated with an Accounts Receivable (AR) by using the invoice number on the AR to find the Document Control Number (DCN), and then using the DCN to look up the claims. This update will improve provider customer service, allowing providers to find the claim associated with the AR and reconcile it back to their patient accounts. Please make certain your billing staff is aware of this enhancement. Detailed instructions on how to use the new feature will be provided closer to implementation.

BACKGROUND

CR 10542 gives providers the ability to find the claims associated with a receivable through DDE screens. Providers will use a new look up feature in DDE to use the invoice number on the receivable to find the DCN. Then, they can use the DCN to find the associated claims.

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**Medicare Claims Processing Manual, Chapter 24, Section 90 – Update**

MLN Matters Number: MM10559  
Related Change Request (CR) Number: 10559  
Related CR Release Date: August 3, 2018  
Effective Date: November 5, 2018  
Related CR Transmittal Number: R4096CP  
Implementation Date: November 5, 2018

**PROVIDER TYPE AFFECTED**

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

**WHAT YOU NEED TO KNOW**

This article is based on Change Request (CR) 10559 which reduces confusion and clarifies the Administrative Simplification Compliance Act (ASCA) waiver process guideline in the Medicare Claims Processing Manual, Chapter 24, Section 90. CR10559 combines two sections (90.3.2 and 90.3.3) into one new Section 90.3.2 with a new title and description.

**BACKGROUND**

Section 3 of the ASCA, Pub. L. 107-105, and the implementing regulation at 42 CFR 424.32 (see https://www.ecfr.gov/cgi-bin/text-idx?SID=c41b2cb8b72f75bd58ae2a26094f4cfe&mc=true&node=pt42.3.424&rgn=div5#se42.3.424_132), require providers to submit all initial claims for reimbursement under Medicare, (except for small providers), electronically as of October 16, 2003, with limited exceptions. Medicare is prohibited from paying claims submitted in a non-electronic manner that do not meet the limited exception criteria. The issuance of waivers under this limited exception criteria to is discussed in Chapter 24, Section 90 of the Medicare Claims Processing Manual.

A provider may submit a waiver request to their MAC claiming other types of “unusual circumstances” outside of their control prevent submission of electronic claims. It is the responsibility of the provider to submit appropriate documentation including request application with Provider name, address, email, and phone number to establish the validity of a waiver request in this situation. Requests received without documentation and above stated information to fully explain and justify why enforcement of the requirement would be against equity and good conscience in these cases will be denied. If the MAC agrees that the waiver request has merit, the MAC sends the request to the Centers for Medicare & Medicaid Services (CMS) for review and issuance of the CMS decision.

If the MAC does not consider an “unusual circumstance” to be met, and does not recommend CMS approval, the MAC must issue a form letter to the provider. As required by the Privacy Act of 1974, letters issued to a provider to announce a waiver decision must be addressed to the organizational name of a provider and not to an individual (whether a sole practitioner, employee, or an owner of the provider organization). The organizational name is generally a corporate name under which the provider is registered as a Medicare provider or that is used to obtain an Employer Identification Number (EIN).

**ADDITIONAL INFORMATION**

The official instruction, CR10559, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4096CP.pdf. The revised manual chapter is attached to the CR.

**DOCUMENT HISTORY**

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<th>Date of Change</th>
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<tr>
<td>August 3, 2018</td>
<td>Initial article released.</td>
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</table>
HCPCS Drug/Biological Code Changes – July 2018 Update – Third Revision

MLN Matters Number: MM10624 Revised
Related Change Request (CR) Number: 10624
Related CR Release Date: July 5, 2018
Effective Date: July 1, 2018
Related CR Transmittal Number: R4083CP
Implementation Date: July 2, 2018

This article was revised on July 6, 2018, to reflect a revised CR issued on July 5. The article is revised to show the Type of Service Code for CPT code 90739 remains as 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
• TOS Code: 9
• MPFSDB Status Indicator: E

In addition to the new codes, the TOS code for CPT Code 90739 remains as V.

ADDITIONAL INFORMATION

DOCUMENT HISTORY

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<td>July 6, 2018</td>
<td>The article was revised to reflect a revised CR issued on July 5. The article is revised to show the Type of Service Code for CPT code 90739 remains as V. Also, the CR release date, transmittal number, and the Web address of the CR are revised. All other information is the same.</td>
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<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>
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HCPCS Drug/Biological Code Changes – October 2018 Update – Second Revision

MLN Matters Number: MM10834 Revised
Related Change Request (CR) Number: 10834
Related CR Release Date: September 13, 2018
Effective Date: July 12, 2018, for Q5108; October 1, 2018, for Q5110
Related CR Transmittal Number: R4134CP
Implementation Date: October 1, 2018

This article was revised on September 20, 2018, to delete the note that stated MACs should hold claims for Q5108 and Q5110 until CR10834 is implemented, since that is no longer a requirement. 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.

WHAT YOU NEED TO KNOW

The HCPCS code set is updated on a quarterly basis. CR 10834 informs MACs of the October 2018 addition of new HCPCS codes, Q5108 and Q5110. The codes are payable by Medicare effective with dates of service on or after July 12, 2018, for Q5108 and effective with dates of service on or after October 1, 2018, for Q5110.

The short descriptor for Q5108 is Injection, fulphila, and the long descriptor is Injection, pegfilgrastim-jmdb, biosimilar, (fulphila), 0.5 mg. The Type of Service (TOS) Codes for Q5108 are 1, P.

The short descriptor for Q5110 is Nivestym, and the long descriptor is Injection, filgrastim-aafi, biosimilar, (nivestym), 1 microgram. The TOS Codes for Q5110 are 1, P. The Medicare Physician Fee Schedule Database (MPFSD) Status Indicator for both codes is E.

ADDITIONAL INFORMATION


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<table>
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<tr>
<td>September 20, 2018</td>
<td>The article was revised to delete the note that stated MACs should hold claims for Q5108 and Q5110 until CR10834 is implemented, since that is no longer a requirement.</td>
</tr>
<tr>
<td>September 13, 2018</td>
<td>This article was revised on September 13, 2018, due to a revised CR 10834 that added a new HCPCS code, Q5110 (Injection, filgrastim-aafi, biosimilar, (nivestym), 1 microgram). The CR release date, transmittal number and link to the transmittal also changed.</td>
</tr>
<tr>
<td>August 10, 2018</td>
<td>Initial article released.</td>
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</table>
HPTCs Code Set – October 2018 Update

MLN Matters Number: MM10857
Related Change Request (CR) Number: 10857
Related CR Release Date: August 24, 2018
Effective Date: January 1, 2019
Related CR Transmittal Number: R4116CP
Implementation Date: No later than January 7, 2019

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) 10857 directs MACs to obtain the most recent Healthcare Provider Taxonomy Codes (HPTCs) code set and use it to update their internal HPTC tables and/or reference files. Make sure your billing staffs are aware of these updates.

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

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

You should note that:
• Valid HPTCs are those codes approved by the NUCC for current use.
• Terminated codes are not approved for use after a specific date.
• Newly approved codes are not approved for use prior to the effective date of the code set update in which each new code first appears.
• Specialty and/or provider type codes issued by any entity other than the NUCC are not valid.
• Medicare would be guilty of non-compliance with HIPAA if MACs accepted claims that contain invalid HPTCs.

Although the NUCC generally posts their updates on the Washington Publishing Company (WPC) website 3 months prior to the effective date, changes are not effective until April 1 or October 1 as indicated in each update. The changes to the code set include the addition of a new code and addition of definitions to existing codes. When reviewing the Health Care Provider Taxonomy code set online, revisions made since the last release are identified.

Note: MACs having the capability to do so will update the HPTC table, such that claims received on and after October 1, 2018, will be validated against the October 1, 2018, HPTC set. MACs lacking the capability to implement the updated October 2018 HPTC set, for claims received on or after October 1, 2018, will implement the October 2018 HPTC update as soon as possible after October 1, 2018, but no later than January 7, 2019.

ADDITIONAL INFORMATION
ICD-10 and Other Coding Revisions to NCDs – Revised

MLN Matters Number: MM10859 Revised
Related CR Number: 10859
Related CR Release Date: September 11, 2018
Effective Date: January 1, 2019
Related CR Transmittal Number: R2138OTN
Implementation Date: January 7, 2019, shared edits, September 28, 2018, local edits

This article was revised on September 12, 2018, to reflect a revised CR10859 issued on September 11. The CR was revised to remove ICD-10 diagnosis code H25.13 from NCD80.11 spreadsheet that was retained in error. In the article, the CR release date, transmittal number, and the Web address for accessing the CR are revised. All other information remains the same.

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 10859 constitutes a maintenance update of International Classification of Diseases, Tenth Revision (ICD-10) conversions and other coding updates specific to national coverage determinations (NCDs). These NCD coding changes are the result of newly available codes, coding revisions to NCDs released separately, or coding feedback received. Please follow the link below for the NCD spreadsheets included with this CR: https://www.cms.gov/Medicare/Coverage/DeterminationProcess/downloads/CR10859.zip. Make sure that your billing staffs are aware of these changes.

BACKGROUND

Previous NCD coding changes appear in ICD-10 quarterly updates that are available at https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html, along with other CRs implementing new NCD policy. Edits to ICD-10, and other coding updates specific to NCDs, will be included in subsequent quarterly releases 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) are separate and distinct areas of the Medicare Program from coverage policy/criteria. Revisions to codes within an NCD are carefully and thoroughly reviewed and vetted by the Centers for Medicare & Medicaid Services and are not intended to change the original intent of the NCD. The exception to this is when coding revisions are released as official implementation of new or reconsidered NCD policy following a formal national coverage analysis.

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

CR10859 makes coding and clarifying adjustments to the following NCDs:
- NCD80.11 Vitrectomy
- NCD110.21 Erythropoiesis-Stimulating Agents (ESAs) for Cancer
- NCD190.3 Cytogenetics
1. NCD190.11 Home Prothrombin Time (PT)/International Normalized Ratio (INR)
2. NCD220.6.17 Positron Emission Tomography (PET) for Oncologic Conditions
3. NCD270.3 Blood-Derived Products for Chronic, Non-Healing Wounds
4. NCD260.1 Adult Liver Transplantation
5. NCD110.18 Aprepitant for Chemo-Induced Emesis
6. NCD270.1 Electrical Stimulation, Electromagnetic Therapy for Wounds

Note/Clarification: A/B MACs shall use default Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) messages where appropriate: Remittance Advice Remark Codes (RARC) N386 with Claim Adjustment Reason Code (CARC) 50, 96, and/or 119. See latest CAQH CORE update. When denying claims associated with the NCDs referenced in CR10859, except where otherwise indicated, A/B MACs shall 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


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<td>The article was revised to reflect a revised CR10859 issued on September 11. The CR was revised to remove ICD-10 diagnosis code H25.13 from NCD80.11 spreadsheet that was retained in error. In the article, the CR release date, transmittal number, and the Web address for accessing the CR are revised. All other information remains the same.</td>
</tr>
<tr>
<td>August 14, 2018</td>
<td>Initial article released.</td>
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Additional Information Required for Coverage and Pricing for Category III CPT Codes – R5

The Local Coverage Article (LCA) Additional Information Required for Coverage and Pricing for Category III CPT® Codes 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.

Medicare Coverage Database (MCD) Number: A55681

LCA Title: Additional Information Required for Coverage and Pricing for Category III CPT® Codes

Effective Date: July 1, 2018

Summary of Changes: This LCA has been updated to include the following Category III CPT® codes into Group 1 as well as wording changes in the coverage section of the article text.

New CPT® codes:

- 0505T - 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.

- 0506T - Macular pigment optical density measurement by heterochromatic flicker photometry, unilateral or bilateral, with interpretation and report.

- 0507T - Near-infrared dual imaging (i.e., simultaneous reflective and trans-illuminated light) of meibomain glands, unilateral or bilateral with interpretation and report.

- 0508T - Pulse-echo ultrasound bone density measurement resulting in indicator of axial bone mineral density, tibia.

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 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
Billing Limitations for Pharmacies

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

Article Summary: Medicare Part B has limitations on pharmacy billing. There are two “Specialty codes” that may be used by pharmacies, each with limitations. Specialty 73-Mass Immunization Roster Billers who may only bill for influenza or pneumococcal immunizations and their administration codes and Specialty A5-Pharmacy who may only bill for patient supplies of hemophilia factor products. Certain other suppliers can also be enrolled as Specialty A5 such as Cochlear Implant suppliers.

Effective Date: October 22, 2018

To view the Future Noridian coverage article:

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

Humanitarian Use Devices and Exemptions Coverage Article Retirement - Effective September 17, 2018

The following JF Local Coverage Article (LCA) 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: A52936

Article Title: Humanitarian Use Devices and Exemptions

Effective Date: September 17, 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.

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.
Hyperbaric Oxygen and E/M Codes Article Retirement - Effective July 27, 2018

The following JF Local Coverage Article (LCA) 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: A52916
Article Title: Hyperbaric Oxygen and E/M codes
Effective Date: July 27, 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.

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.

Maintenance Programs

The Maintenance Programs article has 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.

Summary: This article is being published to provide clarification regarding outpatient therapy services and maintenance programs.

Effective Date: August 31, 2018

View the locally hosted Medicare Coverage Article PDF.

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

To view complete list of Noridian coverage articles:

- Go to the Noridian Medicare Coverage Articles webpage
- View complete list of Noridian coverage articles
- Access the CMS MCD to view a comprehensive revision history for this corresponding article
  - Scroll to bottom of webpage
  - Select state/contract of interest from Active, Future or Retired column (This link will redirect you to the CMS website.)
  - Once in the CMS MCD, select corresponding article title
MolDX: Abbott RealTime IDH2 testing for Acute Myeloid Leukemia (AML) Billing and Coding Guidelines – R1

The MolDX: Abbott RealTime IDH2 testing for Acute Myeloid Leukemia (AML) Billing and Coding Guidelines 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 Coverage: Article is revised to replace 81403 Mopath procedure level 4 with 81121 Brca1&2 seq & com dup/del, effective 1/1/2018.

Effective Date: 10/15/2017

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: Billing and Coding for Lynch Syndrome Testing Services

The MolDX: Billing and Coding for Lynch Syndrome Testing Services 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 requirements for Lynch testing services.

Effective Date: June 1, 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: BRCA1 and BRCA2 Genetic Testing LCD – R1**

The MolDX: BRCA1 and BRCA2 Genetic Testing LCD 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:** Substantial changes to Indications and Limitations of Coverage were made to be consistent with updated NCCN guidelines.

**Effective Date:** July 12, 2018

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.
- This link will direct you to the locally hosted copy of the Active LCD.

Providers may also access Noridian LCDs via the CMS MCD. To view them, select the appropriate state link within MCD section of the Active LCD webpage. Once in the MCD, choose the desired LCD title.

**MolDX: CDH1 Genetic Testing Billing and Coding Guidelines – R1**

The MolDX: CDH1 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 Change:** Article is revised to reword the entire first paragraph.

**Effective Date:** July 15, 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: Microsatellite Instability-High (MSI-H) and Mismatch Repair Deficient (dMMR) Biomarker Billing and Coding Guidelines for Patients with Unresectable or Metastatic Solid Tumors

The MolDX: Microsatellite Instability-High (MSI-H) and Mismatch Repair Deficient (dMMR) Biomarker Billing and Coding Guidelines for Patients with Unresectable or Metastatic Solid Tumors 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: View contractor billing and coverage criteria for the use of Keytruda in treatment of patients with unresectable or metastatic solid tumors having either microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) biomarkers.

Effective Date: October 13, 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 Noridian Medicare Coverage Articles webpage
- View complete list of Noridian coverage articles
- Access 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 CMS MCD, select corresponding article title

MolDX Molecular Test Registration and Claims Submission - R5

The MolDX Molecular Test Registration and Claims Submission coverage document has been revised and republished to the Noridian website.

Summary of Changes: Clarified that only molecular tests falling within MAAA and PLA codes apply to the Program.

Effective Date: August 1, 2018

View the locally hosted 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: myPap Billing and Coding Guidelines – R2

The MolDX: myPap™ Billing and Coding Guidelines 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: Article is updated to correct URL for the MolDX registry.

Effective Date: December 1, 2017

View the locally hosted Medicare Coverage Article PDF.

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

To view complete list of Noridian coverage articles:

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

MolDX: Myriad’s BRACAnalysis CDX Billing and Coding Guidelines Article – R1

The MolDX: Myriad’s BRACAnalysis CDX™ 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 Article: Revised the opening paragraphs and added the following ICD-10 codes:

- C48.0, C48.1, C48.2, C48.8, C50.011, C50.012, C50.021, C50.022, C50.111, C50.112, C50.121, C50.122, C50.211, C50.212, C50.221, C50.222, C50.311, C50.312, C50.321, C50.322, C50.411, C50.412, C50.421, C50.422, C50.511, C50.512, C50.521, C50.522, C50.611, C50.612, C50.621, C50.622, C50.811, C50.812, C50.821, C50.822, C50.911, C50.912, C50.921, C50.922, C57.01, C57.02, Z85.3, Z85.43, Z85.44.

Removed ICD-10 C79.60

Effective Date: July 5, 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: Quidel Solana Strep Complete Assay and Quidel Lyra Direct Strep Assay Billing and Coding Guidelines**

The MolDX: Quidel Solana Strep Complete Assay and Quidel Lyra Direct Strep Assay 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).

**Article Summary:** Article describes conditions of coverage for the Quidel Solana Strep Complete Assay and the Quidel Lyra Direct Strep Assay.

**Effective Date:** September 15, 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: ThermoFisher Oncomine Dx Target Test For Non-Small Cell Lung Cancer Billing and Coding Guidelines – R1**

The MolDX: ThermoFisher Oncomine Dx Target Test For Non-Small Cell Lung Cancer 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 Article:** Replaced CPT code 81445 Targeted genomic seq analys with 0022U Trgt gen seq dna&rna 23 gene.

**Effective Date:** October 1, 2017

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

**Molecular Diagnostic Program (MolDX) Manual - Revised**
The Molecular Diagnostic Program (MolDX®) Manual has been revised and republished to the Noridian website.

**Summary of Article:** Updated CPT table to specify which PLA, MAAA, and NOC codes require Z-codes; removed 88199 Unlisted cytopathology procedure and 88299 Unlisted cytogenetic study.

**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).

**Molecular Diagnostic Program (MolDX) Manual - V24**
The Molecular Diagnostic Program (MolDX®) Manual has been revised and published on the Noridian website.

**Summary of Article:** Corrected list of states for JF territory; removed “CDD” from list of possible coverage determinations

**Effective Date:** July 27, 2018

View the locally hosted Medicare Coverage Article.
  • Go to Noridian Molecular Diagnostics Services (MolDX) webpage
  • The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary)

**Molecular Genetic Testing Article Retirement - Effective August 24, 2018**
The following JF Local Coverage Article (LCA) 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:** A52932

**Article Title:** Molecular Genetic Testing

**Effective Date:** August 24, 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.

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)
Non-Payment for Prefabricated Splints

The Non-Payment for Prefabricated Splints article has 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.

Summary: This article is being published to provide clarification regarding outpatient therapy services and maintenance programs.

Effective Date: August 31, 2018

Peripheral Nerve Blocks Non-covered for the Treatment of Diabetic Peripheral Neuropathic Pain – R1

The Peripheral Nerve Blocks Non-covered for the Treatment of Diabetic Peripheral Neuropathic Pain 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 hyperlinks to the first two articles and deleted the third under Sources. Also, this article is revised to combine the Jurisdiction F Part B (JFB) Local Coverage Article A52724 into the Jurisdiction F Part A (JFA) article A52275 so that both JFA and JFB contract numbers will have the same final MCD article number as JFA with the same effective date of October 1, 2015 and no change in coverage.

Effective Date: October 1, 2015
PIK3CA Gene Tests Billing and Coding Guidelines – R1

The PIK3CA 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: The following sentences were deleted from the first paragraph: Therefore, the MolDX Team has determined PIK3CA gene testing is a statutorily excluded service. MolDX will also deny panels of tests that include the PIK3CA gene.

Effective Date: August 28, 2017

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

Qutenza (Capsaicin) 8% Patch Billing and Coverage Article Retirement - Effective July 27, 2018

The following JF Local Coverage Article (LCA) has been retired under contractor 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 033001 (ND), 03401 (SD), 03501 (UT), 03601 (WY).

Medicare Coverage Database Number: A52736

Article Title: Qutenza® (Capsaicin) 8% Patch Billing and Coverage

Effective Date: July 27, 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.
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.

**Single Chamber and Dual Chamber Permanent Cardiac Pacemakers – Coding and Billing – R5**

The following Noridian coverage requirements for the Single Chamber and Dual Chamber Permanent Cardiac Pacemakers – Coding and Billing 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 – Coding and Billing NCD 20.8.3

**Summary of Changes:** All referenced to ICD-9 codes have been removed

**Effective Date:** 05/01/2016

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

- Go to the National Coverage Determination (NCD) 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 NCD article title

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

To view a complete list of all CMS NCDs available, go to NCDs Alphabetical Index.

**Vestibular Rehabilitation Article Retirement - Effective August 24, 2018**

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

**Medicare Coverage Database Number:** A52764

**Article Title:** Vestibular Rehabilitation

**Effective Date:** August 24, 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.
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.

**Wound Care & Dressing Changes Article Retirement – Effective August 29, 2018**

The following JF Local Coverage Article (LCA) 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:** A52765

**Article Title:** Wound Care & Dressing Changes

**Effective Date:** August 29, 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.

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.

**Zika Virus Testing by PCR and ELISA Methods – R8**

The Zika Virus Testing by PCR and ELISA Methods 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.

**Medicare Coverage Database (MCD) Number:** A55327

**Article Title:** Zika Virus Testing by PCR and ELISA Methods

**Effective Date:** October 1, 2018

**Summary of Changes:** This Coverage Article has been updated to reflect effective date of ICD-10 code update to be 10/01/2018. This Article has been updated to include ICD-10 codes

**New/Revised ICD-10 codes to Group I Codes**

Z20.821: Contact with and (suspected) exposure to Zika virus
Medicare Coverage of Diabetes Supplies

MLN Matters Number: SE18011
Article Release Date: August 16, 2018

PROVIDER TYPE AFFECTED
This MLN Matters® Special Edition (SE) article is intended for physicians, providers, suppliers, and other health care professionals who furnish or provide referrals for and/or file claims to Medicare Administrative Contractors (MACs) for Medicare-covered diabetes supplies.

WHAT YOU NEED TO KNOW
This article is informational only and represents no Medicare policy changes.

BACKGROUND
This special edition article presents a current overview of the diabetes supplies covered by Medicare (Part B and Part D) to assist physicians, providers, suppliers, and other health care professionals who provide diabetic supplies to Medicare beneficiaries.

Medicare Part B Covered Diabetic Supplies
Medicare covers certain supplies if a beneficiary has Medicare Part B and has diabetes. These supplies include:

- Blood glucose self-testing equipment and supplies
- Therapeutic shoes and inserts
- Insulin pumps and the insulin used in the pumps

Blood Glucose Self-testing Equipment and Supplies
Blood glucose self-testing equipment and supplies are covered for all people with Medicare Part B who have diabetes. This includes those who use insulin and those who do not use insulin. Equipment and supplies include:

- Blood glucose monitors
- Continuous Blood Glucose monitors
- Blood glucose test strips
- Lancet devices and lancets
COVERAGE

- Glucose control solutions for checking the accuracy of testing equipment and test strips.
- Supply allowance for therapeutic continuous glucose monitor (CGM), includes all supplies and accessories.

Medicare Part B covers the same type of blood glucose testing supplies for people with diabetes whether or not they use insulin. However, the amount of supplies that are covered varies.

If the beneficiary:

**Uses insulin**, they may be able to get up to 100 test strips and lancets every month, and 1 lancet device every 6 months.

**Does not use insulin**, they may be able to get 100 test strips and lancets every 3 months, and 1 lancet device every 6 months.

If a beneficiary’s doctor documents why it is medically necessary, Medicare will cover additional test strips and lancets for the beneficiary.

Medicare will only cover a beneficiary’s blood glucose self-testing equipment and supplies if they get a prescription from their doctor. Their prescription should include the following information:

- That they have diabetes
- What kind of blood glucose monitor they need and why they need it (that is, if they need a special monitor because of vision problems, their doctor must explain that.)
- Whether they use insulin
- How often they should test their blood glucose

A beneficiary who needs blood glucose testing equipment and/or supplies:

- Can order and pick up their supplies at their pharmacy
- Can order their supplies from a medical equipment supplier, but they will need a prescription from their doctor to place their order
- Must ask for refills for their supplies

**Note:** Medicare will not pay for any supplies not asked for, or for any supplies that were sent to a beneficiary automatically from suppliers. This includes blood glucose monitors, test strips, and lancets. Also, if a beneficiary goes to a pharmacy or supplier that is not enrolled in Medicare, Medicare will not pay. The beneficiary will have to pay the entire bill for any supplies from non-enrolled pharmacies or non-enrolled suppliers.

All Medicare-enrolled pharmacies and suppliers must submit claims for blood glucose monitor test strips. Beneficiaries cannot submit a claim for blood glucose monitor test strips themselves. The beneficiary should make sure that the pharmacy or supplier accepts assignment for Medicare-covered supplies. If the pharmacy or supplier accepts assignment, Medicare will pay the pharmacy or supplier directly. Beneficiaries should only pay their coinsurance amount when they get their supply from their pharmacy or supplier for assigned claims. If a beneficiary’s pharmacy or supplier does not accept assignment, charges may be higher, and the beneficiary may pay more. They may also have to pay the entire charge at the time of service and wait for Medicare to send them its share of the cost.

Before a beneficiary gets a supply, it is important for them to ask the supplier or pharmacy the following questions:

- Are you enrolled in Medicare?
- Do you accept assignment?

If the answer to either of these two (2) questions is “no,” they should call another supplier or pharmacy in their area who answers “yes” to be sure their purchase is covered by Medicare, and to save them money.

If a beneficiary cannot find a supplier or pharmacy in their area that is enrolled in Medicare and accepts assignment, they may want to order their supplies through the mail, which may also save them money.
Therapeutic Shoes and Inserts

If a beneficiary has Medicare Part B, has diabetes, and meets certain conditions (see below), Medicare will cover therapeutic shoes if they need them. The types of shoes that are covered each year include one of the following:

One pair of depth-inlay shoes and three pairs of inserts, or

One pair of custom-molded shoes (including inserts) if the beneficiary cannot wear depth-inlay shoes because of a foot deformity and two additional pairs of inserts.

**Note:** In certain cases, Medicare may also cover shoe modifications instead of inserts.

In order for Medicare to pay for the beneficiary’s therapeutic shoes, the doctor treating their diabetes must certify that they meet **all** of the following three conditions:

- They have diabetes.
- They have at least 1 of the following conditions in one or both feet:
  - Partial or complete foot amputation
  - Past foot ulcers
  - Calluses that could lead to foot ulcers
  - Nerve damage because of diabetes with signs of problems with calluses
  - Poor circulation
  - Deformed foot
- They are being treated under a comprehensive diabetes care plan and need therapeutic shoes and/or inserts because of diabetes.

Medicare also requires the following:

- A podiatrist or other qualified doctor must prescribe the shoes, and
- A doctor or other qualified individual like a pedorthist, orthotist, or prosthetist must fit and provide the shoes to the beneficiary.

Medicare helps pay for one pair of therapeutic shoes and inserts per calendar year, and the fitting of the shoes or inserts is covered in the Medicare payment for the shoes.

Insulin Pumps and the Insulin Used in the Pumps

Insulin pumps worn outside the body (external), including the insulin used with the pump, may be covered for some people with Medicare Part B who have diabetes and who meet certain conditions. If a beneficiary needs to use an insulin pump, their doctor will need to prescribe it. In the Original Medicare Plan, the beneficiary pays 20 percent of the Medicare-approved amount after the yearly Part B deductible. Medicare will pay 80 percent of the cost of the insulin pump. Medicare will also pay for the insulin that is used with the insulin pump.

Medicare Part B covers the cost of insulin pumps and the insulin used in the pumps. Recently, the DME MACs learned of an issue with pharmacies billing Medicare Part D for insulin used in a Durable Medical Equipment (DME) external insulin infusion pump. To assist the pharmacist in billing the correct payer for the insulin, the DME MACs recommend that providers specifically state “Insulin for Insulin Pump” (or similar language indicating the method of administration) on your orders. This will help ensure that the pharmacy bills the correct payer and avoid unnecessary claim denials for your patients.

However, if the beneficiary injects their insulin with a needle (syringe), Medicare Part B does not cover the cost of the insulin, but the Medicare prescription drug benefit (Part D) covers the insulin and the supplies necessary to inject it. This includes syringes, needles, alcohol swabs and gauze. The Medicare Part D plan will cover the insulin and any other medications to treat diabetes at home as long as the beneficiary is on the Medicare Part D plan’s formulary.

Coverage for diabetes-related durable medical equipment (DME) is provided as a Medicare Part B benefit. The Medicare Part B deductible and coinsurance or copayment applies after the yearly Medicare part B deductible is met. In the Original Medicare Plan, Medicare covers 80 percent of the Medicare-
approved amount (after the beneficiary meets their annual Medicare Part B deductible of $183 in 2018), and the beneficiary pays 20 percent of the total payment amount (after the annual Part B deductible of $183 in 2018). This amount can be higher if the beneficiary’s doctor does not accept assignment, and the beneficiary may have to pay the entire amount at the time of service. Medicare will then send the beneficiary its share of the charge.

Medicare Part D Covered Diabetic Supplies and Medications

This section provides information about Medicare prescription drug coverage (Part D) for beneficiaries with Medicare who have or are at risk for diabetes. If a beneficiary wants Medicare prescription drug coverage, they must join a Medicare drug plan. The following diabetic medications and supplies are covered under Medicare drug plans:

- Diabetes supplies
- Insulin
- Anti-diabetic drugs

Diabetes Supplies

Diabetes supplies associated with the administration of insulin may be covered for all people with Medicare Part D who have diabetes. These medical supplies include the following:

- Syringes
- Needles
- Alcohol swabs
- Gauze
- Inhaled insulin devices

Insulin

Injectable insulin not associated with the use of an insulin infusion pump is covered under Medicare Part D drug plans.

Anti-diabetic Drugs

Medicare drug plans can cover anti-diabetic drugs such as:

- Sulfonylureas (such as Glipizide, Glyburide)
- Biguanides (such as metformin)
- Thiazolidinediones (such as Starlix® and Prandin®)
- Alpha glucosidase inhibitors (such as Precose®).

Supplies and Services Not Covered by Medicare

The Original Medicare Plan and Medicare drug plans (Part D) don’t cover everything. Diabetes supplies and services not covered by Medicare include:

- Eye exams for glasses (eye refraction)
- Orthopedic shoes
- Weight loss programs.

ADDITIONAL INFORMATION

The Centers for Medicare & Medicaid Services (CMS) has developed a variety of educational resources for use by health care professionals and their staff as part of a broad outreach campaign to promote awareness and increase utilization of preventive services covered by Medicare. For more information about coverage, coding, billing, and reimbursement of Medicare-covered preventive services and screenings, visit [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/index.html](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/index.html).
Medicare Learning Network - The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information visit the Medicare Learning Network’s web page at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html.

Patient Resources - For literature to share with Medicare patients, please visit http://www.medicare.gov.

The National Diabetes Education Program - NDEP (http://ndep.nih.gov/) provides a wealth of resources for health care professionals, educators, business professionals, and patients about diabetes, its complications, and self-management.


DOCUMENT HISTORY

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
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<tbody>
<tr>
<td>August 16, 2018</td>
<td>Initial article released.</td>
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</table>
This article was revised on September 13, 2018, to advise providers that the public health emergency (PHE) declaration and Section 1135 waiver authority for the U.S. Virgin Islands were renewed again on September 11, 2018. All other information is unchanged.

**PROVIDER TYPE AFFECTED**

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

**PROVIDER INFORMATION AVAILABLE**

On September 18, 2017, pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act, President Trump declared that, as a result of the effects of Hurricane Maria, an emergency exists in the United States Virgin Islands and the Commonwealth of Puerto Rico. Also on September 19, 2017, Secretary Price of the Department of Health & Human Services declared that a public health emergency (PHE) exists in the United States Virgin Islands and the Commonwealth of Puerto Rico and authorized waivers and modifications under Section 1135 of the Social Security Act (the Act), retroactive to September 16, 2017, for the United States Virgin Islands and retroactive to September 17, 2017, for the Commonwealth of Puerto Rico. The PHE declaration and Section 1135 waiver authority for the U.S. Virgin Islands were renewed on December 15, 2017, renewed again on March 15, 2018, June 13, 2018, and again on September 11, 2018. The PHE and Section 1135 waiver authority for Puerto Rico were extended to March 15, 2018, and were extended again on March 16, 2018, to June 13, 2018. **The PHE and Section 1135 waiver authority for Puerto Rico expired on June 13, 2018.**

On September 19, 2017, the Administrator of the Centers for Medicare & Medicaid Services (CMS) authorized waivers under Section 1812(f) of the Social Security Act for the United States Virgin Islands and the Commonwealth of Puerto Rico, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of Hurricane Maria in 2017. Under Section 1135 or 1812(f) of the Social Security Act, the CMS has issued several blanket waivers in the impacted geographical areas of the United States Virgin Islands and the Commonwealth of Puerto Rico. These waivers will prevent gaps in access to care for beneficiaries impacted by the emergency. Providers do not need to apply for an individual waiver if a blanket waiver has been issued. Providers can request an individual Section 1135 waiver, if there is no blanket waiver, by following the instructions available at [https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Requesting-an-1135-Waiver-Updated-11-16-2016.pdf](https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Requesting-an-1135-Waiver-Updated-11-16-2016.pdf).

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

**BACKGROUND**

Section 1135 and Section 1812(f) Waivers

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

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

Answers (Q&As) posted on that webpage and also referenced below are applicable for items and services furnished to Medicare beneficiaries within the United States Virgin Islands and the Commonwealth of Puerto Rico. These Q&As are displayed in two files:

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

- Another file addresses policies and procedures that are applicable only with approved Section 1135 waivers or, when applicable, approved Section 1812(f) waivers. These Q&As are applicable for approved Section 1135 blanket waivers and approved individual 1135 waivers requested by providers and are effective September 16, 2017, for the United States Virgin Islands and September 17, 2017, for the Commonwealth of Puerto Rico.

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

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

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

Blanket Waivers Issued by CMS

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

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

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

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

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

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

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

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

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

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

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


Appeal Administrative Relief for Areas Affected by Hurricane Maria

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

Replacement Prescription Fills

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

Applicability of Reporting Requirements for Inpatient Psychiatric Facilities, Skilled Nursing Facilities, Home Health Agencies, Hospices, Inpatient Rehabilitation Facilities, Ambulatory Surgical Centers, and Renal Dialysis Facilities Affected by Hurricane Maria

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

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

Requesting an 1135 Waiver

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

ADDITIONAL INFORMATION

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

Providers may also want to review the CMS Emergency and Preparedness webpage at https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/EPRO-Home.html.


DOCUMENT HISTORY

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<tr>
<th>Date of Change</th>
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<tr>
<td>September 13, 2018</td>
<td>The article was revised on September 13, 2018, to advise providers that the PHE declaration and Section 1135 waiver authority for the U.S. Virgin Islands were renewed again on September 11, 2018. All other information is unchanged.</td>
</tr>
<tr>
<td>July 25, 2018</td>
<td>This article was revised to advise providers that the PHE declaration and Section 1135 waiver authority for the U.S. Virgin Islands were renewed again on June 13, 2018. The PHE and Section 1135 waiver authority for Puerto Rico expired on June 13, 2018.</td>
</tr>
<tr>
<td>October 2, 2017</td>
<td>The article was updated to include the section on Applicability of Reporting Requirements for Inpatient Psychiatric Facilities, Skilled Nursing Facilities, Home Health Agencies, Hospices, Inpatient Rehabilitation Facilities, Ambulatory Surgical Centers, and Renal Dialysis Facilities Affected by Hurricane Maria. All other information remains the same.</td>
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<tr>
<td>September 21, 2017</td>
<td>Initial article released.</td>
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Hurricane Florence and Medicare Disaster Related North Carolina, South Carolina, and the Commonwealth of Virginia Claims

MLN Matters Number: SE18014
Article Release Date: September 14, 2018

PROVIDER TYPES AFFECTED

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

PROVIDER INFORMATION AVAILABLE

On September 10, 2018, pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act, President Trump declared that, as a result of the effects of Hurricane Florence, an emergency exists in North Carolina and South Carolina. On September 11, 2018, President Trump declared an emergency exists in the Commonwealth of Virginia as a result of Hurricane Florence. Also, on September 11, 2018, Secretary Azar of the Department of Health & Human Services declared that a public health emergency exists in North Carolina and South Carolina and authorized waivers and modifications under Section 1135 of the Social Security Act (the Act), retroactive to September 7, 2018, for the State of North Carolina and retroactive to September 8, 2018, for the State of South Carolina. On September 12, Secretary Azar
declared a public health emergency exists in the Commonwealth of Virginia, retroactive to September 8, 2018.

On September 13, 2018, the Administrator of the Centers for Medicare & Medicaid Services (CMS) authorized waivers under Section 1812(f) of the Social Security Act for the States of North Carolina, South Carolina, and the Commonwealth of Virginia for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of Hurricane Florence in 2018.

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

The most current waiver information is available at https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page.html. See the Background section of this article for more details.

BACKGROUND

Section 1135 and Section 1812(f) Waivers

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

1. Change Request (CR) 6451 (Transmittal 1784, Publication 100-04) issued on July 31, 2009, applies to items and services furnished to Medicare beneficiaries within the State of North Carolina from September 7, 2018, and the States of South Carolina and the Commonwealth of Virginia from September 8, 2018, for the duration of the emergency. In accordance with CR6451, use of the “DR” condition code and the “CR” modifier are mandatory on claims for items and services for which Medicare payment is conditioned on the presence of a “formal waiver” including, but not necessarily limited to, waivers granted under either Section 1135 or Section 1812(f) of the Act.

2. The most current information is available at https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page.html. Medicare FFS Questions & Answers (Q&As) posted on the waivers and flexibilities page at https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Resources/Waivers-and-flexibilities.html, and also referenced below are applicable for items and services furnished to Medicare beneficiaries within the States of North Carolina, South Carolina, and the Commonwealth of Virginia. These Q&As are displayed in two files:

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

   • Another file addresses policies and procedures that are applicable only with approved Section 1135 waivers or, when applicable, approved Section 1812(f) waivers. These Q&As are applicable for approved Section 1135 blanket waivers and approved individual 1135 waivers requested by providers and are effective September 7, 2018, for North Carolina and September 8, 2018, for South Carolina and the Commonwealth of Virginia.

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

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

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

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

Skilled Nursing Facilities

- Section 1812(f): Waiver of the requirement for a 3-day prior hospitalization for coverage of a Skilled Nursing Facility (SNF) stay provides temporary emergency coverage of SNF services without a qualifying hospital stay, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of Hurricane Florence in the States of North Carolina, South Carolina, and the Commonwealth of Virginia in 2018. In addition, for certain beneficiaries who recently exhausted their SNF benefits, it authorizes renewed SNF coverage without first having to start a new benefit period (Blanket waiver for all impacted facilities).

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

Home Health Agencies

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

- To ensure the correct processing of home health disaster related claims, Medicare Administrative Contractors (MACs) are allowed to extend the auto-cancellation date of Requests for Anticipated Payment (RAPs).

Critical Access Hospitals

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

Housing Acute Care Patients In Excluded Distinct Part Units

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

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

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

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

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

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

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


Medicare Advantage Plan or other Medicare Health Plan Beneficiaries

CMS remind suppliers that Medicare beneficiaries enrolled in a Medicare Advantage or other Medicare Health Plans should contact their plan directly to find out how it replaces DMEPOS damaged or lost in an emergency or disaster. Beneficiaries who do not have their plan’s contact information can contact 1-800-MEDICARE (1-800-633-4227) for assistance.

Replacement Prescription Fills

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

Requesting an 1135 Waiver

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

ADDITIONAL INFORMATION

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

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

Providers may also want to review the CMS Emergency and Preparedness webpage at https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/EPRO-Home.html.


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<td>September 14, 2018</td>
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DMEPOS Fee Schedule – October 2018 Update

MLN Matters Number: MM10881
Related Change Request (CR) Number: 10881
Related CR Release Date: August 10, 2018
Effective Date: October 1, 2018
Related CR Transmittal Number: R4108CP
Implementation Date: October 1, 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) 10881 informs DME MACs about the changes to the DMEPOS fee schedule which is updated on a quarterly basis, when necessary, to implement fee schedule amounts for new codes and correct any fee schedule amounts for existing codes. Make sure that your billing staffs are aware of these changes.

BACKGROUND

The DMEPOS fee schedules are updated on a quarterly basis, when necessary, in order to implement fee schedule amounts for new and existing codes, as applicable, and apply changes in payment policies. The update process for the DMEPOS fee schedule is located in the Medicare Claims Processing Manual, Chapter 23, Section 60.

Payment on a fee schedule basis is required for Durable Medical Equipment (DME), prosthetic devices, orthotics, prosthetics and surgical dressings by Section 1834(a), (h), and (i) of the Social Security Act (the Act). Additionally, payment on a fee schedule basis is a regulatory requirement at 42 Code of Federal Regulations (CFR) 414.102 for Parenteral and Enteral Nutrition (PEN), 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 making adjustments to the fee schedule amount for enteral nutrients, equipment and supplies (enteral nutrition) based on information from CBPs.

The methodologies for adjusting DMEPOS fee schedule amounts under this authority are established at 42 CFR, Section 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.

October quarterly updates are only required for the DMEPOS Rural Zip code file containing the Quarter 4 2018 Rural ZIP code changes. An October update to the 2018 DMEPOS and PEN fee schedule files is not required.

The October 2018 DMEPOS Rural Zip file (PUF) will be available for State Medicaid Agencies, managed care organizations, and other interested parties shortly after the release of the data files at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html.
ADDITIONAL INFORMATION


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EDI Dial-Up Modem Support Ending October 1, 2018

Effective October 1, 2018, the Noridian Electronic Data Interchange (EDI) Department will no longer support dial-up modem technology. If using a dial-up modem, see EDI Support Services for additional information.

EDI Dial-Up Modem Support Ends October 1, 2018: Check out Available Connectivity Vendors

Effective October 1, 2018, the Noridian Electronic Data Interchange (EDI) Department will no longer support dial-up modem technology used for exchanging electronic transactions. Ensure a contract is, or will be, in place with either a Network Service Vendor (NSV) or Billing Service/Clearinghouse, to prevent claim payment disruptions.

NSVs offer services and benefits that include, but are not limited to:

- Secure internet connection to Noridian for electronic data exchange
- Access to Fiscal Intermediary Shared System (FISS)/Direct Data Entry (DDE) for Medicare Part A providers
- Access to the CMS HIPPA Eligibility Transaction System (HETS) application for eligibility inquiry and response.

For additional information on Network Service Vendors, see EDISS to End Support of Modem Technology.
Do Not Forward Initiative Reminder

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

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

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

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

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

Policy

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

Implementation Process

- “Return service requested” envelopes are used for all hardcopy remittance advices starting October 1, 2002. These envelopes will be used for all providers.
- “Return service requested” envelopes will not be used for beneficiary correspondence, such as Medicare Summary Notices (MSNs) or for overpayment demand letters.
- When the post office returns a remittance advice due to an incorrect address, A/B MACs/carriers will follow the same procedures as followed for returned checks, that is:
  - Flag the provider’s file DNF.
  - A/B MAC/carrier staff will notify provider enrollment team.
  - A/B MAC/carriers will cease generating any further payments or remittance advice to that provider or supplier until furnished with a new, verified address.
  - When the provider establishes a new, verified address, A/B MACs/carriers will remove the DNF flag and pay the provider any funds which are still being held due to a DNF flag. A/B MAC/carriers must also reissue any remittance advices, which have been held.
  - Previously, CMS only required corrections to the “pay to” address. However, with the implementation of this initiative, CMS requires corrections to all addresses before the contractor can remove the DNF flag and begin paying the provider or supplier again. Therefore, A/B MAC/carriers cannot release any payments to DNF providers until the provider enrollment department has verified and updated all addresses for that provider’s location.

IRS-1099 Reporting

Provider or supplier checks returned and voided during the same year they were issued are not reported on the Internal Revenue Service (IRS) Form 1099 until the returned check is reissued (i.e., the DNF flag is removed and the A/B MAC/carrier reissues payment to the provider.) Checks returned and voided in the current year that were issued in prior years are not netted from the current year’s IRS Form 1099.
Monies withheld because a DNF flag exists on a provider or supplier record are not reported on IRS-1099s until the calendar year in which payment is made (i.e., the point at which the A/B MAC/carrier pays the provider once the DNF flag is removed.) If DNF amounts are erroneously included on IRS-1099 forms, A/B MACs/carriers will issue corrected IRS Form 1099s to affected providers.

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

Undersea and Hyperbaric Medicine Physician Specialty Code

MLN Matters Number: MM10666
Related Change Request (CR) Number: 10666
Related CR Release Date: July 13, 2018
Effective Date: January 1, 2019
Related CR Transmittal Number: R4087CP, R306FM
Implementation Date: January 7, 2019

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) 10666 informs you that the Centers for Medicare & Medicaid Services (CMS) has established a new Physician Specialty code for Undersea and Hyperbaric Medicine. This new code is D4. Make sure 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 via the 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. Specialty codes are used by CMS for programmatic and claims processing purposes.

The CMS-855I and CMS-855O paper applications will be updated to reflect the new physician specialty in the future. In the interim, providers shall select the ‘Undefined physician type’ option on the enrollment application and specify Undersea and Hyperbaric Medicine in the space provided.

Existing enrolled providers who want to update their specialty to reflect the new specialty must submit a change of information application to their Medicare Administrative Contractor (MAC). Providers may submit an enrollment application to initially enroll or update their specialty within 60 days of the implementation date of the new specialty.

MACs will recognize Undersea and Hyperbaric Medicine (D4) as a valid specialty type for the following edits:

- Ordering/Referring
- Critical Access Hospital (CAH) Method II Attending and Rendering
- Attending, operating, or other physician or non-physician practitioner listed on a CAH claim

ADDITIONAL INFORMATION

DOCUMENT HISTORY

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
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<tbody>
<tr>
<td>July 13, 2018</td>
<td>Initial article released.</td>
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Provider Enrollment Requirements for Writing Prescriptions for Medicare Part D Drugs – Rescinded

MLN Matters® Number: SE1434 Rescinded
Revised Article Release Date: August 2, 2018
This article was rescinded on August 2, 2018.

Chapter 15, Pub. 100-08, Certification Statement Policies Update – Revised

MLN Matters Number: MM10845 Revised
Related Change Request (CR) Number: 10845
Related CR Release Date: September 5, 2018
Effective Date: October 1, 2018
Related CR Transmittal Number: R824PI
Implementation Date: October 1, 2018

This article was revised on September 5, 2018, to reflect a revised CR10845 issued the same day. The revised CR did not change any substantive information in the article. Within the article, there is a revised transmittal number, CR release date, and Web address for accessing the CR. All other information remains the same.

PROVIDER TYPE AFFECTED

This MLN Matters® Article is intended for physicians and providers, including Home Health Agencies (HHAs), submitting certain Internet-based applications to Medicare Administrative Contractors (MACs) via the Provider Enrollment Chain and Ownership System (PECOS).

PROVIDER ACTION NEEDED

Change Request (CR) 10845 makes modifications to certain provider enrollment certification statement policies. Specifically, you may upload provider enrollment certification statements using PECOS functionality.

CR10845 and the accompanying revised portion of the manual requires your MACs to:

- Accept all handwritten signatures for paper forms CMS-855, CMS-20134, CMS-460 and CMS-588 application submissions
- Accept e-signed or uploaded signatures for web-based application submissions. MACs will no longer accept paper certification statements for web-based application submissions (CMS-855 and CMS-20134 only) via mail. If the provider chooses to submit its certification statement via paper rather than through e-signature, it shall do so via PECOS upload functionality
- Not accept stamped signatures
- Accept uploaded, faxed and emailed paper certification statements in response to a development request.
- Begin processing ALL applications upon receipt and shall develop for missing certification statements and all other missing information, including application fee, upon review
• Consider the web-based application date of receipt as the date of the web-based application submission
Note: There is no legislative or regulatory impact associated with CR10845.

ADDITIONAL INFORMATION

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<td>The article was revised to reflect a revised CR10845 issued the same day. The revised CR did not change any substantive information in the article. Within the article, there is a revised transmittal number, CR release date, and Web address for accessing the CR. All other information remains the same.</td>
</tr>
<tr>
<td>August 24, 2018</td>
<td>Initial article released.</td>
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</table>
**Epoetin Alfa Biosimilar, Retacrit for ESRD and AKI Claims to Implement System Changes**

**MLN Matters Number: MM10839**
**Related Change Request (CR) Number: 10839**
**Related CR Release Date: August 3, 2018**
**Effective Date: January 1, 2019**
**Related CR Transmittal Number: R245BP and R4105CP**
**Implementation Date: January 7, 2019**

**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) 10839 updates the list of supplies, drugs, and labs included in the End Stage Renal Disease (ESRD) consolidated billing list and therefore included in the base rate payment for Acute Kidney Injury (AKI). This includes erythropoietin stimulating agents billed with the ESRD-specific Healthcare Common Procedure Coding System (HCPCS) or the non-ESRD specific HCPCS.

CR10839 adds Q5106 (Injection, epoetin alfa, biosimilar, (Retacrit) (for non-esrd use), 1000 units) to the list established in CR9987. Claims that include Q5106 with dates of service between July 1, 2018, and December 31, 2018 will need to be reprocessed. Make sure 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 Acute Kidney Injury (AKI), effective January 1, 2017.

CRs9598 (see https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm9598.pdf) and 9814 (see https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm9814.pdf) implemented the initial requirements for this legislation.

MACs will not separately pay HCPCS code Q5106 (not found on the consolidated billing list) for AKI claims for Dates of Service (DOS) on or after July 1, 2018.

AKI claims are on Type of Bill 72X, submitted with condition code 84, CPT code G0491 and one of the following ICD-10 diagnosis codes:

- N17.0 Acute kidney failure with tubular necrosis
- N17.1 Acute kidney failure with 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

Note: Line should be indicated as covered and lines billed with modifier AY will not receive separate payment.

MACs will mass adjust AKI claims where HCPCS code Q5106 is present for DOS on or after July 1, 2018.
through December 31, 2018. Mass adjustment should be completed within 90 days of the implementation date of CR10839.

ADDITIONAL INFORMATION


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<tr>
<td>August 3, 2018</td>
<td>Initial article released.</td>
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</table>
IPF PPS Updates for FY 2019
MLN Matters Number: MM10880
Related Change Request (CR) Number: 10880
Related CR Release Date: August 3, 2018
Effective Date: October 1, 2018
Related CR Transmittal Number: R4104CP
Implementation Date: October 1, 2018

PROVIDER TYPES AFFECTED
This MLN Matters Article is intended for Inpatient Psychiatric Facilities (IPFs) billing Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED
Change Request (CR) 10880 identifies required changes as part of the annual IPF PPS update established in the Medicare Program; FY 2019 Inpatient Psychiatric Facilities Prospective Payment System and Quality Reporting Updates for Fiscal Year Beginning October 1, 2018 (FY 2019) Final Rule. These changes are applicable to discharges occurring from October 1, 2018 through September 30, 2019 (FY 2019), and they relate to Chapter 3, Section 190.49 of the Medicare Claims Processing Manual. This update includes technical corrections and updates to various parts of Section 190 from prior rulemaking. Please make sure your billing staffs are aware of these updates.

BACKGROUND
On November 15, 2004, the Centers for Medicare & Medicaid Services (CMS) published in the Federal Register a final rule that established the IPF PPS under the Medicare program in accordance with provisions of Section 124 of Public Law 106-113, the Medicare, Medicaid, and State Children’s Health Insurance Program (CHIP) Balanced Budget Refinement Act of 1999 (BBRA).

Payments to IPFs under the IPF PPS are based on a Federal per-diem base rate, which includes both inpatient operating and capital-related costs (including routine and ancillary services), but excludes certain pass-through costs (that is, bad debts and graduate medical education). CMS is required to make updates to this IPF PPS annually.

Market Basket Update:
For FY 2019, CMS is using the 2012-based IPF market basket to update the IPF PPS payment rates (that is, the Federal per-diem base rate and Electroconvulsive Therapy (ECT) payment per treatment). The 2012-based IPF market basket update for FY 2019 is 2.9 percent. However, this 2.9 percent is subject to two reductions required by the Social Security Act (the Act).

- Section 1886(s)(2)(A)(ii) of the Act requires the application of an "other adjustment" that reduces any update to the IPF market basket update by percentages specified in Section 1886(s)(3) of the Act for Rate Year (RY) beginning in 2010 through the RY beginning in 2019. For the FY beginning in 2018 (that is, FY 2019), Section 1886(s)(3)(E) of the Act requires the reduction to be 0.75 percentage points. CMS implemented that provision in the FY 2019 IPF PPS and Quality Reporting Updates Final Rule.

- Section 1886(s)(2)(A)(i) of the Act requires the application of the "productivity adjustment" described in Section 1886(b)(3)(B)(xi)(II) of the Act to the IPF PPS for the RY beginning in 2012 (that is, the RY that coincides with a FY), and each subsequent RY. For the FY beginning in 2018 (that is, FY 2019), the reduction is 0.8 percent. CMS implemented that provision in the FY 2019 IPF PPS and Quality Reporting Updates Final Rule.

Therefore, CMS updates the IPF PPS base rate for FY 2019 by applying the adjusted market basket update of 1.35 percent (which includes the 2012-based IPF market basket update of 2.9 percent, the 0.75 percentage point reduction to the market basket update required by the Affordable Care Act, and a required productivity adjustment reduction of 0.8 percent), and the wage index budget neutrality factor of 1.0013 to the FY 2018 Federal per-diem base rate of $771.35, yielding a FY 2019 Federal per-diem base rate of $782.78.
Similarly, applying the adjusted market basket update of 1.35 percent and the wage index budget neutrality factor of 1.0013 to the FY 2018 Electroconvulsive Therapy (ECT) payment per treatment of $332.08 yields an ECT payment per treatment of $337.00 for FY 2019.

**IPF Quality Reporting Program (IPFQR)**

Section 1886(s)(4) of the Act requires the establishment of a quality data-reporting program for the IPF PPS beginning in FY 2014. CMS finalized initial requirements for quality reporting for IPFs in the Hospital Inpatient Prospective Payment System for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System and Fiscal Year 2013 Rates, Final Rule (August 31, 2012) (77 FR 53258, 53644 through 53360).

Section 1886(s)(4)(A)(i) of the Act requires that, for FY 2014 and each subsequent FY, the Secretary shall reduce any annual update to a standard Federal rate for discharges occurring during the FY by 2 percentage points for any IPF that does not comply with the quality data submission requirements with respect to an applicable year. Therefore, a 2-percentage-point reduction is applied when calculating the Federal per-diem base rate and the ECT payment per treatment:

- For IPFs that failed to submit quality reporting data under the IPFQR program, for FY 2019, CMS applied a -0.65 percent payment rate update (a negative update that reflects the IPF market basket increase for FY 2019 of 2.9 percent, less the productivity adjustment of 0.8 percentage point, reduced by the Affordable Care Act required 0.75 percent point, and further reduced by 2 percentage points in accordance with section 1886(s)(4)(A)(ii) of the Act and the wage index budget neutrality factor of 1.0013 to the FY 2018 Federal per diem base rate of $771.35, yielding a FY 2019 Federal per diem base rate of $767.33.

- Similarly, for FY 2019, CMS applied a -0.65 percent payment rate update to the FY 2018 ECT payment per treatment of $332.08, yielding a FY 2019 ECT payment per treatment of $330.35.

**PRICER Updates: IPF PPS FY 2019 (October 1, 2018 - September 30, 2019)**

- The Federal per-diem base rate is $782.78 for IPFs that complied with quality data submission requirements.

- The Federal per-diem base rate is $767.33, when applying the 2-percentage-point reduction, for IPFs that failed to comply with quality data submission requirements.

- The fixed dollar loss threshold amount is $12,865.

- The IPF PPS wage index is based on the FY 2018 pre-floor, pre-reclassified acute care hospital wage index.

- The labor-related share is 74.8 percent.

- The non-labor-related share is 25.2 percent.

- The ECT payment per treatment is $337.00 for IPFs that complied with quality data submission requirements.

- The ECT payment per treatment is $330.35 when applying the 2-percentage-point reduction for IPFs that failed to comply with quality data submission requirements.

**Provider-Specific File (PSF) Updates**

The FY 2019 IPF PPS wage index uses the most recent Office of Management and Budget (OMB) statistical area delineations to identify a facility’s urban or rural status for the purpose of determining if a rural adjustment will apply to the facility. There were no changes made to the OMB designations in the FY 2019 IPF PPS wage index. For FY 2019, no IPFs should have any special pay indicators or receive any wage index value other than those given in the FY 2019 IPF PPS wage index.

**The National Urban and Rural Cost to Charge Ratios for the IPF PPS FY 2019**

CMS is applying the national Cost-to-Charge Ratios to the following situations:

- New IPFs that have not yet submitted their first Medicare cost report. For new facilities, CMS is using these national ratios until the facility’s actual CCR can be computed using the first tentatively settled or final settled cost report, which will then be used for the subsequent cost report period.
The IPFs whose operating or capital CCR is in excess of 3 standard deviations above the corresponding national geometric mean (that is, above the ceiling).

- Other IPFs for whom the fiscal intermediary obtains inaccurate or incomplete data with which to calculate either an operating or capital CCR or both.

The CCRs are:

- **National Median CCRs**
  - Rural - 0.5890
  - Urban - 0.4365

- **National Ceiling CCRs**
  - Rural - 2.0068
  - Urban - 1.6862

The Cost of Living Adjustments (COLAs) factor for IPF PPS Fiscal Year 2019 for Alaska and Hawaii is 1.25, except for the County of Hawaii, for which the factor is 1.21.

**ICD-10 CM/PCS Updates**

For FY 2019, the IPF PPS adjustment factors are unchanged from those used in FY 2018. However, CMS updated the ICD-10-CM/PCS code set, effective October 1, 2018. These updates affect the ICD-10-CM/PCS codes that underlie the IPF PPS MS-DRGs and the IPF PPS comorbidity categories. The updated FY 2019 MS-DRG code lists are available on the IPPS website at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html), and the updated FY 2019 IPF PPS comorbidity categories are available at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/tools.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/tools.html).

There were no changes from FY 2018 to FY 2019 to the IPF Code First list or the IPF ECT procedure code list.

**FY 2019 IPF PPS Wage Index**

The FY 2019 final IPF PPS wage index is available at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/WageIndex.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/WageIndex.html).

**Rural Adjustment**

For FY 2019, IPFs designated as “rural” continue to receive a 17-percent rural adjustment.

**ADDITIONAL INFORMATION**


**DOCUMENT HISTORY**

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<tbody>
<tr>
<td>August 3, 2018</td>
<td>Initial article released.</td>
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IRF Annual Update: PPS Pricer Changes for FY 2019

MLN Matters Number: MM10826
Related Change Request (CR) Number: 10826
Related CR Release Date: August 3, 2018
Effective Date: October 1, 2018
Related CR Transmittal Number: R4101CP
Implementation Date: October 1, 2018

PROVIDER TYPE AFFECTED

This MLN Matters Article is intended for Inpatient Rehabilitation Facilities (IRFs) billing Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

WHAT YOU NEED TO KNOW

Change Request (CR) 10826 notifies MACs that a new IRF PRICER software package will be released prior to October 1, 2018, that will contain the updated rates that are effective for claims with discharges that fall within October 1, 2018, through September 30, 2019. MACs will install and pay IRF claims with the FY 2019 IRF Prospective Payment System (PPS) PRICER for discharges on or after October 1, 2018. Be sure your billing staffs are aware of these changes.

BACKGROUND

On August 7, 2001, the Centers for Medicare & Medicaid Services (CMS) published in the Federal Register a final rule that established the PPS for IRFs, as authorized under Section 1886(j) of the Social Security Act (the Act). In that final rule, CMS set forth per discharge Federal rates for Federal fiscal year (FY) 2002. These IRF PPS payment rates became effective for cost reporting periods beginning on or after January 1, 2002. Annual updates to the IRF PPS rates are required by Section1886(j)(3)(C) of the Act.

KEY POINTS FOR FY 2019 IRF PPS

The FY 2019 IRF PPS Final Rule sets forth the prospective payment rates applicable for IRFs for FY 2019. The PRICER updates for FY2019 are in the following table.

<table>
<thead>
<tr>
<th>Pricer Update</th>
<th>Amount</th>
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<tbody>
<tr>
<td>Standard Federal Rate</td>
<td>$16,021</td>
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<tr>
<td>Adjusted Standard Federal Rate</td>
<td>$15,705</td>
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<tr>
<td>Fixed Loss Amount</td>
<td>$9,402</td>
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<tr>
<td>Labor-related Share</td>
<td>0.705</td>
</tr>
<tr>
<td>Non-labor Related Share</td>
<td>0.295</td>
</tr>
<tr>
<td>Urban National Average Cost to Charge Ratio (CCR)</td>
<td>0.412</td>
</tr>
<tr>
<td>Rural National Average CCR</td>
<td>0.515</td>
</tr>
<tr>
<td>Low Income Patient (LIP) Adjustment</td>
<td>0.3177</td>
</tr>
<tr>
<td>Teaching Adjustment</td>
<td>1.0163</td>
</tr>
<tr>
<td>Rural Adjustment</td>
<td>1.149</td>
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</table>

Section 1886(j)(7)(A)(ii) of the Act requires application of a 2 percentage point reduction of the applicable market basket increase factor for IRFs that fail to comply with the quality data submission requirements. The mandated reduction will be applied in FY 2019 for IRFs that failed to comply with the data submission requirements during the data collection period January 1, 2017 through December 31, 2017. Thus, in compliance with 1886(j)(7)(A)(ii) of the Act, CMS will apply a 2 percentage point reduction to the applicable FY 2019 market basket increase factor (1.35 percent) in calculating an adjusted FY 2019 standard payment conversion factor to apply to payments for only those IRFs that failed to comply with the data submission requirements.
Application of the 2 percentage point reduction may result in an update that is less than 0.0 for a fiscal year and in payment rates for a fiscal year being less than such payment rates for the preceding fiscal year. Also, reporting-based reductions to the market basket increase factor will not be cumulative; they will only apply for the FY involved.

The adjusted FY 2019 standard payment conversion factor that will be used to compute IRF PPS payment rates for any IRF that failed to meet the quality reporting requirements for the period from January 1, 2017 through December 31, 2017 will be $15,705.

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</table>
Laboratory NCD Edit Software Changes for October 2018

MLN Matters Number: MM10873
Related Change Request (CR) Number: 10873
Related CR Release Date: July 20, 2018
Effective Date: October 1, 2018
Related CR Transmittal Number: R4092CP
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 provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED
This article is based on Change Request (CR) 10873 which informs MACs about the changes that will be included in the October 2018 quarterly release of the edit module for clinical diagnostic laboratory services. Make sure that your billing staffs are aware of these changes.

BACKGROUND
CR 10873 announces the changes that will be included in the October 2018 quarterly release of the edit module for clinical diagnostic laboratory services. The National Coverage Determinations (NCDs) for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee, and the final rule was published on November 23, 2001. Nationally uniform software was developed and incorporated in the Medicare shared systems so that laboratory claims subject to one of the 23 NCDs (Publication 100-03, Sections 190.12 - 190.34) were processed uniformly throughout the nation, effective April 1, 2003.

In accordance with Chapter 16, Section 120.2, Publication 100-04, the laboratory edit module is updated quarterly as necessary to reflect ministerial coding updates and substantive changes to the NCDs developed through the NCD process. The changes are a result of coding analysis decisions developed under the procedures for maintenance of codes in the negotiated NCDs and biannual updates of the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes.

CR 10873 communicates requirements to Shared System Maintainers (SSMs) and contractors, notifying them of changes to the laboratory edit module to update it for changes in laboratory NCD code lists for October 2018. Please access the link below for the NCD spreadsheet of changes included with CR 10873: https://www.cms.gov/Medicare/Coverage/DeterminationProcess/downloads/October2018.zip.

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

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<td>July 20, 2018</td>
<td>Initial article released.</td>
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Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment Update

MLN Matters Number: MM10875
Related Change Request (CR) Number: 10875
Related CR Release Date: July 20, 2018
Effective Date: October 1, 2018
Related CR Transmittal Number: R4090CP
Implementation Date: October 1, 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) 10875 provides instructions for the quarterly update to the Clinical Laboratory Fee Schedule (CLFS). These updates apply to Chapter 16, Section 20 of the Medicare Claims Processing Manual. Please make sure your billing staffs are aware of these updates.

BACKGROUND
Effective January 1, 2018, CLFS rates will be based on weighted median private payer rates as required by the Protecting Access to Medicare Act (PAMA) of 2014. For more details, the PAMA regulations are available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/PAMA-Regulations.html.

Note: Part B deductible and coinsurance do not apply for services paid under the CLFS.

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

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 Healthcare Common Procedure Coding System (HCPCS) Pricing Indicator Code – 22: Price established by A/B MACs Part B (for example, gap-fills, A/B MACs Part B established panels) instead of Pricing Indicator – 21: Price Subject to National Limitation Amount. (Code, Long Descriptor, Short Descriptor, Effective Date, Type of Service (TOS)).

These new codes are effective July 1, 2018
• 0045U TOS 5; Short Descriptor—ONC BRST DUX CARC IS 12 GENE; Long Descriptor—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
• 0046U TOS 5; Short Descriptor—FLT3 GENE ITD VARIANTS QUAN; Long Descriptor—FLT3 (fms-related tyrosine kinase 3) (e.g., acute myeloid leukemia) internal tandem duplication (ITD) variants, quantitative
• 0047U TOS 5; Short Descriptor—ONC PRST8 MRNA 17 GENE ALG; Long Descriptor—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

• 0048U TOS 5; Short Descriptor—ONC SLD ORG NEO DNA 468 GENE; Long Descriptor—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)

• 0049U TOS 5; Short Descriptor—NPM1 GENE ANALYSIS QUAN; Long Descriptor—NPM1 (nucleophosmin) (e.g., acute myeloid leukemia) gene analysis, quantitative

• 0050U TOS 5; Short Descriptor—TRGT GEN SEQ DNA 194 GENES; Long Descriptor—Targeted genomic sequence analysis panel, acute myelogenous leukemia, DNA analysis, 194 genes, interrogation for sequence variants, copy number variants or rearrangements

• 0051U TOS 5; Short Descriptor—RX MNTR LC-MS/MS UR 31 PNL; Long Descriptor—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

• 0052U TOS 5; Short Descriptor—LPOPRTN BLD W/5 MAJ CLASSES; Long Descriptor—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

• 0053U TOS 5; Short Descriptor—ONC PRST8 CA FISH ALYS 4 GEN; Long Descriptor—Oncology (prostate cancer), FISH analysis of 4 genes (ASAP1, HDAC9, CHD1 and PTEN), needle biopsy specimen, algorithm reported as probability of higher tumor grade

• 0054U TOS 5; Short Descriptor—RX MNTR 14+ DRUGS & SBSTS; Long Descriptor—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

• 0055U TOS 5; Short Descriptor—CARD HRT TRNSPL 96 DNA SEQ; Long Descriptor—Cardiology (heart transplant), cell-free DNA, PCR assay of 96 DNA target sequences (94 single nucleotide polymorphism targets and two control targets), plasma

• 0056U TOS 5; Short Descriptor—HEM AML DNA GENE REARGMT; Long Descriptor—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)

• 0057U TOS 5; Short Descriptor—ONC SLD ORG NEO MRNA 51 GENE; Long Descriptor—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

• 0058U TOS 5; Short Descriptor—ONC MERKEL CLL CARC SRM QUAN; Long Descriptor—Oncology (Merkel cell carcinoma), detection of antibodies to the Merkel cell polyoma virus oncoprotein (small T antigen), serum, quantitative

• 0059U TOS 5; Short Descriptor—ONC MERKEL CLL CARC SRM +/-; Long Descriptor—Oncology (Merkel cell carcinoma), detection of antibodies to the Merkel cell polyoma virus capsid protein (VP1), serum, reported as positive or negative

• 0060U TOS 5; Short Descriptor—TWN ZYG GEN SEQ ALYS CHRMS2; Long Descriptor—Twin zygosity, genomic targeted sequence analysis of chromosome 2, using circulating cell-free fetal DNA in maternal blood

• 0061U TOS 5; Short Descriptor—TC MEAS 5 BMRK SFDI M-S ALYS; Long Descriptor—Transcutaneous measurement of five biomarkers (tissue oxygenation [StO2], oxyhemoglobin [ctHbO2], deoxyhemoglobin [ctHbR], papillary and reticular dermal hemoglobin concentrations [ctHb1 and ctHb2]), using spatial frequency domain imaging)
This following existing code are revised, effective July 1, 2018:

- 0006U TOS 5; Short Descriptor—DETC IA MEDS 120+ ANALYTES; Long Descriptor—Detection of interacting medications, substances, supplements and foods, 120 or more analytes, definitive chromatography with mass spectrometry, urine, description and severity of each interaction identified per date of service

This following existing code is approved as an Advanced Diagnostic Laboratory Test (ADLT) and was added to the CLFS effective July 1, 2018:

- 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

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

ADDITIONAL INFORMATION


DOCUMENT HISTORY

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 20, 2018</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>
New Medicare Card - Progress Updates

The CMS continues to successfully mail newly-designed Medicare cards with the new Medicare Number and we’re excited to share important progress updates with you.

As of August 31, we’ve mailed nearly 35 million cards and continue to mail more every day. We’re processing claims and eligibility requests with the Medicare Beneficiary Identifier (MBI), showing that providers are successfully using the new number.

We started mailing new cards to people with Medicare who live in Wave 6 states this week and finished mailing cards to people who live in Waves 1, 2, 3 and 4 states. Because card mailing is progressing so well, we updated the mailing schedule to include an approximate start date for the last wave and we’re on track to finish mailing new cards to all people with Medicare before April 2019.

With our ongoing focus on fraud and protecting the identities of people with Medicare, we’re continuously adjusting and improving our mailing strategy to make sure we’re mailing new cards to accurate addresses and using the highest levels of fraud protection throughout the mailing. To do this, we’re:

- Using trusted industry tools and standards to verify addresses.
- Comparing each address against multiple information sources to ensure we’re mailing to the right person and the right address.
- Mailing cards to people with Medicare when we have high confidence in their identity and address.

If someone with Medicare says they didn’t get a card after their mailing wave ends, you should instruct them to:

- Call 1-800-MEDICARE (1-800-633-4227) where we can verify their identity, check their address and help them get their new card.
- Continue to use their current card to get health care services until they get their new card.

People with Medicare should continue to protect their new number to prevent medical identity theft and healthcare fraud. We’ll continue to raise awareness about potential scams and how they can prevent fraud through our outreach and launched a national fraud prevention campaign in September before Medicare Open Enrollment.

Source
- CMSLISTS Email Update dated September 19, 2018

MBI – Get It, Use It – Second Revision

MLN Matters Number: SE18006 Revised
Article Release Date: July 11, 2018

This article was revised on July 11, 2018, to provide additional information regarding the format of the MBI not using letters S, L, O, I, B, and Z (page 2). 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 mailing wave, give them the “Still Waiting for Your New Card?” handout (in English or Spanish) or 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. If the tool indicates the card hasn’t 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). 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 MBI uses numbers 0-9 and all uppercase letters except for S, L, O, I, B, and Z. We exclude these letters to avoid confusion when differentiating some letters and numbers (e.g., between “0” and “O”).

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 because they’re railroad retirees. 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 (276 transactions) 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

The MBI format specifications, which provide more details on the construct of the MBI, are available at https://www.cms.gov/Medicare/New-Medicare-Card/Understanding-the-MBI.pdf.


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<td>July 11, 2018</td>
<td>This article was revised to provide additional information regarding the format of the MBI not using letters S, L, O, I, B, and Z (page 2).</td>
</tr>
<tr>
<td>June 25, 2018</td>
<td>This article was revised to provide additional information regarding the ways your staff can get MBIs (page 1).</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.</td>
</tr>
<tr>
<td>May 25, 2018</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>
Antiarrhythmic Drug Initiation Coverage Article Retirement - Effective August 9, 2018

The following JF Local Coverage Article (LCA) 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:** A52934  
**Article Title:** Antiarrhythmic Drug Initiation  
**Effective Date:** August 9, 2018  
**Summary:** This coverage articles is retired due to lack of evidence of current problems. The Noridian guidance in the retired article may still be helpful in assessing medical necessity. Where providers have adjusted their billing and coding practices to correspond to the guidance in a coverage article, they will want to be very careful in departing from these practices just because the article is retired. Provider offices remain responsible for correct performance, coding, billing, and medical necessity under Medicare. This responsibility for correct claims submission is unchanged whether or not there is a coverage article in place.

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

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

Benign Skin Lesion Removal (Excludes Actinic Keratosis, and Mohs)  
**LCD – R8**

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

**Medicare Coverage Database (MCD) Number:** L33979  
**LCD Title:** Benign Skin Lesion Removal (Excludes Actinic Keratosis, and Mohs)  
**Effective Date:** October 1, 2018  
**Summary of Changes:** This LCD has been updated to reflect effective date of ICD-10 code update to be 10/01/2018 and has been updated to include and/or remove ICD-10 codes.

**Deleted ICD-10 codes to Group II Codes**

- D22.11: Melanocytic nevi of right eyelid, including canthus  
- D22.12: Melanocytic nevi of left eyelid, including canthus  
- D23.11: Other benign neoplasm skin/ right eyelid, including canthus (Other benign neoplasm of skin of right eyelid, including canthus)  
- D23.12: Other benign neoplasm skin/ left eyelid, including canthus (Other benign neoplasm of skin of left eyelid, including canthus)

**Deleted ICD-10 codes to Group IV Codes**

- C4A.11: Merkel cell carcinoma of right eyelid, including canthus  
- C4A.12: Merkel cell carcinoma of left eyelid, including canthus  
- C44.102: Unspecified malignant neoplasm skin/ right eyelid, including canthus (Unspecified malignant neoplasm of skin of right eyelid, including canthus)
MEDICAL POLICIES

- C44.109: Unspecified malignant neoplasm skin/ left eyelid, including canthus (Unspecified malignant neoplasm of skin of left eyelid, including canthus)
- C44.112: Basal cell carcinoma skin/ right eyelid, including canthus (Basal cell carcinoma of skin of right eyelid, including canthus)
- C44.119: Basal cell carcinoma skin/ left eyelid, including canthus (Basal cell carcinoma of skin of left eyelid, including canthus)
- C44.122: Squamous cell carcinoma skin/ right eyelid, including canthus (Squamous cell carcinoma of skin of right eyelid, including canthus)
- C44.129: Squamous cell carcinoma of skin of left eyelid, including canthus
- C44.192: Other malignant neoplasm skin/ right eyelid, including canthus (Other specified malignant neoplasm of skin of right eyelid, including canthus)
- C44.199: Other malignant neoplasm skin/ left eyelid, including canthus (Other specified malignant neoplasm of skin of left eyelid, including canthus)
- D04.11: Carcinoma in situ of skin of right eyelid, including canthus
- D04.12: Carcinoma in situ of skin of left eyelid, including canthus

New ICD-10 codes to Group II Codes

D22.111: Melanocytic nevi of right upper eyelid, including canthus
D22.112: Melanocytic nevi of right lower eyelid, including canthus
D22.121: Melanocytic nevi of left upper eyelid, including canthus
D22.122: Melanocytic nevi of left lower eyelid, including canthus
D23.111: Other benign neoplasm skin/ right upper eyelid, including canthus (Other benign neoplasm of skin of right upper eyelid, including canthus)
D23.112: Other benign neoplasm skin/ right lower eyelid, including canthus (Other benign neoplasm of skin of right lower eyelid, including canthus)
D23.121: Other benign neoplasm skin/ left upper eyelid, including canthus (Other benign neoplasm of skin of left upper eyelid, including canthus)
D23.122: Other benign neoplasm skin/ left lower eyelid, including canthus (Other benign neoplasm of skin of left lower eyelid, including canthus)

New ICD-10 codes to Group IV Codes

C4A.111: Merkel cell carcinoma of right upper eyelid, including canthus (Merkel cell carcinoma of right upper eyelid, including canthus)
C4A.112: Merkel cell carcinoma of right lower eyelid, including canthus (Merkel cell carcinoma of right lower eyelid, including canthus)
C4A.121: Merkel cell carcinoma of left upper eyelid, including canthus (Merkel cell carcinoma of left upper eyelid, including canthus)
C4A.122: Merkel cell carcinoma of left lower eyelid, including canthus (Merkel cell carcinoma of left lower eyelid, including canthus)
C44.1021: Unspecified malignant neoplasm skin/ right upper eyelid, including canthus (Unspecified malignant neoplasm of skin of right upper eyelid, including canthus)
C44.1022: Unspecified malignant neoplasm skin/ right lower eyelid, including canthus (Unspecified malignant neoplasm of skin of right lower eyelid, including canthus)
C44.1091: Unspecified malignant neoplasm skin/ left upper eyelid, including canthus (Unspecified malignant neoplasm of skin of left upper eyelid, including canthus)
C44.1092: Unspecified malignant neoplasm skin/ left lower eyelid, including canthus (Unspecified malignant neoplasm of skin of left lower eyelid, including canthus)
C44.1121: Basal cell carcinoma skin/ right upper eyelid, including canthus (Basal cell carcinoma of skin of right upper eyelid, including canthus)
C44.1122: Basal cell carcinoma skin/ right lower eyelid, including canthus (Basal cell carcinoma of skin of right lower eyelid, including canthus)
C44.1191: Basal cell carcinoma skin/ left upper eyelid, including canthus (Basal cell carcinoma of skin of left upper eyelid, including canthus)
C44.1192: Basal cell carcinoma skin/ left lower eyelid, including canthus (Basal cell carcinoma of skin of left lower eyelid, including canthus)
C44.1221: Squamous cell carcinoma skin/ right upper eyelid, including canthus (Squamous cell carcinoma of skin of right upper eyelid, including canthus)
C44.1222: Squamous cell carcinoma skin/ right lower eyelid, including canthus (Squamous cell carcinoma of skin of right lower eyelid, including canthus)
C44.1291: Squamous cell carcinoma skin/ left upper eyelid, including canthus (Squamous cell carcinoma of skin of left upper eyelid, including canthus)
C44.1292: Squamous cell carcinoma skin/ left lower eyelid, including canthus (Squamous cell carcinoma of skin of left lower eyelid, including canthus)
C44.1921: Other malignant neoplasm skin/ right upper eyelid, including canthus (Other specified malignant neoplasm of skin of right upper eyelid, including canthus)
C44.1922: Other malignant neoplasm skin/ right lower eyelid, including canthus (Other specified malignant neoplasm of skin of right lower eyelid, including canthus)
C44.1991: Other malignant neoplasm skin/ left upper eyelid, including canthus (Other specified malignant neoplasm of skin of left upper eyelid, including canthus)
C44.1992: Other malignant neoplasm skin/ left lower eyelid, including canthus (Other specified malignant neoplasm of skin of left lower eyelid, including canthus)
D03.111: Melanoma in situ of right upper eyelid, including canthus
D03.112: Melanoma in situ of right lower eyelid, including canthus
D03.121: Melanoma in situ of left upper eyelid, including canthus
D03.122: Melanoma in situ of left lower eyelid, including canthus
D04.111: Ca in situ skin of right upper eyelid, including canthus (Carcinoma in situ of skin of right upper eyelid, including canthus)
D04.112: Ca in situ skin of right lower eyelid, including canthus (Carcinoma in situ of skin of right lower eyelid, including canthus)

View the locally hosted Noridian Active LCD.
- 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
**Bladder/Urothelial Tumor Markers 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:** L36680  
**LCD Title:** Bladder/Urothelial Tumor Markers  
**Effective Date:** May 16, 2018  
**Summary of Changes:** LCD revised to add ICD-10-CM codes: C7A.010, C7A.011, C7A.012, C7A.019, C7A.020, C7A.021, C7A.022, C7A.023, C7A.024, C7A.025, C7A.026, C7A.029, C7A.090, C7A.091, C7A.092, C7A.093, C7A.094, C7A.095, C7A.096, C7B.01, C7B.02, C7B.03, C7B.04 and E34.0. There is no change in the LCD coverage.

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**Blepharoplasty, Eyelid Surgery, Brow Lift 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:** L34194  
**LCD Title:** Blepharoplasty, Eyelid Surgery, Brow Lift  
**Effective Date:** October 1, 2018  
**Summary of Changes:** This LCD has been updated to include ICD-10 codes and to reflect effective date of ICD-10 code update to be 10/01/2018.  
**New ICD-10 codes to Group I Codes**  
- H57.811: Brow ptosis, right  
- H57.812: Brow ptosis, left  
- H57.813: Brow ptosis, bilateral

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- Go to Active LCD webpage  
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- Locate and select above listed LCD title
Cardiovascular Stress Testing, Including Exercise and/or Pharmacological Stress and Stress Echocardiography 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: L36889

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

Effective Date: October 1, 2018

Summary of Changes: This LCD has been updated to reflect effective date of ICD-10 code update to be 10/01/2018 and has been updated to include and/or remove ICD-10 codes.

Deleted ICD-10 codes to Group I Codes

- E78.4: Other hyperlipidemia

New ICD-10 codes to Group I Codes

- E78.89: Other lipoprotein metabolism disorders

View the locally hosted Noridian Active LCD.

- 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

Controlled Substance Monitoring and Drugs of Abuse Testing LCD – R6

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

Medicare Coverage Database (MCD) Number: L36707

LCD Title: Controlled Substance Monitoring and Drugs of Abuse Testing

Effective Date: October 1, 2018

Summary of Changes: This LCD has been updated to reflect effective date of ICD-10 code update to be 10/01/2018 and has been updated to include and/or remove ICD-10 codes.

Deleted ICD-10 codes to Group I Codes

- M79.1: Myalgia

New ICD-10 codes to Group I Codes

- F12.23: Cannabis abuse, uncomplicated
- F12.93: Cannabis use, unspecified with withdrawal
- T43.641A: Poisoning by ecstasy, accidental (unintentional), init (Poisoning by ecstasy, accidental (unintentional), initial encounter)
- T43.641D: Poisoning by ecstasy, accidental (unintentional), subs (Poisoning by ecstasy, accidental (unintentional), subsequent encounter)
- T43.641S: Poisoning by ecstasy, accidental (unintentional), sequela
- T43.642A: Poisoning by ecstasy, self-harm, initial encounter (Poisoning by ecstasy, intentional self-harm, initial encounter)
• T43.642D: Poisoning by ecstasy, self-harm, subsequent encounter (Poisoning by ecstasy, intentional self-harm, subsequent encounter)
• T43.642S: Poisoning by ecstasy, intentional self-harm, sequela
• T43.643A: Poisoning by ecstasy, assault, initial encounter
• T43.643D: Poisoning by ecstasy, assault, subsequent encounter
• T43.643S: Poisoning by ecstasy, assault, sequela
• T43.644A: Poisoning by ecstasy, undetermined, initial encounter
• T43.644D: Poisoning by ecstasy, undetermined, subsequent encounter
• T43.644S: Poisoning by ecstasy, undetermined, sequela

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**Electrocardiograms LCD – R2**

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

**Medicare Coverage Database (MCD) Number:** L37283

**LCD Title:** Electrocardiograms

**Effective Date:** October 1, 2018

**Summary of Changes:** This LCD has been updated to add, remove and revise ICD-10 codes.

• New/Revised ICD-10 codes: E78.41, E78.49, I63.81, I63.89, I67.850, I67.858, K82.A2, K83.01, T43.641A, T43.641D, T43.641S, T43.642A, T43.642D, T43.642S, T43.643A, T43.643D, T43.643S, T43.644A, T43.644D and T43.644S.
• Deleted ICD-10 codes: E78.4 and I63.8.
• Revised ICD-10 codes: I63.333 and T81.11XA, T81.11XD and T81.11XS.

View the Noridian Future LCD

• 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).
• Locate and select above listed LCD title
**Flow Cytometry LCD – R11**

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

**Medicare Coverage Database (MCD) Number:** L36094

**LCD Title:** Flow Cytometry

**Effective Date:** October 1, 2018

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

- New/Revised ICD-10 codes: C44.1121, C44.1122, C44.1191, C44.1192, C44.1221, C44.1222, C44.1291, C44.1292, C44.1921, C44.1922, C44.1991 and C44.1992.
- Deleted ICD-10 codes: C44.112, C44.119, C44.122, C44.129, C44.192 and C44.199.

View the Noridian Future LCD

- 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).
- Locate and select above listed LCD title

**Intensity Modulated Radiation Therapy LCD – R8**

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

**Medicare Coverage Database (MCD) Number:** L34080

**LCD Title:** Intensity Modulated Radiation Therapy

**Effective Date:** October 1, 2018

**Summary of Changes:** This LCD has been updated to reflect effective date of ICD-10 code update to be 10/01/2018 and has been updated to include ICD-10 codes.

**New ICD-10 codes to Group I Codes**

C43.111: Malignant melanoma of right upper eyelid, including canthus

C43.112: Malignant melanoma of right lower eyelid, including canthus

C43.121: Malignant melanoma of left upper eyelid, including canthus

C43.122: Malignant melanoma of left lower eyelid, including canthus

C4A.111: Merkel cell carcinoma of right eyelid, including canthus

C4A.112: Merkel cell carcinoma of right eyelid, including canthus

C4A.121: Merkel cell carcinoma of left upper eyelid, including canthus (Merkel cell carcinoma of left upper eyelid, including canthus)

C4A.122: Merkel cell carcinoma of left lower eyelid, including canthus (Merkel cell carcinoma of left lower eyelid, including canthus)

C4A.122: Merkel cell carcinoma of left lower eyelid, including canthus (Merkel cell carcinoma of left lower eyelid, including canthus)

C4A.122: Merkel cell carcinoma of left lower eyelid, including canthus (Merkel cell carcinoma of left lower eyelid, including canthus)

C4A.122: Merkel cell carcinoma of left lower eyelid, including canthus (Merkel cell carcinoma of left lower eyelid, including canthus)

C4A.122: Merkel cell carcinoma of left lower eyelid, including canthus (Merkel cell carcinoma of left lower eyelid, including canthus)

C4A.122: Merkel cell carcinoma of left lower eyelid, including canthus (Merkel cell carcinoma of left lower eyelid, including canthus)

C4A.122: Merkel cell carcinoma of left lower eyelid, including canthus (Merkel cell carcinoma of left lower eyelid, including canthus)
C44.1192: Basal cell carcinoma skin/ left lower eyelid, including canthus (Basal cell carcinoma of skin of left lower eyelid, including canthus)  
C44.1221: Squamous cell carcinoma skin/ r upper eyelid, including canthus (Squamous cell carcinoma of skin of right upper eyelid, including canthus)  
C44.1222: Squamous cell carcinoma skin/ right lower eyelid, including canthus (Squamous cell carcinoma of skin of right lower eyelid, including canthus)  
C44.1921: Other malignant neoplasm skin/ right upper eyelid, including canthus (Other specified malignant neoplasm of skin of right upper eyelid, including canthus)  
C44.1922: Other malignant neoplasm skin/ right lower eyelid, including canthus (Other specified malignant neoplasm of skin of right lower eyelid, including canthus)  
C44.1991: Other malignant neoplasm skin/ left upper eyelid, including canthus (Other specified malignant neoplasm of skin of left upper eyelid, including canthus)  
C44.1992: Other malignant neoplasm skin/ left lower eyelid, including canthus (Other specified malignant neoplasm of skin of left lower eyelid, including canthus)  
D03.111: Melanoma in situ of right upper eyelid, including canthus  
D03.112: Melanoma in situ of right lower eyelid, including canthus  
D03.121: Melanoma in situ of left upper eyelid, including canthus  
D03.122: Melanoma in situ of left lower eyelid, including canthus

- 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

**Intensity Modulated Radiation Therapy (IMRT) Draft LCD Retirement - Effective May 1, 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 (MCD) Number:** DL34080  
**LCD Title:** Intensity Modulated Radiation Therapy (IMRT)  
**Effective Date:** May 1, 2018

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

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

- Go to [Retired LCD webpage](#)  
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary)  
  - Select state of interest  
  - This link will redirect you to the CMS website  
  - Select “Retired LCDs” and click Submit  
  - Locate above listed CMS MCD number and LCD title and select title of interest
MEDICAL POLICIES

In Vitro Chemosensitivity & Chemoresistance Assays Final LCD - Effective October 1, 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: L37630

LCD Title: In Vitro Chemosensitivity & Chemoresistance Assays

Effective Date: October 1, 2018

Summary of LCD: To avoid ineffective chemotherapy toxicity, the intent of chemosensitivity and chemoresistance assays is to assist oncologists with the selection of chemotherapy drugs at initial diagnosis and tumor recurrence. However, review of the literature does not identify any CSRAs for which the evidence base is sufficient to support use in oncology practice. Therefore, CSRAs are considered investigational and not a covered Medicare benefit.

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

• Go to the 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.

In Vitro Chemosensitivity & Chemoresistance Assays Final LCD - Revised Effective October 8, 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: L37630

LCD Title: In Vitro Chemosensitivity & Chemoresistance Assays

Effective Date: October 8, 2018

Summary of LCD: Revised the Effective Date to 10/08/18 to match that of the Response to Comments. The Notice Period Start and End dates were also adjusted. No other changes were made.

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

• Go to the 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.
Lumbar MRI 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: L37281

LCD Title: Lumbar MRI

Effective Date: October 1, 2018

Summary of Changes: This LCD has been updated to reflect effective date of ICD-10 code update to be 10/01/2018 and has been updated to include and/or remove ICD-10 codes.

New/Revised ICD-10 codes to Group II Codes

- T81.42XA: Infection following a procedure, deep incisional surgical site, initial (Infection following a procedure, deep incisional surgical site, initial encounter)
- T81.42XD: Infection following a procedure, deep incisional surgical site, subsequent (Infection following a procedure, deep incisional surgical site, subsequent encounter)
- T81.42XS: Infection following a proc, superficial incisional surgical site, sequela (Infection following a procedure, superficial incisional surgical site, sequela)

Deleted ICD-10 codes to Group II Codes

- T81.4XXA: Infection following a procedure, initial encounter
- T81.4XXD: Infection following a procedure, subsequent encounter
- T81.4XXS: Infection following a procedure, sequela

New/Revised ICD-10 codes to Group I Codes

- C4A.111: Merkel cell carcinoma of right upper eyelid, inc canthus (Merkel cell carcinoma of right upper eyelid, including canthus)
- C4A.112: Merkel cell carcinoma of right lower eyelid, inc canthus (Merkel cell carcinoma of right lower eyelid, including canthus)
- C4A.121: Merkel cell carcinoma of left upper eyelid, inc canthus (Merkel cell carcinoma of left upper eyelid, including canthus)
- C4A.122: Merkel cell carcinoma of left lower eyelid, inc canthus (Merkel cell carcinoma of left lower eyelid, including canthus)

Deleted ICD-10 codes to Group I Codes

- C4A.11: Merkel cell carcinoma of right eyelid, including canthus
- C4A.12: Merkel cell carcinoma of left eyelid, including canthus

View the locally hosted Noridian Active LCD.

- 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
**Mohs Micrographic Surgery 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:** L36094

**LCD Title:** Mohs Micrographic Surgery

**Effective Date:** October 1, 2018

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

**New/Revised ICD-10 codes:** C43.111, C43.112, C43.121, C43.122, C4A.111, C4A.112, C4A.121, C4A.122, C44.1121, C44.1122, C44.1191, C44.1192, C44.1221, C44.1222, C44.1291, C44.1292, C44.1921, C44.1922, C44.1991, C44.1992, D03.111, D03.112, D03.121, D03.122, D04.111, D04.112, D04.121 and D04.122.

**Deleted ICD-10 codes:** C43.11, C43.12, C4A.11, C4A.12, C44.112, C44.119, C44.122, C44.129, C44.192, C44.199, D03.11, D03.12, D04.11 and D04.12.

View the Noridian Future LCD

- 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).
  - Locate and select above listed LCD title

**MolDX: Breast Cancer IndexTM (BCI) Gene Expression Test 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:** MolDX: Breast Cancer IndexTM (BCI) Gene Expression Test

**Medicare Coverage Database Number:** DL37824

**Comment period:** October 4 – December 14, 2018

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

**MolDX: Decipher Biopsy Prostate Cancer Classifier Assay for Men with Very Low and Low Risk Disease 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:** MolDX: Decipher® Biopsy Prostate Cancer Classifier Assay for Men with Very Low and Low Risk Disease

**Medicare Coverage Database Number:** DL37820

**Comment period:** October 4 – December 14, 2018

See the Noridian Draft LCDs webpage to access the draft LCDs and address details for comment submission.
MolDX: EndoPredict Breast Cancer Gene Expression Test 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: L37311

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

Effective Date: January 30, 2018

Summary of Changes: The link in the first bibliography entry is corrected.

View the locally hosted Noridian Active LCD.

- 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

Providers may also access Noridian LCDs via the CMS MCD. To view them, select the appropriate state link within MCD section of the Active LCD webpage. Once in the MCD, choose the desired LCD title.

MolDX: GeneSight Assay for Refractory Depression 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: L36325

LCD Title: MolDX: GeneSight® Assay for Refractory Depression

Effective Date: March 8, 2018

Summary of Changes: LCD was updated to complete 21st Century Act fields.

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

Go to Active LCD webpage.

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- Locate the above listed LCD title.
  - This link will direct you to the locally hosted copy of the Active LCD.

Providers may also access Noridian LCDs via the CMS MCD. To view them, select the appropriate state link within MCD section of the Active LCD webpage. Once in the MCD, choose the desired LCD title.
MolDX: Guardant360 Plasma-Based Comprehensive Genomic Profiling in Non-Small Cell Lung Cancer (NSCLC) Final LCD - Effective October 20, 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: L37651

LCD Title: MolDX: Guardant360® Plasma-Based Comprehensive Genomic Profiling in Non-Small Cell Lung Cancer (NSCLC)

Effective Date: October 20, 2018

Summary of LCD: This policy provides limited coverage for Guardant360® (Guardant Health, Redwood City, CA), a plasma-based comprehensive somatic genomic profiling test (hereafter called CGP) for patients with Stage IIIB/IV non-small cell lung cancer (NSCLC) at diagnosis or at progression.

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

- Go to the 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.

MolDX: Molecular Diagnostic Tests (MDT) 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: L36256

LCD Title: MolDX: Molecular Diagnostic Tests (MDT)

Effective Date: June 21, 2018


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.

- This link will direct you to the locally hosted copy of the Active LCD.

Providers may also access Noridian LCDs via the CMS MCD. To view them, select the appropriate state link within MCD section of the Active LCD webpage. Once in the MCD, choose the desired LCD title.
MolDX: myPath Melanoma Assay 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: MolDX: myPath Melanoma Assay

Medicare Coverage Database Number: DL37881

Comment period: October 4 – December 14, 2018

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

MolDX: NeuroIDgenetix Test for Depression 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: MolDX: NeuroIDgenetix® Test for Depression

Medicare Coverage Database Number: DL37877

Comment period: October 4 – December 14, 2018

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

MolDX: Oncotype DX Genomic Prostate Score for Men with Favorable Intermediate Risk Prostate Cancer LCD - R2

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

Medicare Coverage Database (MCD) Number: L37321

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

Effective Date: August 16, 2018

Summary of Changes: Minor revisions to update the NCCN reference to the 2018 version under Table: 1.

View the locally hosted Noridian Active LCD.

- 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

Providers may also access Noridian LCDs via the CMS MCD. To view them, select the appropriate state link within MCD section of the Active LCD webpage. Once in the MCD, choose the desired LCD title.
MolDX: Prolaris Prostate Cancer Genomic Assay for Men with Favorable Intermediate Risk Disease LCD - R2

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

Medicare Coverage Database (MCD) Number: L37082

LCD Title: MolDX: Prolaris™ Prostate Cancer Genomic Assay for Men with Favorable Intermediate Risk Disease

Effective Date: January 1, 2018

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

View the locally hosted Noridian Active LCD.

- 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

Providers may also access Noridian LCDs via the CMS MCD. To view them, select the appropriate state link within MCD section of the Active LCD webpage. Once in the MCD, choose the desired LCD title.

MolDX: Genetic Testing for Lynch Syndrome 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: MolDX: Genetic Testing for Lynch Syndrome

Medicare Coverage Database Number: DL36374

Comment period: October 4 – December 14, 2018

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

MRI and CT Scans of the Head and Neck Final LCD - Effective October 8, 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: L35175

LCD Title: MRI and CT Scans of the Head and Neck

Effective Date: October 8, 2018

Summary of LCD: Added and deleted ICD-10 codes in Group 1 due to codes being omitted from the Draft LCD after published, annual ICD-10 updates and Response to Comments. No change in coverage was made.
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.

**MRI and CT Scans of the Head and Neck LCD - R8**

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

Medicare Coverage Database (MCD) Number: L35175

LCD Title: MRI and CT Scans of the Head and Neck

Effective Date: October 1, 2018

Summary of Changes: This LCD has been updated to add and remove ICD-10 codes and only these codes are effective 10/01/2018. All other ICD-10-CM codes in this LCD are effective 10/08/2018 as a 45-day notice period is required when a LCD is finalized. See “MRI and CT Scans of the Head and Neck Final LCD - Effective October 8, 2018” Latest Updates article.

**New/Revised ICD-10 codes to Group 1:** C43.111, C43.112, C43.121, C43.122, C4A.111, C4A.112, C4A.121, C4A.122, C44.1121, C44.1122, C44.1191, C44.1192, C44.1221, C44.1222, C44.1291, C44.1292, C44.1921, C44.1922, C44.1991, C44.1992, D03.111, D03.112, D03.121, D03.122, D04.111, D04.112, D04.121, D04.122, D22.111, D22.112, D22.121, D22.122, D23.111, D23.112, D23.121, D23.122, E75.26, F53.0, F53.1, G51.31, G51.32, G51.33, H02.23A, H02.23B, H02.23C, H57.811, H57.812, H57.813, H57.819, H57.89, I63.81, I63.89, I67.850, I67.858, T81.40XA*, T81.40XD*, T81.40XS*, T81.41XA*, T81.41XD*, T81.41XS*, T81.42XA*, T81.42XD*, T81.42XS*, T81.43XA*, T81.43XD*, T81.43XS*, T81.44XA*, T81.44XD*, T81.44XS*, T81.49XA*, T81.49XD* and T81.49XS*

**New/Revised ICD-10 codes to Group 2:** F53.0 and F53.1

**Deleted ICD-10 codes from Group 1:** C43.11, C43.12, C4A.11, C4A.12, C44.112, C44.119, C44.122, C44.129, C44.192, C44.199, D03.11, D03.12, D04.11, D04.12, D22.11, D22.12, D23.11, D23.12, F53, G51.3, H57.8, I63.8, T81.4XXA*, T81.4XXD* and T81.4XXS*

**Deleted ICD-10 codes from Group 2:** F53.

**Revised ICD-10 codes from Group 1:** I63.333, I63.343, M50.01, M50.21, M50.31, M50.81 and M50.91.

View the Noridian Future LCD

- 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).
  - Locate and select above listed LCD title
Nerve Blockade for Treatment of Chronic Pain and Neuropathy LCD - R13

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

Medicare Coverage Database (MCD) Number: L35457

**LCD Title:** Nerve Blockade for Treatment of Chronic Pain and Neuropathy

**Effective Revision Date:** October 1, 2017

**Summary of Changes:** LCD revised to approve the Annual Review Date to be able to relate the LCD to the Local Coverage Article A52725 Peripheral Nerve Blocks Non-covered for the Treatment of Diabetic Peripheral Neuropathic Pain. No change in coverage was made.

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.
- This link will direct you to the locally hosted copy of the Active LCD.

Providers may also access Noridian LCDs via the CMS MCD. To view them, select the appropriate state link within MCD section of the Active LCD webpage. Once in the MCD, choose the desired LCD title.

Non-Covered Services LCD – R28

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:** August 24, 2018

**Summary of Changes:** The Non-Covered Services LCD has been updated to remove CPT code 32998 from Group 1.
- 32988 - Ablation therapy for reduction or eradication of 1 or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, radiofrequency, unilateral.

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.
- This link will direct you to the locally hosted copy of the Active LCD.

Providers may also access Noridian LCDs via the CMS MCD. To view them, select the appropriate state link within MCD section of the Active LCD webpage. Once in the MCD, choose the desired LCD title.
Peripheral Nerve Stimulation Final LCD - Revised Effective November 2, 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:** L37360

**LCD Title:** Peripheral Nerve Stimulation  
**Effective Date:** November 2, 2018

**Summary of LCD:** This Final LCD is updated to provide a new Notice Period and Effective Date. No Notice article was published for this final LCD when it initially was finalized as per CMS requirements in error.

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

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

Pulmonary Function Testing - Draft LCD Retirement – Effective June 28, 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 (MCD) Number:** DL37289

**LCD Title:** Pulmonary Function Testing  
**Effective Date:** June 28, 2018

**Rationale:** Effective June 28, 2018, this Draft LCD is being retired. A new Draft LCD will be published on the CMS MCD at a later date. The new Draft LCD may have the same Draft LCD ID as the Draft LCD.

To access the Noridian Retired draft LCD, follow the instructions below.

Go to CMS Medicare Coverage Database Archive

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

Respiratory Care (Respiratory Therapy) 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:** L37293

**LCD Title:** Respiratory Care (Respiratory Therapy)  
**Effective Revision Date:** July 9, 2018

**Summary of Changes:** Corrected ICD-10 code I27.9 noted in the Associated Information section above to I27.29.

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.
  - This link will direct you to the locally hosted copy of the Active LCD.

Providers may also access Noridian LCDs via the CMS MCD. To view them, select the appropriate state link within MCD section of the Active LCD webpage. Once in the MCD, choose the desired LCD title.

**Stereotactic Radiation Therapy: Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiation Therapy (SBRT) LCD – R6**

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

**Medicare Coverage Database (MCD) Number:** L34151

**LCD Title:** Stereotactic Radiation Therapy: Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiation Therapy (SBRT)

**Effective Date:** October 1, 2018

**Summary of Changes:** This LCD has been updated to reflect effective date of ICD-10 code update to be 10/01/2018 and has been updated to include ICD-10 codes.

**Deleted ICD-10 codes to Group I Codes**

- G51.3: Clonic hemifacial spasm

**Added ICD-10 codes to Group I Codes**

- G51.31: Clonic hemifacial spasm, right
- G51.32: Clonic hemifacial spasm, left
- G51.33: Clonic hemifacial spasm, bilateral

- 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

**Treatment of Ulcers & Symptomatic Hyperkeratoses LCD – R10**

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:** L34199

**LCD Title:** Treatment of Ulcers & Symptomatic Hyperkeratoses

**Effective Date:** October 1, 2017

**Summary of Changes:** LCD revised to add the following two ICD-10-CM codes to the Group 2 ICD-10 Codes that Support Medical Necessity.

- E10.621 - Type 1 diabetes mellitus with foot ulcer
- E11.621 - Type 2 diabetes mellitus with foot ulcer

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.
  - This link will direct you to the locally hosted copy of the Active LCD.

Providers may also access Noridian LCDs via the CMS MCD. To view them, select the appropriate state link within MCD section of the Active LCD webpage. Once in the MCD, choose the desired LCD title.

**Trigger Point Injections LCD - R3**

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

**Medicare Coverage Database (MCD) Number:** L36859

**LCD Title:** Trigger Point Injections

**Effective Date:** October 1, 2018

**Summary of Changes:** This LCD has been updated to reflect effective date of ICD-10 code update to be 10/01/2018. This LCD has been updated to include and/or remove ICD-10 codes

**New/Revised ICD-10 codes to Group I Codes**

- **M79.18:** Myalgia, Other Site

**Deleted ICD-10 codes to Group I Codes**

- **M79.1:** Myalgia

View the locally hosted Noridian Active LCD.

- 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

**MolDX: Envisia, Veracyte, Idiopathic Pulmonary Fibrosis Diagnostic Test Draft LCD - Published for Review and Comments**

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).

**LCD Title:** MolDX: Envisia, Veracyte, Idiopathic Pulmonary Fibrosis Diagnostic Test

**Medicare Coverage Database Number:** DL37891

**Comment Period:** October 4 – December 14, 2018

See the Noridian Draft LCDs webpage to access the draft LCDs and address details for comment submission
MolDX: Inivata, InVisionFirst, Liquid Biopsy for Patients with Lung Cancer Draft LCD - Published for Review and Comments

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).

**LCD Title:** MolDX: Envisia, Veracyte, Idiopathic Pulmonary Fibrosis Diagnostic Test

**Medicare Coverage Database Number:** DL37899

**Comment Period:** October 4 – December 14, 2018

See the Noridian Draft LCDs webpage to access the draft LCDs and address details for comment submission.
CMS Takes Action to Modernize Medicare Home Health

On July 2, CMS proposed significant changes to the Home Health Prospective Payment System (PPS) to strengthen and modernize Medicare, drive value, and focus on individual patient needs rather than volume of care. Specifically, CMS is proposing changes to improve access to solutions via remote patient monitoring technology, and to update the payment model for home health care.

“Today’s proposals would give doctors more time to spend with their patients, allow home health agencies to leverage innovation and drive better results for patients,” said CMS Administrator Seema Verma. “The redesign of the home health payment system encourages value over volume and removes incentives to provide unnecessary care.”

CMS’s proposed changes promote innovation to modernize home health by allowing the cost of remote patient monitoring to be reported by home health agencies as allowable costs on the Medicare cost report form. This is expected to help foster the adoption of emerging technologies by home health agencies and result in more effective care planning, as data is shared among patients, their caregivers, and their providers. Supporting patients in sharing this data will advance the Administration’s MyHealthEData initiative.

As required by the Bipartisan Budget Act of 2018, this proposed rule would also implement a new Patient-Driven Groupings Model (PDGM) for home health payments. The proposed rule also includes information on the implementation of home infusion therapy temporary transitional payments as required by the Bipartisan Budget Act of 2018. In addition, the proposed rule solicits comments on elements of the new home infusion therapy benefit category and proposes standards for home infusion therapy suppliers and accrediting organizations of these suppliers as required by the 21st Century Cures Act.

Physicians who order home health services for their patients would also see administrative burden reduced under this rule. CMS is proposing to eliminate the requirement that the certifying physician estimate how much longer skilled services would be needed when recertifying the need for continuing home health care, as this information is already gathered on a patient’s plan of care.

The proposed rule helps advance the Trump Administration’s Meaningful Measures Initiative. CMS is proposing changes to the Home Health Quality Reporting Program (HH QRP). The cost impact related to updated data collection processes as a result of the proposed implementation of the PDGM and proposed changes to the HH QRP are estimated to result in a net $60 million in annualized cost savings to Home Health Agencies (HHAs), or $5,150 in annualized cost savings per HHA, beginning in CY 2020.

In the proposed rule CMS is releasing a Request for Information to welcome continued feedback on the Medicare program and interoperability. CMS is gathering stakeholder feedback on revising the CMS patient health and safety standards that are required for providers and suppliers participating in the Medicare and Medicaid programs to further advance electronic exchange of information that supports safe, effective transitions of care between hospitals and community providers.

For More Information:

Proposed Rule
Fact Sheet
Home Health PPS website
HHA Center website
Home Health Value-Based Purchasing Model webpage
Home Health Quality Reporting Requirements webpage

See the full text of this excerpted CMS Press Release (issued July 2).
MLN Connects – July 5, 2018
MLN Connects® for Thursday, July 5, 2018
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News & Announcements
• New Medicare Card: MBI Changes
• MIPS Payment Adjustment Targeted Review: Request by September 30
• Open Payments Program 2017 Financial Data
• Laboratory Date of Service Exception
• Qualified Medicare Beneficiary Information on RAs and MSNs

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

Claims, Pricers & Codes
• Rejected Claims for Medicare Diabetes Prevention Program Services
• ESRD Claims Error: Transitional Drug Adjustment Add-On Payment Adjustment

Upcoming Events
• CMS Data Element Library Webinar — July 11
• Public Reporting on Physician Compare Webinar — July 24 or 26

Medicare Learning Network® Publications & Multimedia
• NCCI PTP Edits, Version 24.3: Quarterly Update MLN Matters Article — New
• Medicare Diabetes Prevention Program Call: Audio Recording and Transcript — New
• IMPACT Act Call: Audio Recording and Transcript — New
• Prohibition Billing Dually Eligible Individuals Enrolled in the QMB Program MLN Matters Article — Revised
• Global Surgical Days for CAH Method II MLN Matters Article — Revised
• HCPCS Drug/Biological Code Changes: July 2018 Quarterly Update MLN Matters Article — Revised
• Comprehensive ESRD Care Model Telehealth: Implementation MLN Matters Article — Revised
• ASC Payment System: July 2018 Update MLN Matters Article — Revised
Combined actions would increase access to durable medical equipment, reduce administrative burden, and encourage development of innovative therapies for beneficiaries on dialysis.

On July 11, CMS proposed innovative changes to the payment rules for Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) and the End-Stage Renal Disease (ESRD) program. The DME proposals in the proposed rule aim to increase access to items for patients and simplify Medicare's DMEPOS Competitive Bidding Program (CBP) to drive competition and increase affordability. The rule also includes ESRD proposals, including a proposal to address new renal dialysis drug and biological costs and foster innovations in treatment by incentivizing new therapies for patients on dialysis and a proposal to reduce facility-related documentation burden.

“At CMS, we celebrate innovation in the health care system and encourage new therapies that will help save lives and lower costs for patients,” said CMS Administrator Seema Verma. “Today’s proposals will help secure sustainable access to durable medical equipment and reward dialysis facilities that adopt innovative new therapies.”

The proposed rule takes key steps towards changing Medicare’s DME fee schedule payments and the DMEPOS CBP. CMS sought ways to improve competitive bidding going forward and worked with market experts to leverage opportunities to increase the program’s effectiveness. This rule proposes market-oriented reforms to the DMEPOS CBP. The process for recompeting contracts with suppliers currently in effect under the DMEPOS CBP has not yet been initiated. As a result, we note that the current contracts for the DMEPOS CBP will expire on December 31, 2018. Beginning January 1, 2019, and until new contracts are awarded under the DMEPOS CBP, beneficiaries may receive DMEPOS items from any Medicare enrolled DMEPOS supplier.

As required by the 21st Century Cures Act, this rule also includes proposals that address Medicare fee schedule payments for DME furnished on or after January 1, 2019, in areas of the country where competitive bidding is not in effect. The proposed rule also solicits stakeholder feedback on CMS’ approach to establishing the fee schedule amounts for new DME technologies. These improvements will modernize the Medicare DME program.

CMS is also taking steps to promote innovation in Medicare’s ESRD prospective payment system by expanding the ESRD Transitional Drug Add-on Payment Adjustment to encourage the use of new drug therapies and the development and use of new treatments and therapies. We are proposing to make changes to Medicare’s payment structure that will support access to new renal dialysis drugs and foster innovation in this critical area of health care.

This proposed rule also takes significant steps forward by strengthening quality incentives and reducing administrative burden. Based on stakeholder feedback, CMS intends to reduce ESRD facility-related documentation burdens for certain payment adjustments so that requirements are more consistent with other payment systems. These changes will allow doctors to spend less time on paperwork and more time with their patients, which is in line with the CMS Patients Over Paperwork initiative. Also, CMS is proposing to update the measure set for the ESRD Quality Incentive Program so that it is more closely aligned with the quality priorities the agency has adopted as part of the Meaningful Measures Initiative.

**For More Information:**

- [Proposed Rule](#)
- [Fact Sheet](#)

See the full text of this excerpted [CMS Press Release](#) (issued July 11).
MLN Connects – July 12, 2018
MLN Connects® for Thursday, July 12, 2018
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News & Announcements

• New Medicare Card Reminder: Wave 1 Mailing Complete
• Qualified Medicare Beneficiary: Learn about State Medicaid Agency Requirements
• MIPS 2019 Payment Adjustment Fact Sheet
• Quality Payment Program: Obtaining Your EIDM Credentials
• IRF QRP Non-Compliance Letters: Request for Reconsideration by August 7
• LTCH QRP Non-Compliance Letters: Request for Reconsideration by August 7
• SNF QRP Non-Compliance Letters: Request for Reconsideration by August 7
• HQRP Non-Compliance Letters: Request for Reconsideration by August 7

Provider Compliance

• Proper Use of the KX Modifier for Part B Immunosuppressive Drug Claims — Reminder

Medicare Learning Network® Publications & Multimedia

• HHA Star Ratings Call: Audio Recording and Transcript — New
• Ambulance Services Listening Session: Audio Recording and Transcript — New
• HCPCS Drug/Biological Code Changes: July 2018 Quarterly Update MLN Matters Article — Revised
• Dual Eligible Beneficiaries under Medicare and Medicaid Booklet — Revised
• Medicare Vision Services Fact Sheet — Revised
• SNF Consolidated Billing Web-Based Training Course — Revised
• Looking for Educational Materials?

MLN Connects Special Edition – July 12, 2018

CMS Proposes Historic Changes to Modernize Medicare and Restore the Doctor-Patient Relationship

Proposed changes to the Medicare Physician Fee Schedule and Quality Payment Program would streamline clinician billing and expand access to high-quality care

On July 12, CMS proposed historic changes that would increase the amount of time that doctors and other clinicians can spend with their patients by reducing the burden of paperwork that clinicians face when billing Medicare. The proposed rules would fundamentally improve the nation’s health care system and help restore the doctor-patient relationship by empowering clinicians to use their Electronic Health Records (EHRs) to document clinically meaningful information, instead of information that is only for billing purposes.

“Today’s reforms proposed by CMS bring us one step closer to a modern health care system that delivers better care for Americans at a lower cost,” said HHS Secretary Alex Azar. “Such a system requires empowering American patients by giving them price and quality transparency and control over their own interoperable health records, goals supported by CMS’s proposals. These proposals will also advance the successful Medicare Advantage program and accomplish a historic regulatory rollback to help physicians put patients over paperwork. Further, today’s proposed reforms to how CMS pays for medicine demonstrate the commitment of HHS to implementing President Trump’s blueprint for lowering drug prices. The ambitious reforms proposed by CMS under Administrator Verma will help deliver on two HHS priorities: creating a value-based health care system for the 21st century and making prescription drugs more affordable.”
“Today’s proposals deliver on the pledge to put patients over paperwork by enabling doctors to spend more time with their patients,” said CMS Administrator Seema Verma. “Physicians tell us they continue to struggle with excessive regulatory requirements and unnecessary paperwork that steal time from patient care. This Administration has listened and is taking action. The proposed changes to the Physician Fee Schedule and Quality Payment Program address those problems head-on, by streamlining documentation requirements to focus on patient care and by modernizing payment policies so seniors and others covered by Medicare can take advantage of the latest technologies to get the quality care they need.”

The proposals, part of the Physician Fee Schedule (PFS) and the Quality Payment Program (QPP), would also modernize Medicare payment policies to promote access to virtual care, saving Medicare beneficiaries time and money while improving their access to high-quality services no matter where they live. Such changes would establish Medicare payment for when beneficiaries connect with their doctor virtually using telecommunications technology (e.g., audio or video applications) to determine whether they need an in-person visit. Additionally, the QPP proposal would make changes to quality reporting requirements to focus on measures that most significantly impact health outcomes. The proposed changes would also encourage information sharing among health care providers electronically, so patients can see various medical professionals according to their needs while knowing that their updated medical records will follow them through the health care system. The QPP proposal would make important changes to the Merit-based Incentive Payment System (MIPS) “Promoting Interoperability” performance category to support greater EHR interoperability and patient access to their health information, as well as to align this clinician program with the proposed new “Promoting Interoperability” program for hospitals.

If these proposals were finalized, clinicians would see a significant increase in productivity – leading to substantially more and better care provided to their patients. Removing unnecessary paperwork requirements through the PFS proposal would save individual clinicians an estimated 51 hours per year if 40 percent of their patients are in Medicare. Changes in the QPP proposal would collectively save clinicians an estimated 29,305 hours and approximately $2.6 million in reduced administrative costs in CY 2019.

Proposed CY 2019 PFS Key Changes:

The PFS establishes payment for physicians and medical professionals treating Medicare patients. It is updated annually to make changes to payment policies, payment rates and quality-related provisions. Extensive public feedback the agency has received has highlighted a need to streamline documentation requirements for physician services known as Evaluation and Management (E&M) visits, as well as a need to support greater access to care using telecommunications technology. The proposed changes to the PFS would reinforce CMS’ Patients Over Paperwork initiative focused on reducing administrative burden while improving care coordination, health outcomes, and patients’ ability to make decisions about their own care.

Streamlining E&M Payment and Reducing Clinician Burden:

CMS and the Office of the National Coordinator for Health Information Technology have heard from stakeholders that CMS’s extensive documentation requirements for E&M codes have resulted in unintended consequences. To meet these documentation requirements, providers have to create medical records that are a collection of predefined templates and boilerplate text for billing purposes, in many cases reflecting very little about the patients’ actual medical care or story.

Responding to stakeholder concerns, several provisions in the proposed CY 2019 PFS would help to free EHRs to be powerful tools that would actually support efficient care while giving physicians more time to spend with their patients, especially those with complex needs, rather than on paperwork. Specifically, this proposal would:

- Simplify, streamline and offer flexibility in documentation requirements for E&M office visits — which make up about 20 percent of allowed charges under the PFS and consume much of clinicians’ time
- Reduce unnecessary physician supervision of radiologist assistants for diagnostic tests
- Remove burdensome and overly complex functional status reporting requirements for outpatient therapy

Advancing Virtual Care:

“CMS is committed to modernizing the Medicare program by leveraging technologies, such as audio/video applications or patient-facing health portals, that will help beneficiaries access high-quality services in a convenient manner,” said Administrator Verma.
Getting to the doctor can be a challenge for some beneficiaries, whether they live in rural or urban areas. Innovative technology that enables remote services can expand access to care and create more opportunities for patients to access personalized care management as well as connect with their physicians quickly. Provisions in the proposed CY 2019 PFS would support access to care using telecommunications technology by:

- Paying clinicians for virtual check-ins – brief, non-face-to-face appointments via communications technology
- Paying clinicians for evaluation of patient-submitted photos
- Expanding Medicare-covered telehealth services to include prolonged preventive services

Lowering Drug Costs:

President Trump is putting American patients first and lowering prescription drug costs, and CMS is committed to advancing this effort. CMS is proposing changes as part of the continued rollout of the Administration’s blueprint to lower drug prices and reduce out-of-pocket costs. The changes would affect payment under Medicare Part B. Part B covers medicines that patients receive in a doctor’s office, such as infusions. CMS is proposing a change in the payment amount for new drugs under Part B, so that the payment amount would more closely match the actual cost of the drug. This change would be effective January 1, 2019, and would reduce the amount that seniors would have to pay out-of-pocket, especially for drugs with high launch prices. This is one of many steps that CMS is taking to ensure that seniors have access to the drugs they need.

Proposed CY 2019 Quality Payment program Key Changes:

To implement the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), CMS established the QPP, which consists of two participation pathways for doctors and other clinicians – MIPS, which measures performance in four categories to determine an adjustment to Medicare payment, and Advanced Alternative Payment Models (Advanced APMs), in which clinicians may earn an incentive payment through sufficient participation in risk-based payment models. The proposed changes to QPP aim to reduce clinician burden, focus on outcomes, and promote interoperability of EHRs, including by:

- Removing MIPS process-based quality measures that clinicians have said are low-value or low-priority, in order to focus on meaningful measures that have a greater impact on health outcomes

Overhauling the MIPS “Promoting Interoperability” performance category to support greater EHR interoperability and patient access to their health information, as well as to align this performance category for clinicians with the proposed new Promoting Interoperability Program for hospitals

Under the requirements of the Bipartisan Budget Act of 2018, CMS is continuing the gradual implementation of certain MIPS requirements to ease administrative burden on clinicians. The proposed changes to the QPP reflect feedback and input from clinicians and stakeholders, and we will continue to offer free and customized support from CMS’s technical assistance networks.

Medicare Advantage Qualifying Payment Arrangement Incentive Demonstration:

Aligning with the agency’s goals of improving quality of care and responding to the feedback we have received from clinicians, CMS also proposes waivers of MIPS requirements as part of testing a demonstration called the Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) demonstration. The MAQI demonstration would test waiving MIPS reporting requirements and payment adjustments for clinicians who participate sufficiently in Medicare Advantage (MA) arrangements that are similar to Advanced APMs.

Some MA plans are developing innovative arrangements that resemble Advanced APMs. However, without this demonstration, physicians are still subject to MIPS even if they participate extensively in Advanced APM-like arrangements under Medicare Advantage. The demonstration will look at whether waiving MIPS requirements would increase levels of participation in such MA payment arrangements and whether it would change how clinicians deliver care.

Price transparency: Request for information:

Finally, as part of its commitment to price transparency, CMS is seeking comment through a Request for Information asking whether providers and suppliers can and should be required to inform patients about charge and payment information for health care services and out-of-pocket costs, what data elements
would be most useful to promote price shopping, and what other changes are needed to empower health care consumers.

Public comments on the proposed rules are due by September 10.

For More Information:

**Proposed Rule**

**Proposed Policy, Payment, and Quality Provisions Changes to the Medicare PFS for CY 2019** [Fact Sheet](#)

**Proposed Rule for the QPP Year 3** [Fact Sheet](#)

**MA Qualifying Payment Arrangement Incentive Demonstration** [Fact Sheet](#)

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**MLN Connects – July 19, 2018**

**MLN Connects® for Thursday, July 19, 2018**

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**News & Announcements**

- MIPS 2017 Performance Feedback User Guide
- MIPS Payment Adjustment Targeted Review: Request by October 1
- PEPPERs for Home Health Agencies, Partial Hospitalization Programs
- July Quarterly Provider Update

**Provider Compliance**

- Cardiac Device Credits: Medicare Billing

**Upcoming Events**

- CY 2018 eCQM Self-Directed Tools and Resources Webinar — July 24
- IMPACT Act and SPADE Special Open Door Forum — July 25
- Meeting the Behavioral Health Needs of the Dually Eligible Webinar — August 2
- ESRD Quality Incentive Program: CY 2019 ESRD PPS Proposed Rule Call — August 14
- CBR on Independent Diagnostic Testing Facilities Referring Providers Webinar — August 22

**Medicare Learning Network® Publications & Multimedia**

- New MBI: Get It, Use It MLN Matters® Article — Revised
- Medical Review of E/M Documentation MLN Matters Article — New
- New Physician Specialty Code for Undersea and Hyperbaric Medicine MLN Matters Article — New
- Medicare Part A SNF PPS Pricer Update MLN Matters Article — New
- Automating First Claim Review in Serial Claims for DMEPOS MLN Matters Article — Revised
- Medicare Preventive Services Educational Tool — Revised
- Behavioral Health Integration Services Fact Sheet — Reminder
- Chronic Care Management Services: Changes for 2017 Fact Sheet — Reminder
- Chronic Care Management Services Fact Sheet — Reminder
- Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians Web-based Training — Reminder
MLN Connects Special Edition – July 23, 2018

New Medicare Card Mailing Update – Wave 4 Begins, Wave 2 Ends

CMS started mailing new Medicare cards to people with Medicare who live in Wave 4 states: Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Rhode Island, and Vermont. We continue to mail new cards to people who live in Wave 3 states, as well as nationwide to people who are new to Medicare.

We finished mailing cards to people with Medicare who live in Wave 1 and Wave 2 states and territories (Alaska, American Samoa, California, Delaware, District of Columbia, Guam, Hawaii, Maryland, Northern Mariana Islands, Pennsylvania, Oregon, 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 instruct 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.

To ensure that people with Medicare continue to get care, health care providers and suppliers can use either the former Social Security number-based Health Insurance Claim Number or the new alpha-numeric Medicare Beneficiary Identifier (MBI) for all Medicare transactions through December 31, 2019.

Check the mailing strategy as the mailings progress. Continue to direct people with Medicare to 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 are committed to mailing new cards to all people with Medicare by April 2019.

Information on the transition to the new MBI:

New MBI Get It, Use It MLN Matters® Article (Updated 7/11/18)
Transition to New Medicare Numbers and Cards MLN Fact Sheet
New Medicare Card information website

MLN Connects Special Edition – July 25, 2018

CMS Empowers Patients and Ensures Site-Neutral Payment in Proposed Rule

Outpatient Prospective Payment System (OPPS) & Ambulatory Surgical Center (ASC) proposed rule advances CMS commitment to increasing transparency and lowering drug prices

On July 25, CMS took steps to strengthen the Medicare program with proposed changes to ensure that seniors can access the care they need at the site of care that they choose. In addition, as part of the agency’s ongoing efforts to lower drug prices as outlined in the President’s Blueprint, CMS included a Request for Information on how best to develop a model leveraging authority provided to the agency under the Competitive Acquisition Program (CAP) to strengthen negotiations for prescription drugs.

“Our healthcare system should always put patients first, and CMS today is taking important steps to empower patients and provide more affordable choices and options,” said CMS Administrator Seema Verma. “In line with President Trump and Secretary Azar’s priority to lower drug prices, today’s proposed rule is also an important step towards expanding competition for drug payment in Medicare, in order to get the best deal for patients.”

The proposed policies in the CY 2019 Medicare Hospital OPPS and ASC Payment System proposed rule would help lay the foundation for a patient-driven healthcare system. To increase the sustainability of the Medicare program and improve quality of care for seniors, CMS is moving toward site neutral payments for clinic visits (which are essentially check-ups with a clinician). Clinic visits are the most common service billed under the OPPS. Currently, CMS often pays more for the same type of clinic visit in the hospital outpatient setting than in the physician office setting.
If finalized, this proposal is projected to save patients about $150 million in lower copayments for clinic visits provided at an off-campus hospital outpatient department. CMS is also proposing to close a potential loophole through which providers are billing patients more for visits in hospital outpatient departments when they create new service lines.

Additionally, CMS is giving patients more options on where to obtain care, in order to improve access and convenience and ensure that CMS policies are not favoring any particular provider type from the start. The proposed rule aims to address other payment differences between sites of service, so that patients can choose the setting that best meets their needs among safe and clinically appropriate options. For 2019, CMS is proposing to:

- Expand the number of procedures payable at ASCs to include additional procedures that can safely be performed in that setting
- Ensure ASC payment for procedures involving certain high-cost devices parallels the payment amount provided to hospital outpatient departments for these devices
- Help ensure that ASCs remain competitive by stabilizing the differential between ASC payment rates and hospital outpatient department payment rates

As part of active efforts to reduce the cost of prescription drugs, CMS is issuing a Request for Information to solicit public comment on how best to leverage the authority provided under the CAP to get a better deal for beneficiaries as part of a CMS Innovation Center model. We believe a CAP-based model would allow CMS to introduce competition to Medicare Part B, the part of Medicare that pays for medicines that patients receive in a doctor’s office. Currently, CMS pays the average sales price for these therapies plus an extra add-on payment. A CAP-based model would allow CMS to bring on vendors to negotiate payment amounts for Part B drugs, so that Medicare is no longer merely a price taker for these medicines. We are seeking public comment on how the vendors that CMS brings on could help the agency structure value-based payment arrangements with manufacturers, especially for high-cost products, so that seniors and taxpayers will know that medicines are working before they have to pay.

In 2018, CMS implemented a payment policy to help beneficiaries save on coinsurance on drugs that were administered at hospital outpatient departments and that were acquired through the 340B program—a program that allows hospitals to buy certain outpatient drugs at a lower cost. Due to CMS’s policy change, Medicare beneficiaries are now benefiting from the discounts that 340B hospitals enjoy when they receive 340B-acquired drugs. In 2018 alone, beneficiaries are saving an estimated $320 million on out-of-pocket payments for these drugs. For 2019, CMS is expanding this policy by proposing to extend the 340B payment change to non-excepted off-campus departments of hospitals that are paid under the Physician Fee Schedule.

In response to recommendations from the President’s Commission on Combatting Drug Addiction and the Opioid Crisis, CMS also is proposing to pay separately for certain non-opioid pain management drugs in ASCs; is seeking feedback on evidence to support that other non-opioid alternative treatments for acute or chronic pain warrant separate payment under the OPPS or ASC payment systems; and is proposing to eliminate questions regarding pain communication from the hospital patient experience survey.

As part of its commitment to price transparency, CMS is seeking comment through a Request for Information asking whether providers and suppliers can and should be required to inform patients about charge and payment information for healthcare services and out-of-pocket costs, what data elements would be most useful to promote price shopping, and what other changes are needed to empower healthcare consumers.

In the proposed rule, CMS is releasing a Request for Information to welcome continued feedback on the Medicare program and interoperability. CMS is gathering public feedback on revising the CMS patient health and safety standards that are required for providers and suppliers participating in the Medicare and Medicaid programs to further advance electronic exchange of information that supports safe, effective transitions of care between hospitals and community providers.

Across all the Fiscal Year and CY proposed Medicare payment rules, we have proposed the elimination of reporting requirements for over 100 measures across the health care delivery system, saving providers more than $175 million over the next two years.
See the full text of this excerpted CMS Press Release (issued July 25).

For More Information:
- Proposed Rule
- Fact Sheet

**MLN Connects – July 26, 2018**

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

View this edition as a PDF

**News & Announcements**

- New Medicare Card: Using Your MAC’s MBI Look-Up Tool
- E/M Coding Reform: Recording of Panel Discussion
- Patients Over Paperwork July Newsletter
- Hospice Quality Reporting Program Quick Reference Guide
- HQRP Non-Compliance Letters: Request for Reconsideration by August 7
- IRF QRP Non-Compliance Letters: Request for Reconsideration by August 7
- LTCH QRP Non-Compliance Letters: Request for Reconsideration by August 7
- SNF QRP Non-Compliance Letters: Request for Reconsideration by August 7
- Emergency Preparedness: Information on Radiological Incidents, DME, and Blood
- World Hepatitis Day: Medicare Coverage for Viral Hepatitis

**Provider Compliance**

- Proper Coding for Specimen Validity Testing Billed in Combination with Urine Drug Testing

**Upcoming Events**

- MIPS Improvement Activities Performance Category Year 2 Overview Webinar — August 1
- MIPS Quality Performance Category Year 2 Overview Webinar — August 6
- ESRD Quality Incentive Program: CY 2019 ESRD PPS Proposed Rule Call — August 14

**Medicare Learning Network® Publications & Multimedia**

- IOM Update to Publication 100-02, Chapter 11 – ESRD MLN Matters Article — New
- New Waived Tests MLN Matters Article — New
- HCPCS Codes Used for SNF CB Enforcement: Annual Update MLN Matters Article — New
- Changes to the Laboratory NCD Edit Software: October 2018 MLN Matters Article — New
- CLFS and Laboratory Services Payment: Quarterly Update MLN Matters Article — New
MLN Connects – August 2, 2018
MLN Connects® for Thursday, August 2, 2018

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News & Announcements

• SNF FY 2019 Payment and Policy Changes
• IRF FY 2019 Prospective Payment System Final Rule
• IPF FY 2019 Final Medicare Payment and Quality Reporting Updates
• Qualified Medicare Beneficiary Program Billing Requirements FAQs
• Data Element Library Webinar: Video Recording
• CMS Administrator Address on Strengthening Medicare
• 2018 QRDA III Implementation Guide for Eligible Professionals — Updated
• LTCH Provider Preview Reports Reissued

Provider Compliance

• Ophthalmology Services: Questionable Billing and Improper Payments — Reminder

Upcoming Events

• MIPS Quality Performance Category for Year 2 (2018) Overview Webinar — August 6
• ESRD Quality Incentive Program: CY 2019 ESRD PPS Proposed Rule Call — August 14
• Sharing Federal Strategies to Address the Opioid Epidemic Open Door Forum — August 15
• Physician Fee Schedule Proposed Rule: Understanding 3 Key Topics Listening Session – August 22

Medicare Learning Network® Publications & Multimedia

• Provider Minute Video: Physician Orders/Intent to Order Laboratory Services and Other Diagnostic Services - New
• PECOS Technical Assistance Contact Information Fact Sheet — Reminder
• Medicare Enrollment Resources Educational Tool — Reminder
• PECOS for DMEPOS Suppliers Booklet — Reminder

MLN Connects Special Edition – August 2, 2018

Changes to Empower Patients and Reduce Administrative Burden

Changes in the IPPS and LTCH PPS final rule will advance price transparency and electronic health records

On August 2, CMS finalized a rule to empower patients and advance the White House MyHealthEData initiative and the CMS Patients Over Paperwork initiative. This final rule and others issued earlier this week will help improve access to hospital price information, give patients greater access to their health information and allow clinicians to spend more time with their patients.

Individually and collectively, these final rules put patients first, ease provider burden, and make significant strides in modernizing Medicare. The August 2 final rule makes 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) that will incentivize value-based, quality care at these facilities. CMS also issued final rules this week on fiscal year (FY) 2019 Medicare payments and policies for the Skilled Nursing Facility (SNF) PPS, Inpatient Psychiatric Facility (IPF) PPS, Inpatient Rehabilitation Facility (IRF) PPS, and the Hospice Wage Index and Payment Rate Update.

“We’re excited to make these changes to ensure care will focus on the patient, not on needless paperwork,” said CMS Administrator Seema Verma. “We’ve listened to patients and their doctors who urged us to remove the obstacles getting in the way of quality care and positive health outcomes. Today’s
final rule reflects public feedback on CMS proposals issued in April, and the agency’s patient-driven priorities of improving the quality and safety of care, advancing health information exchange and usability, and removing outdated or redundant regulations on healthcare providers to make way for innovation and greater value.”

Along with policy changes, the FY 2019 IPPS/LTCH PPS final rule provides acute care hospitals an average payment increase of approximately 3 percent, which reflects rate updates required by law and payments for new technologies and uncompensated care.

The IPPS/LTCH PPS final rule also updates geographic payment adjustments for IPPS hospitals. CMS looks forward to continuing to work on geographic payment disparities, particularly for rural hospitals, to the extent permitted under current law and appreciates responses to our request for public input on this issue. By allowing the imputed wage index floor to expire for all-urban states, CMS has begun the process of making geographic payments more equitable for rural hospitals.

In addition, CMS is updating the LTCH PPS standard federal payment rate by 1.35 percent. Overall, under the changes included in the final rule, CMS projects that LTCH PPS payments will increase by approximately 0.9 percent, or $39 million in FY 2019. In addition, CMS is finalizing the proposal to eliminate the 25 percent threshold policy in a budget neutral manner.

MyHealthEData and Interoperability

The policies in the FY 2019 IPPS/LTCH PPS final rule will bring us closer to the agency’s goal of creating a patient-centered healthcare system by increasing price transparency and fluid information exchange—essential components of value-based care—while also significantly lifting the administrative burden on hospitals so they can operate with greater flexibility and patients have the information they need to make decisions about their own care. CMS received stakeholder feedback on solutions for achieving interoperability, or the sharing of healthcare data between providers, through responses to a Request for Information (RFI) issued in April in the IPPS/LTCH PPS proposed rule.

While CMS previously required hospitals to make publicly available a list of their standard charges or their policies for allowing the public to view this list upon request, CMS has updated its guidelines to specifically require hospitals to post this information on the Internet in a machine-readable format. The agency is considering future actions based on the public feedback it received on ways hospitals can display price information that would be most useful to stakeholders and how to create patient-friendly interfaces that allow consumers to more easily access relevant healthcare data and compare providers.

The policies released on August 2 begin implementing core pieces of the White House-led MyHealthEData initiative through several steps to strengthen interoperability. In the IPPS/LTCH PPS final rule, CMS overhauls the Medicare and Medicaid Promoting Interoperability Programs (formerly known as the “Meaningful Use” program or Medicare and Medicaid Electronic Health Record Incentive Programs) 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

Meaningful Measures and Transparency

CMS’s Meaningful Measures initiative is centered on patient safety, quality of care, transparency and ensuring that the measure sets providers are asked to report make the most sense. In the IPPS/LTCH PPS final rule, CMS is removing unnecessary, redundant and process-driven measures from several pay-for-reporting and pay-for-performance quality programs. The final rule eliminates a number of measures acute care hospitals are currently required to report across the four hospital pay-for-reporting and value-based purchasing quality programs. It also “de-duplicates” certain measures that are in multiple programs, keeping them in the program where they can best incentivize improvement and maintaining transparency through public reporting. In all, these changes will remove a total of 18 measures from the programs and de-duplicate another 25 measures while still ensuring meaningful measures of hospital quality and patient safety. In addition to the changes that apply to acute care hospitals, the final rule eliminates three measures in the LTCH Quality Reporting Program. Lastly, CMS is making a variety of other changes to reduce the hours providers spend on paperwork. This new flexibility will allow hospitals to spend more time providing care to their patients, thereby improving the quality of care their patients receive. Overall, changes in the hospital quality and value measures across the four programs will eliminate more than 2 million burden
hours for hospitals impacted by the IPPS/LTCH PPS rule, saving them about $75 million annually after these changes are implemented.

Similarly, the SNF PPS, IPF PPS and IRF PPS final rules establish policies that ensure the measures those providers must report are patient-centered and outcome-driven rather than process-oriented. Where applicable, these changes will allow providers to work with a smaller set of more meaningful healthcare measures and spend more time on patient care.

CMS is also advancing Meaningful Measures through the Hospice Wage Index and Payment Rate Update. This final rule will make Hospice Compare public data easier and more efficient to use.

**Patients Over Paperwork**

The SNF PPS final rule incorporates the agency’s Patients Over Paperwork initiative through avenues that reduce unnecessary burden on providers by easing documentation requirements and offering more flexibility. As part of the agency’s actions to modernize Medicare, the SNF PPS rule establishes an innovative new classification system, the Patient Driven Payment Model (PDPM), which ties skilled nursing facility payments to patients’ conditions and care needs rather than volume of services provided. The new model will better incentivize treating the needs of the whole patient, rather than focusing on the amount of services for that patient, which requires substantial paperwork to track over time. The PDPM approach advances CMS’s efforts to build a patient-driven healthcare system starting with innovation throughout Medicare’s payment systems. Under this new SNF payment model, patients will have more opportunity to choose a skilled nursing facility that offers services tailored to their condition and preferences, as the payment to these facilities will be based more on the patient’s condition rather than the specific services each skilled nursing facility provides.

Modernizing Medicare in additional ways to benefit patients, the final IRF PPS rule adopts advances in telecommunications technology and removes obstacles that may prevent rehabilitation physicians from conducting certain meetings without being physically in the room. The rule also removes overly prescriptive documentation requirements for admission orders for these rehabilitation facilities.

Read the full text of this excerpted Press Release (issued August 2).

Final Rules:
- IPPS/LTCH
- SNF
- IPF
- Hospice
- IRF

Fact Sheets:
- IPPS/LTCH
- SNF
- IPF
- Hospice
- IRF
MLN Connects – August 9, 2018
MLN Connects® for Thursday, August 9, 2018
View this edition as a PDF

News & Announcements
• Help Your Medicare Patients Avoid and Report Scams
• SNF VBP FY 2019 Annual Performance Score Report: Submit Correction Requests by August 31
• Quality Payment Program Exception Applications Due by December 31
• Quality Payment Program: 2017 MIPS Performance Feedback and Payment Adjustment
• Quality Payment Program Performance Feedback and Targeted Review Videos
• Medicare Diabetes Prevention Program Suppliers: Separate Medicare Enrollment
• Vaccines are Not Just for Kids

Provider Compliance
• Reporting Changes in Ownership — Reminder

Upcoming Events
• ESRD Quality Incentive Program: CY 2019 ESRD PPS Proposed Rule Call — August 14
• Physician Fee Schedule Proposed Rule: Understanding 3 Key Topics Listening Session — August 22
• Comparative Billing Report on Licensed Clinical Social Workers Webinar — September 12

Medicare Learning Network® Publications & Multimedia
• Quarterly Influenza Virus Vaccine Code Update: January 2019 MLN Matters Article — New
• Update to Medicare Claims Processing Manual, Chapter 24 MLN Matters Article — New
• IRF Annual Update: PPS Pricer Changes for FY 2019 MLN Matters Article — New
• Implementing Epoetin Alfa Biosimilar, Retacrit for ESRD/AKI Claims MLN Matters Article — New
• Medicare Claims Processing Manual, Chapter 24 Update: Form Letters — New
• IPF PPS Updates for FY 2019 MLN Matters Article — New
• ASP Medicare Part B Drug Pricing Files and Revisions: October 2018 MLN Matters Article — New
• August 2018 Catalog — Revised
• Medicare Preventive Services Educational Tool — Revised
• Medicare Enrollment for Providers Who Solely Order, Certify, or Prescribe Booklet — Revised
• Quality Payment Program Year 2 Overview Web-Based Training Course — Revised
• Quality Payment Program: MIPS Promoting Interoperability Performance Category Year 2 Web-Based Training Course — Revised
• Quality Payment Program MIPS Quality Performance Category Year 2 Web-Based Training Course — Revised
• Safeguard Your Identity and Privacy Using PECOS Booklet — Reminder
• PECOS FAQs Booklet — Reminder
• PECOS for Provider and Supplier Organizations Booklet — Reminder
MLN Connects – August 16, 2018
MLN Connects® for Thursday, August 16, 2018
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News & Announcements
• New Medicare Card: Order Handouts for Patients That Did Not Get Their New Cards
• Proposed Pathways to Success for the Medicare Shared Savings Program
• Quality Payment Program: Design Examples for CY 2019 Proposed Rule
• Quality Payment Program: Participation Status Tool Includes 2018 Data Snapshot

Provider Compliance
• Cochlear Devices Replaced Without Cost: Bill Correctly — Reminder

Upcoming Events
• Physician Fee Schedule Proposed Rule: Understanding 3 Key Topics Listening Session — August 22

Medicare Learning Network® Publications & Multimedia
• Inclusion of PMD Codes in DMEPOS Prior Authorization Program MLN Matters® Article — New
• Medicare Physician Fee Schedule Database: October 2018 Update MLN Matters Article — New
• Hospice Payment Rates, Cap, Wage Index, and Pricer: FY 2019 Update MLN Matters Article — New
• HCPCS Drug/Biological Code Changes: October 2018 Update MLN Matters Article — New
• 2018 DMEPOS Fee Schedule: October Update MLN Matters Article — New
• Advance Care Planning Fact Sheet — Revised
• PECOS for Physicians and NPPs Booklet — Reminder
• Medicare Enrollment for Institutional Providers Booklet — Reminder
• Medicare Part D Vaccines and Vaccine Administration Fact Sheet — Reminder

MLN Connects Special Edition – August 20, 2018
New Medicare Card Mailing Update – Wave 5 Begins, Wave 3 Ends

We started mailing new Medicare cards to people with Medicare who live in Wave 5 states: Alabama, Florida, Georgia, North Carolina, and South Carolina. We continue to mail new cards to people who live in Wave 4 states, as well as nationwide to people who are new to Medicare.

We finished mailing cards to people with Medicare who live in Wave 1, 2 and 3 states and territories. If your Medicare patients say they did not get a card, instruct them to:

Sign into MyMedicare.gov to see if we mailed their card. If so, they can print an official card. They must create an account if they do not already have one.

Call 1-800-MEDICARE (1-800-633-4227). There might be something that needs to be corrected, such as updating their mailing address.

You can also print out and give them a copy of “Still Waiting for Your New Card?” or you can order copies to hand out.

To ensure your Medicare patients continue to get care, you can use either the former Social Security number-based Health Insurance Claim Number or the new alpha-numeric Medicare Beneficiary Identifier (MBI) for all Medicare transactions through December 31, 2019.

Check this website as the mailings progress. Continue to direct your Medicare patients to Medicare.gov/NewCard for information about the mailings and to sign up to get email about the status of card mailings in their state.
Information on the transition to the new MBI:
New MBI Get It, Use It MLN Matters® Article
Transition to New Medicare Numbers and Cards MLN Fact Sheet
New Medicare Card information website

MLN Connects – August 23, 2018
MLN Connects® for Thursday, August 23, 2018
View this edition as a PDF

News & Announcements
• New Medicare Card: 0 not O
• Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier
• 2016 PQRS and 2018 Value Modifier Experience Reports
• Patients Over Paperwork: Medicare Physician Fee Schedule Proposed Rule Presentation
• 2019 MIPS Performance Year Virtual Groups Toolkit
• Hospice Compare Quarterly Refresh
• 2016 Inpatient Hospital Utilization and Payment Data
• Hospices: Second Quarter HQRP Update

Provider Compliance
• Medicare Hospital Claims: Avoid Coding Errors — Reminder

Claims, Pricers & Codes
• 2019 MS-DRG Definitions Manual and Software
• Hospice: NOE information in the HETS Transaction

Upcoming Events
• Quality Payment Program Virtual Groups Webinar — August 27
• Person-Centered Approaches to Support Dual Eligibles for Medicare & Medicaid- September 6
• Dementia Care: Opioid Use & Impact for Persons Living with Dementia Call — September 18

Medicare Learning Network® Publications & Multimedia
• Additional Search Features on FISS Provider DDE Screen MLN Matters Article — New
• ICD-10 and Other Coding Revisions to NCDs MLN Matters Article — New
• Clarifying Language for Chapters 3 and 5 of the MSP Manual MLN Matters Article — New
• Medicare Coverage of Diabetes Supplies MLN Matters Article — New
• Improvements in Hospice Billing and Claims Processing MLN Matters Article — Revised
MLN Connects – August 30, 2018
MLN Connects® for Thursday, August 30, 2018

View this edition as a PDF

News & Announcements
- ACOs Taking Risk in Innovative Payment Model Generate Savings for Patients and Taxpayers
- Physician Fee Schedule Year 3 Proposed Rule: Comments due September 10
- Call for Panel on 2018 MIPS IA Performance Category — Nominations due September 21
- MIPS Targeted Review Request: Deadline October 1
- Hospice Public Reporting: Key Dates
- 2019 eCQM Flows for EPs
- Home Health Agencies: 2016 Utilization and Payment Data

Provider Compliance
- Provider Minute: Laboratory and Diagnostic Services Billing Video

Claims, Pricers & Codes
- Integrated OCE Files for October 2018
- Claims for Biosimilar Drug Code Q5108

Upcoming Events
- New Medicare Card Open Door Forum — September 13
- Dementia Care: Opioid Use & Impact for Persons Living with Dementia Call — September 18
- Medicare Diabetes Prevention Program: New Covered Service Call—September 26

Medicare Learning Network® Publications & Multimedia
- Next Generation ACO Model 2019 Benefit Enhancement MLN Matters Article — New
- Update to Chapter 15: Certification Statement Policies MLN Matters Article — New
- HPTCs Code Set Update: October 2018 MLN Matters Article — New
- I/OCE Specifications Version 19.3: October 2018 MLN Matters Article — New
- Implement Operating Rules - Phase III ERA EFT MLN Matters Article — New
- Claim Status Category and Codes Update MLN Matters Article — New
- Medicare Billing for Outpatient Physical Therapy Fact Sheet — New
- Diabetes Self-Management Training Accrediting Organizations Fact Sheet — New
- ESRD Quality Incentive Program Call: Audio Recording and Transcript — New
- Medical Privacy of Protected Health Information Fact Sheet — Revised
- Diagnosis Coding: Using the ICD-10-CM Web-Based Training Course — Revised
- Medicare Enrollment for Physicians, NPPs, and Other Part B Suppliers Booklet — Reminder
- Screening Pap Tests and Pelvic Examinations Booklet — Reminder
MLN Connects – September 6, 2018
MLN Connects® for Thursday, September 6, 2018
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News & Announcements
• Physician Fee Schedule Year 3 Proposed Rule: Comments due September 10
• QRDA III Implementation Guide: Submit Comments by September 21
• PEPPERs for Short-term Acute Care Hospitals
• Hospice Quality Reporting Program: Training Materials from August Webinar
• Healthy Aging® Month: Discuss Preventive Services with your Patients

Provider Compliance
• CMS Provider Minute Video: The Importance of Proper Documentation — Reminder

Claims, Pricers & Codes
• Average Sales Price Files: October 2018

Upcoming Events
• Quality Payment Program All-Payer Combination Option Overview Webinar — September 12
• New Medicare Card Open Door Forum — September 13
• Dementia Care: Opioid Use & Impact for Persons Living with Dementia Call — September 18
• Medicare Diabetes Prevention Program: New Covered Service Call — September 26

Medicare Learning Network® Publications & Multimedia
• Review of Opioid Use during the IPPE and AWV MLN Matters® Article — New
• Update of the Hospital OPPS: October 2018 MLN Matters Article — New
• Physician Fee Schedule Listening Session: Audio Recording and Transcript — New
• Next Generation ACO Model 2019 Benefit Enhancement MLN Matters Article — Revised
• Mass Immunizers and Roster Billing Booklet — Revised

MLN Connects – September 13, 2018
MLN Connects® for Thursday, September 13, 2018
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News & Announcements
• Help Your Medicare Patients Avoid and Report Scams
• Hospice Provider Preview Reports: Review Your Data by October 5
• IRF Provider Preview Reports: Review Your Data by October 8
• LTCH Provider Preview Reports: Review Your Data by October 8
• Open Payments: Key Thresholds for Program Year 2019 Reporting
• Open Payments: Program Year 2019 Teaching Hospital List
• Hand in Hand: A Training Series for Nursing Homes
• Quality Payment Program: Other Payer Advanced APM Resources
• Mapping Medicare Disparities Tool: Hospital View
MLN CONNECTS

• Physician Compare: Public Reporting Webinar Materials
• Prostate Cancer Awareness Month

Provider Compliance
• Bill Correctly for Device Replacement Procedures - Reminder

Upcoming Events
• Dementia Care: Opioid Use & Impact for Persons Living with Dementia Call — September 18
• Medicare Diabetes Prevention Program: New Covered Service Call — September 26
• Final Modifications to the Quality of Patient Care Star Rating Algorithm Call — October 3
• Comparative Billing Report on Psychologists Webinar — October 17

Medicare Learning Network® Publications & Multimedia
• Billing Requirements Implemented for non-OPPS Providers MLN Matters® Article — New
• Annual Clotting Factor Furnishing Fee: 2019 Update MLN Matters Article — New
• ASC Payment System: October 2018 Update MLN Matters Article — New
• Influenza Vaccine Payment Allowances: Annual Update MLN Matters Article — New
• Influenza Virus Vaccine Code: January 2019 Update MLN Matters Article — Revised
• Certification Statement Policies MLN Matters Article — Revised
• Telehealth Billing Requirements for Distant Site Services MLN Matters Article — Revised
• Complying with Documentation Requirements for Laboratory Services Fact Sheet — Revised
• Global Surgery Booklet— Revised
• Medicare Provider-Supplier Enrollment National Educational Products — Reminder

MLN Connects Special Edition – September 14, 2018
Hurricane Florence and Medicare Disaster Related North Carolina, South Carolina, and the Commonwealth of Virginia Claims MLN Matters Article — New

The President declared a state of emergency for the states of North Carolina, South Carolina, and the Commonwealth of Virginia, and the HHS Secretary declared a Public Health Emergency, which allows for CMS programmatic waivers based on Section 1135 of the Social Security Act. An MLN Matters Special Edition Article on Hurricane Florence and Medicare Disaster Related North Carolina, South Carolina, and the Commonwealth of Virginia Claims is available. Learn about blanket waivers CMS issued for the impacted geographical areas. These waivers will prevent gaps in access to care for beneficiaries impacted by the emergency.

MLN Connects Special Edition – September 17, 2018
New Medicare Card Mailing Update – Wave 6 Begins, Wave 4 Ends


We finished mailing cards to people with Medicare who live in Waves 1, 2, 3, and now Wave 4 states and territories. If your Medicare patients say they did not get a card, ask them to:

Sign into MyMedicare.gov to see if we mailed their card. If so, they can print an official card. They must create an account if they do not already have one.
• Call 1-800-MEDICARE (1-800-633-4227). There might be something that needs to be corrected, such as updating their mailing address.
You can also print out and give them a copy of Still Waiting for Your New Card?, or you can order copies to hand out.

To ensure your Medicare patients continue to get care, you can use either the former Social Security number-based Health Insurance Claim Number or the new alpha-numeric Medicare Beneficiary Identifier (MBI) for all Medicare transactions through December 31, 2019.

Check this website as the mailings progress. Continue to direct your Medicare patients to 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 are committed to mailing new cards to all people with Medicare by April 2019.

Information on the transition to the new MBI:

New MBI Get It, Use It MLN Matters® Article
Transition to New Medicare Numbers and Cards Fact Sheet
New Medicare Card information website

MLN Connects Special Edition – September 19, 2018

New Medicare Card – Progress Updates

CMS continues to successfully mail newly-designed Medicare cards with the new Medicare number and we are excited to share important progress updates with you.

As of August 31, we mailed nearly 35 million cards and continue to mail more every day. We are processing claims and eligibility requests with the Medicare Beneficiary Identifier (MBI), showing that providers are successfully using the new number.

We started mailing new cards to people with Medicare who live in Wave 6 states this week and finished mailing cards to people who live in Waves 1, 2, 3 and 4 states. Because card mailing is progressing so well, we updated the mailing schedule to include an approximate start date for the last wave, and we are on track to finish mailing new cards to all people with Medicare before April 2019.

With our ongoing focus on fraud and protecting the identities of people with Medicare, we are continuously adjusting and improving our mailing strategy to make sure we are mailing new cards to accurate addresses and using the highest levels of fraud protection throughout the mailing. To do this, we are:

• Using trusted industry tools and standards to verify addresses
• Comparing each address against multiple information sources to ensure we are mailing to the right person and the right address
• Mailing cards to people with Medicare when we have high confidence in their identity and address

If your Medicare patients say they did not get a card after their mailing wave ends, ask them to:

• Call 1-800-MEDICARE (1-800-633-4227) where we can verify their identity, check their address, and help them get their new card
• Continue to use their current card to get health care services until they get their new card

Your Medicare patients should continue to protect their new number to prevent medical identity theft and health care fraud. We will continue to raise awareness about potential scams and how they can prevent fraud through our outreach and launched a national fraud prevention campaign in September before Medicare Open Enrollment.
MLN Connects – September 20, 2018

MLN Connects® for Thursday, September 20, 2018

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News & Announcements

• CMS Proposes to Lift Unnecessary Regulations and Ease Burden on Providers
• Hospital Quality Reporting System Open for CY 2018 eCQM Data
• eCQM Value Sets: Updates for 2019 Reporting and Performance Periods
• MIPS Targeted Review Request: Deadline Extended to October 15
• Quality Payment Program: MIPS Resources
• Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier

Provider Compliance

• Billing for Stem Cell Transplants — Reminder

Claims, Pricers & Codes

• ASP Pricing Files and Coverage for Drugs

Upcoming Events

• Medicare Diabetes Prevention Program: New Covered Service Call — September 26
• FY 2019 IPPS/LTCH PPS Final Rule Webinar—September 26
• Final Modifications to the Quality of Patient Care Star Rating Algorithm Call — October 3
• Provider Compliance Focus Group Meeting — October 5
• Submitting Your Medicare Part A Cost Report Electronically Webcast — October 15
• Home Health Quality Reporting Program In-Person Training Event — November 6 and 7

Medicare Learning Network® Publications & Multimedia

• IMRT Planning Services Editing MLN Matters Article — New
• Payment Policy Changes Affecting Hospice Aggregate Cap Calculation and Designation of Hospice Attending Physicians MLN Matters Article — New
• Medicare Claims Processing Manual, Chapter 23: Update MLN Matters Article — New
• Procedure Coding: Using the ICD-10-PCS Web-Based Training — New
• ICD-10 and Other Coding Revisions to NCDs MLN Matters Article — Revised
• HCPCS Drug/Biological Code Changes: October 2018 Update MLN Matters Article — Revised
• Hurricane Maria and Medicare Disaster Related U.S Virgin Islands and Commonwealth of Puerto Rico Claims MLN Matters Article — Revised
• Preventive Services Poster Educational Tool — Revised
• Medicare Fraud & Abuse Poster — Revised
MLN Connects – September 27, 2018
MLN Connects® for Thursday, September 27, 2018

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News & Announcements

• New Medicare Card: MBI on Remittance Advice October 1
• Quality Payment Program: Funding for Quality Measure Development
• Patients Over Paperwork September Newsletter
• Hospice Provider Preview Reports: Review Your Data by October 5
• IRF Provider Preview Reports: Review Your Data by October 8
• LTCH Provider Preview Reports: Review Your Data by October 8
• QRURs and PQRS Feedback Reports: Access Ends December 31
• 2019 Eligible Hospital eCQM Flows
• Connected Care Toolkit
• Development of a Disability Index
• Hurricane Resources from ASPR TRACIE
• Medicare Appeals Council: New Decision Format
• National Cholesterol Education Month and World Heart Day

Provider Compliance

• Improper Payment for Intensity-Modulated Radiation Therapy Planning Services

Claims, Pricers & Codes

• FY 2019 IPPS and LTCH PPS Claims Hold

Upcoming Events

• Final Modifications to the Quality of Patient Care Star Rating Algorithm Call - October 3
• Provider Compliance Focus Group Meeting - October 5
• Submitting Your Medicare Part A Cost Report Electronically Webcast - October 15

Medicare Learning Network® Publications & Multimedia

• New Waived Tests MLN Matters Article - New
• HCPCS Drug/Biological Code Changes: October Update MLN Matters Article - Revised
CERT Claim Look Up Tool Available in the Noridian Medicare Portal

The Noridian Medicare Portal (NMP) now offers users the ability to look up CERT claims as part of the Claim Status Inquiry function. This new feature will allow access to look up outcomes for CERT claims that can be searched by a specific Claim Identifier (CID) number or the provider/supplier information to obtain a list of all CERT claims.

View the CERT Look Up Tool Brainshark and the NMP User Manual to get started today.

Send Us A Message on the Noridian Medicare Portal

Effective July 27, 2018, all Noridian Medicare Portal (NMP) users have the ability to send Noridian Medical Review teams a direct, secure message regarding their medical review concerns.

Click the “Send Us A Message” link in the upper right-hand corner of any screen on NMP to begin.

Exchanges with Noridian are intended to help providers understand Medical Review decisions, and learn how to avoid future denials.

Messages sent regarding non-Medical Review/CERT will be redirected to contact the Provider/Supplier Contact Centers.

Below are the Topics and Subtopics available.

<table>
<thead>
<tr>
<th>Topic</th>
<th>Subtopic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Noridian CERT</td>
<td>CID Status</td>
</tr>
<tr>
<td></td>
<td>Noridian CERT Letter/Communication Questions</td>
</tr>
<tr>
<td></td>
<td>Other</td>
</tr>
<tr>
<td>Medical Review Case</td>
<td>Question on Claim Determination</td>
</tr>
<tr>
<td></td>
<td>Education Information</td>
</tr>
<tr>
<td></td>
<td>Prior Authorization</td>
</tr>
<tr>
<td></td>
<td>Other</td>
</tr>
</tbody>
</table>

A New Message notification displays when Noridian has responded. Please allow 2-3 business days for a response. This is not intended to be a way of instant messaging with Noridian.

Note: Supporting documentation for an Additional Documentation Requests can not be submitted through this function.

To learn how to get started and other important information, view the Send Us A Message section of the Noridian Medicare Portal User Manual and view the Send Us A Message self-paced tutorial.
Noridian Medicare Portal (NMP) Offers Expanded Denial Details - MSP and HMO

Noridian Medicare Portal (NMP) now offers the ability to view claim denial details for Medicare Secondary Payer (MSP) and Medicare Advantage/Health Maintenance Organization (HMO) denials. For claims with MSP and HMO denials, this new feature will allow access to the related MSP and HMO insurance information without the need to perform a separate eligibility search.

Go to the MSP and HMO Denial Details section of the NMP User Manual and view the MSP and HMO Denial Details self-paced tutorial to get started today.
**I/OCE Specifications Version 19.3 – October 2018**

MLN Matters Number: MM10900  
Related Change Request (CR) Number: 10900  
Related CR Release Date: August 24, 2018  
Effective Date: October 1, 2018  
Related CR Transmittal Number: R4122CP  
Implementation Date: October 1, 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) 10900 informs MACs about the changes to the Integrated Outpatient Code Editor (I/OCE) instructions and specifications for the Integrated 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 Prospective Payment System or to a hospice patient for the treatment of a non-terminal illness. Make sure your billing staffs are aware of these changes.

**BACKGROUND**

CR10900 informs the A/B MACs, RHHIs, and the Fiscal Intermediary Shared System (FISS) that the I/OCE is being updated for October 1, 2018. The I/OCE routes all institutional outpatient claims (which includes non-OPPS hospital claims) through a single integrated OCE.

The modifications of the IOCE for the October 2018 V19.3 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. Some I/OCE modifications in the update may be retroactively added to prior releases. If so, the retroactive date appears in the ‘Effective Date’ column. The I/OCE specifications will be posted at [http://www.cms.gov/OutpatientCodeEdit/](http://www.cms.gov/OutpatientCodeEdit/).

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Edits Affected</th>
<th>Modification</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/1/2018</td>
<td>1, 2, 3, 5, 86</td>
<td>Updated diagnosis code editing for validity, age, gender and manifestation based on the FY 2019 ICD-10-CM code revisions to the Medicare Code Editor (MCE).</td>
</tr>
<tr>
<td>10/1/2018</td>
<td>29</td>
<td>Updated the mental health diagnosis list based on the FY 2019 ICD-10-CM code revisions.</td>
</tr>
<tr>
<td>4/1/2018</td>
<td>106, 107, 108</td>
<td>Update Critical Care exception under Add-on Code Editing to only be applicable to bill type 85x submitting professional services with revenue codes 96x, 97x, and 98x.</td>
</tr>
<tr>
<td>4/1/2018</td>
<td>107</td>
<td>Update the logic for Add-on Code Edit 107 to be applied only for claims with bill type 85x (Critical Access Hospital (CAH)) and only for professional services reported with revenue codes 96x, 97x and 98x. See also the Edits Applied by Bill Type tables.</td>
</tr>
<tr>
<td>4/1/2018</td>
<td>106, 107, 108</td>
<td>Update logic for Add-on Code Editing to implement the edit processing at the claim level rather than line level (line item date of service (LIDOS)). Exception: Claims with 85x bill type reporting professional services with revenue codes 96x, 97x, and 98x continue to process add-on edits at the day level (LIDOS).</td>
</tr>
<tr>
<td>Date</td>
<td>Description</td>
<td></td>
</tr>
<tr>
<td>------------</td>
<td>------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>1/1/2012</td>
<td>Update logic for NCCI Editing to not apply edits 20 or 40 across professional revenue codes (96x, 97x, or 98x) and facility revenue codes submitted on an 85x bill type for CAH. (Note: This change will be made retroactively to both edits inception)</td>
<td></td>
</tr>
<tr>
<td>10/1/2018</td>
<td>Update Add-on Code Editing section to include additional conditions for editing.</td>
<td></td>
</tr>
<tr>
<td>10/1/2018</td>
<td>Update Partial Hospitalization section to note that PHP/DMH processing logic does not occur if there is an inpatient only procedure on the same claim. This is already existing logic that just needed to be documented within the respective processing section.</td>
<td></td>
</tr>
<tr>
<td>10/1/2018</td>
<td>Update National Correct Coding Initiative (NCCI) section to include the new condition for editing for Critical Access Hospitals (85x) submitting both professional and facility services on the same day/claim.</td>
<td></td>
</tr>
<tr>
<td>10/1/2018</td>
<td>Update the following lists for the release (see quarterly data files): Add on Type I (edit 106)Add on Type III (edit 108) Comprehensive Ambulatory Payment Classification (APC) list Device Procedure list (edit 92) Terminated device procedures for offset Pass-through radiopharmaceutical HCPCS for offset APC (edit 99) Pass-through skin substitute product HCPCS (edit 99) Pass-through contrast HCPCS for offset APC (edit 99) Radiological HCPCS reported with FX or FY modifier Skin Substitute Product (edit 87) Edit 99 Exclusion (edit 99) Contrast HCPCS</td>
<td></td>
</tr>
<tr>
<td>10/1/2018</td>
<td>Make all HCPCS/APC/SI changes as specified by CMS (quarterly data files).</td>
<td></td>
</tr>
<tr>
<td>10/1/2018</td>
<td>Implement version 24.3 of the 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>August 24, 2018</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>

**Hospital OPPS October 2018 Update**

MLN Matters Number: MM10923
Related Change Request (CR) Number: 10923
Related CR Release Date: August 24, 2018
Effective Date: October 1, 2018
Related CR Transmittal Number: R4123CP
Implementation Date: October 1, 2018

**PROVIDER TYPES AFFECTED**

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

CR10923 describes changes to and billing instructions for various payment policies implemented in the October 2018 Outpatient Prospective Payment System (OPPS) update. The October 2018 Integrated Outpatient Code Editor (I/OCE) will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in CR10923. Make sure your billing staffs are aware of these updates.

BACKGROUND

CR 10923 informs you of the following changes to billing instructions for various payment policies implemented in the October 2018 OPPS update.

Key changes are as follows:

1. New Separately Payable Procedure Code

Effective October 1, 2018, HCPCS code C9750 is created, as described in Table 1, and assigned to APC 5223 (Level 3 Pacemaker and Similar Procedures) with a payment rate of $9,747.99. This procedure was previously described by Category III Current Procedural Terminology (CPT) code 0302T, which was deleted December 31, 2017.

Table 1 - New Separately Payable Procedure Code, Effective October 1, 2018

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>SI</th>
<th>APC</th>
<th>Payment Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9750</td>
<td>Ins/rem-replace compl iims</td>
<td>Insertion or removal and replacement of intracardiac ischemia monitoring system including imaging supervision and interpretation and peri-operative interrogation and programming; complete system (includes device and electrode)</td>
<td>J1</td>
<td>5223</td>
<td>$9,747.99</td>
</tr>
</tbody>
</table>

2. Drugs, Biologicals, and Radiopharmaceuticals

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

For Calendar (CY) 2018, payment for separately payable, non-pass-through drugs, biologicals and therapeutic radiopharmaceuticals that were not acquired through the 340B Program is made at a single rate of ASP + 6 percent (or ASP - 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 October 1, 2018, and drug price restatements are in the October 2018 update of the OPPS Addendum A and Addendum B on the Centers for Medicare & Medicaid Services (CMS) website at http://www.cms.gov/HospitalOutpatientPPS/.

b. Drugs and Biologicals Based on ASP Methodology with Restated Payment Rates

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

c. Drugs and Biologicals with OPPS Pass-Through Status Effective October 1, 2018

Eight drugs and biologicals have been granted OPPS pass-through status, effective October 1, 2018. These drugs and biologicals are described in Section 2b and 2c of this article and are in Tables 2 and 3.

Four drugs and biologicals have been granted new OPPS pass-through status, effective October 1, 2018. CMS received a completed pass-through application for these drugs, which passed both the newness
and cost criteria to receive pass-through payment. These items, along with their descriptors and APC assignments, are identified in Table 2.

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

Table 2 – Drugs and Biologicals with OPPS Pass-Through Status Effective October 1, 2018

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
<th>SI</th>
<th>APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9033</td>
<td>Injection, fosnetupitant 235 mg and palonosetron 0.25 mg</td>
<td>G</td>
<td>9099</td>
</tr>
<tr>
<td>C9034</td>
<td>Injection, dexamethasone 9%, intraocular, 1 mcg</td>
<td>G</td>
<td>9172</td>
</tr>
<tr>
<td>Q5105</td>
<td>Injection, epoetin alfa, biosimilar, (Retacrit) (for esrd on dialysis), 100 units</td>
<td>G</td>
<td>9096</td>
</tr>
<tr>
<td>Q5106</td>
<td>Injection, epoetin alfa, biosimilar, (Retacrit) (for non-esrd use), 1000 units</td>
<td>G</td>
<td>9097</td>
</tr>
</tbody>
</table>

Table 3 – Drugs and Biologicals Receiving Pass-Through Status in Accordance with Public Law 115-141 Effective October 1, 2018

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
<th>SI</th>
<th>APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>A9586</td>
<td>Florbetapir f18, diagnostic, per study dose, up to 10 millicuries</td>
<td>G</td>
<td>9084</td>
</tr>
<tr>
<td>C9447</td>
<td>Injection, phenylephrine and ketorolac, 4 ml vial</td>
<td>G</td>
<td>9083</td>
</tr>
<tr>
<td>Q4172</td>
<td>PuraPly, and PuraPly Antimicrobial, any type, per square centimeter</td>
<td>G</td>
<td>9082</td>
</tr>
<tr>
<td>Q9950</td>
<td>Injection, sulfur hexafluoride lipid microsphere, per ml</td>
<td>G</td>
<td>9085</td>
</tr>
</tbody>
</table>

d. Proposed Drugs, Biologicals, and Radiopharmaceuticals with Pass-Through Status as a Result of Section 1301 of the Consolidated Appropriations Act of 2018 (Public Law 115-141)

Section 1301(a)(1) of the Consolidated Appropriations Act of 2018 (Pub. L. 115-141) amended section 1833(t)(6) of the Social Security Act and added a new section 1833(t)(6)(G), which provides that, for drugs or biologicals whose period of pass-through payment status ended on December 31, 2017, and for which payment was packaged into a covered hospital outpatient service furnished beginning January 1, 2018, such pass-through payment status shall be extended for a 2-year period beginning on October 1, 2018, through September 30, 2020. There are four products whose period of drug and biological pass-through payment status ended on December 31, 2017; these four drugs and biologicals will have pass-through status reinstated effective October 1, 2018. These products are listed in Table 3.

Beginning in CY 2019, CMS proposed to continue pass-through payment status for these drugs and biologicals (83 FR 37114).

Section 1301(a)(1) of Pub. L. 115-141 also added a new subparagraph (H) to section 1833(t)(6) to the Act, which provides for a temporary payment rule for drugs and biologicals whose period of pass-through payment ended on December 31, 2017. Under this provision, the payment amount for such drugs or biologicals furnished during the period beginning on October 1, 2018 and ending on March 31, 2019, shall be the greater of the payment amount that would otherwise apply under subparagraph (D)(i) for such drug or biological or the payment amount that applied under subparagraph (D)(i) for such drug or biological on December 31, 2017. In addition, section 1301(a)(1) of Pub. L. 115-141 added a new subparagraph (I) to section 1833(t)(6) to require that, for any drug or biological whose period of pass-through payment ended on December 31, 2017, and for which payment under this subsection is packaged into a payment amount for a covered hospital Outpatient Department (OPD) service (or group of services) furnished during the period beginning on October 1, 2018, and ending on December 31, 2018, the Secretary shall remove the packaged costs of such drug or biological from the payment amount for the covered OPD service with which it is packaged. Finally, section 1301(a)(3) of Pub. L. 115-141 permits the Secretary to implement the amendments made by section 1301(a)(1) and (2) by program instruction or otherwise. CR10923 implements the requirement in section 1833(t)(6)(l)(i) to remove the packaged costs of the drugs or biologicals listed in Table 3 from the payment amounts for the covered OPD services (or groups of services) with which they are packaged.

As explained above, these drugs and biologicals will be receiving separate payment under the OPPS instead of having their costs packaged into the payment amount for associated procedures for the period
beginning October 1, 2018 through December 31, 2018. Therefore, CMS updated the CY 2018 payment rates to reflect the separate payment for the drugs and biologicals listed in Table 3 and found the payment rates for the 10 APCs listed in Table 4 were affected by the separate payment for these drugs and biologicals, and therefore, CMS removed the costs of the drugs and biologicals from the payment amounts for these APCs. The updated payment rates for these APCs, which are effective October 1, 2018 through December 31, 2018, are in the October 2018 update of the OPPS Addendum A and Addendum B at http://www.cms.gov/HospitalOutpatientPPS/.

Table 4 – APCs with New Payment Rates because of the Separate Payment for Certain Drugs and Biologicals Receiving Pass-Through Status in Accordance with Public Law 115-141 Effective October 1, 2018, through December 31, 2018

<table>
<thead>
<tr>
<th>Long Descriptor</th>
<th>SI</th>
<th>APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 5 Intraocular Procedures</td>
<td>J1</td>
<td>5495</td>
</tr>
<tr>
<td>Level 1 Intraocular Procedures</td>
<td>J1</td>
<td>5491</td>
</tr>
<tr>
<td>Level 3 Imaging with Contrast</td>
<td>S</td>
<td>5573</td>
</tr>
<tr>
<td>Level 4 Nuclear Medicine and Related Services</td>
<td>S</td>
<td>5594</td>
</tr>
<tr>
<td>Level 3 Intraocular Procedures</td>
<td>J1</td>
<td>5493</td>
</tr>
<tr>
<td>Level 2 Intraocular Procedures</td>
<td>J1</td>
<td>5492</td>
</tr>
<tr>
<td>Level 3 ENT Procedures</td>
<td>T</td>
<td>5163</td>
</tr>
<tr>
<td>Level 2 Imaging with Contrast</td>
<td>S</td>
<td>5572</td>
</tr>
<tr>
<td>Pulmonary Treatment</td>
<td>S</td>
<td>5791</td>
</tr>
<tr>
<td>Level 4 Extraocular, Repair, and Plastic Eye Procedures</td>
<td>J1</td>
<td>5504</td>
</tr>
</tbody>
</table>

e. New Biosimilar HCPCS Code

HCPCS code Q5108, listed in Table 5, is a biosimilar with the trade name Fulphila that will be paid separately in the OPPS. The code will be included in the OPPS with an effective date retroactive to July 12, 2018, per CR10834, which states that HCPCS code is payable for Medicare for claims with a date of service on or after July 12, 2018.

Table 5 - New Biosimilar HCPCS Code Effective July 12, 2018

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
<th>SI</th>
<th>APC</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5108</td>
<td>Injection, pegfilgrastim-jmdb, biosimilar, (fulphila), 0.5 mg</td>
<td>K</td>
<td>9173</td>
<td>07/12/2018</td>
</tr>
</tbody>
</table>

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

One skin substitute product, HCPCS code Q4181, is 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 6.

Table 6 – Reassignment of Skin Substitute Product from the Low Cost Group to the High Cost Group Effective October 1, 2018

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>SI</th>
<th>Low/High Cost Skin Substitute</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q4181</td>
<td>Amnio wound, per square cm</td>
<td>N</td>
<td>High</td>
</tr>
</tbody>
</table>

4. Changes to OPPS Pricer Logic

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

b. Effective October 1, 2018, there will be one contrast agent, Q9950, receiving pass-through payment in the OPPS Pricer logic. For APCs containing nuclear medicine procedures, the I/OCE will send the off-set
amount of the pass-through for the contrast agent, then Pricer will reduce the amount of the pass-through contrast agent payment by the wage-adjusted offset for the APC with the highest offset amount when the contrast agent with pass-through appears on a claim with a nuclear procedure. The offset will cease to apply when the contrast agent expires from pass-through status. The offset amounts for diagnostic radiopharmaceuticals are the “policy-packaged” portions of the CY 2018 APC payments for nuclear medicine procedures and are on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html.

5. 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>
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</thead>
<tbody>
<tr>
<td>August 27, 2018</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>

Billing Requirements Implemented for Non-OPPS Providers – Reminder

MLN Matters Number: SE18012
Related Change Request (CR) Number: 10504; 10699
Related CR Release Dates: March 16, 2018; June 15, 2018
Effective Date: April 1, 2018; July 1, 2018
Related CR Transmittal Numbers: R2044OTN and R4074CP
Implementation Date: April 2, 2018 for CR10504 and July 2, 2018 for CR10699

PROVIDER TYPES AFFECTED
This MLN Matters® Special Edition Article is intended for non-Outpatient Prospective Payment System (OPPS) hospital providers (for example, Maryland Waiver hospitals, Critical Access Hospitals (CAH)) and other non-OPPS provider types (for example, Outpatient Rehabilitation Facility (ORF), Comprehensive Outpatient Rehabilitation Facility (CORF), Skilled Nursing Facility (SNF), End Stage Renal Disease (ESRD) Facility, Home Health Agency (HHA)).

WHAT YOU NEED TO KNOW
This article conveys enforcement editing requirements for the Medicare Claims Processing Manual, Chapter 12, Section 30 which describes Correct Coding Policy, Section D. Coding Services Supplemental to Principal Procedure (Add-On Codes) Code and Chapter 23, Section 20.9 which describes the Correct Coding Initiative. These requirements are not new requirements. Previously, these requirements were discussed in CRs 10504 and 10699, which were effective on April 1, 2018 and July 1, 2018. MLN Matters article for CR 10699 is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10699.pdf. CR 10504 is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R2044OTN.pdf. Make sure your billing staff is aware of these instructions.
BACKGROUND

Correct Coding Initiative (CCI) Edits History

The Centers for Medicare & Medicaid Services (CMS) developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims. CMS developed its coding policies based on coding conventions defined in the American Medical Association’s CPT Manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices.

Since 1996 the Medicare NCCI procedure to procedure (PTP) edits have been assigned to either the Column One/Column Two Correct Coding edit file or the Mutually Exclusive edit file based on the criterion for each edit. The Mutually Exclusive edit file included edits where two procedures could not be performed at the same patient encounter because the two procedures were mutually exclusive based on anatomic, temporal, or gender considerations. All other edits were assigned to the Column One/Column Two Correct Coding edit file.

In order to simplify the use of PTP edit files, CMS consolidated the two edit files into the Column One/Column Two Correct Coding edit file. This change occurred for PTP edits in NCCI version 18.1 scheduled for April 1, 2012. After this date, it will only be necessary to search the Column One/Column Two Correct Coding edit file for active or previously deleted edits.

NCCI PTP edits are used by Medicare Administrative Contractors (MACs) to adjudicate provider claims for physician services, outpatient hospital services, and outpatient therapy services. They are not applied to facility claims for inpatient services.

Although the NCCI was initially developed for use by Medicare Carriers (A/B MACs processing practitioner service claims) to process Part B claims, many of the edits were added to the Outpatient Code Editor (OCE) in August, 2000, for use by Fiscal Intermediaries (A/B MACs processing outpatient hospital service claims) to process claims for Part B outpatient hospital services. Some of the edits applied to outpatient hospital claims through OCE differ from the comparable edits in NCCI. Effective January 2006, all therapy claims at most sites of service paid by A/B MACs processing facility claims (Fiscal Intermediaries) were also subject to NCCI PTP edits in the OCE. These include, but are not limited to, therapy services reported by SNFs, CORFs, HHAs, and outpatient rehabilitation agencies (OPTs - outpatient physical therapy and speech pathology services). NCCI PTP edits used for practitioner claims are also used for Ambulatory Surgical Center claims.

Prior to January 1, 2012, NCCI PTP edits incorporated into OCE appeared in OCE one calendar quarter after they appear in NCCI. Effective January 1, 2012, NCCI PTP edits in OCE appear synchronously with NCCI PTP edits for practitioners. Hospitals, like physicians and other providers, must code correctly even in the absence of NCCI or OCE edits. For example, new category I CPT codes are generally effective on January 1 each year, and many new edits for these codes appear in NCCI on January 1. Prior to January 1, 2012, the new edits for these codes did not appear in OCE until the following April 1. Hospitals were required to code correctly during the three month delay.

OCE will generate CCI edit dispositions. All current CCI edits will be incorporated in the OCE.

The CCI edits are applicable to claims submitted on behalf of the same beneficiary, provided by the same provider and on the same date of service. The edits are of two major types of coding situations. One type, referred to as the comprehensive/component edits, are those edits which are applied to code combinations where one of the codes is a component of the more comprehensive code. In this instance only the comprehensive code is paid. The other type, referred to as the mutually exclusive edits, are those edits which are applied to code combinations where one of the codes is considered to be either impossible or improbable to be performed with the other code. Other unacceptable code combinations are also included. One such code combination consists of one code that represents a service “with” something and the other is “without” the something. The edit is set to pay the lesser priced service.

OCE / OPPS OCE / Non-OPPS OCE / IOCE History

OCE

Prior to OPPS implementation in August 2000, all outpatient claims processed through the OCE for basic editing. The software focused solely on editing claims without specifying any action to take when an
edit occurred. It also did not compute any information for payment purposes. With the implementation of the OPPS in August 2000, CMS planned to apply CCI edits within the OCE, with the exception of anesthesiology, to hospital outpatient claims. The purpose of the CCI edits is to ensure the most comprehensive groups of codes are billed rather than the component parts. Additionally, CCI edits check for mutually exclusive code pairs. These edits were being implemented to ensure that only appropriate codes are grouped and priced. All of this editing was maintained by a single OCE.

While the software maintained the editing logic of previous versions, assignment of APC numbers for services has been added to meet Medicare’s mandated OPPS implementation. The revised program indicates what actions to take when an edit occurs, and the reason(s) why the actions are necessary. For example, an edit can cause a line item to be denied payment while still allowing the claim to be processed for payment. In this case, the line item cannot be resubmitted but can be appealed.

A major change was the processing of claims with service dates that span more than one day. Each claim is represented by a collection of data, consisting of all necessary demographic (header) data, plus all services provided (line items).

Note: It is the user’s responsibility to organize all applicable services into a single claim record and pass them as a unit to the software.

The OCE only functions on a single claim and does not have any cross claim capabilities. The software can accept up to 450 line items per claim.

Certain services (for example, physical therapy, diagnostic clinical laboratory) are excluded from Medicare’s prospective payment system for hospital outpatient departments. These services are exceptions paid under fee schedules and other prospectively determined rates.

**OPPS OCE versus non-OPPS OCE**

Due to the uniqueness of some institutional claims processing and payment methodologies, it was necessary to separate the OCE into two separate software packages (an OPPS OCE and a non-OPPS OCE) until the differences could be addressed. This separation began in January 1, 2001. It continued until January 2008. Many of the specific editing with dispositions had to be abandoned for the non-OPPS hospital claims.

**The ‘Integrated’ Outpatient Code Editor (I/OCE)**

Finally in July 2007, the OCE logic could be updated and implemented with an “Integrated” approach. The I/OCE program processes claims for all outpatient institutional providers including hospitals that are subject to the OPPS as well as hospitals that are NOT (Non-OPPS). Claim will be identified as ‘OPPS’ or ‘Non-OPPS’ by passing a flag to the OCE in the claim record, 1=OPPS, 2=Non-OPPS; a blank, zero, or any other value is defaulted to 1.

The I/OCE software combines editing logic to disposition with the new Ambulatory Payment Classification (APC) assignment program designed to meet the mandated OPPS implementation. The software performs the following functions when processing a claim:

- Edits a claim for accuracy of submitted data
- Assigns APCs
- Assigns CMS-designated status indicators
- Assigns payment indicators
- Computes discounts, if applicable
- Determines a claim disposition based on generated edits
- Determines if packaging is applicable
- Determines payment adjustment, if applicable

This integration does not change current logic that is applied to outpatient bill types that already pass through the OPPS OCE software.

Editing that only applied to OPPS hospitals (for example, blood, drug, partial hospitalization logic) in the past will not be applied to non-OPPS hospitals at this time. However, with the I/OCE, line items on claims from
non-OPPS hospitals will be assigned specific edit numbers and dispositions, where in the past; this type of detail was not provided.

**Addition of Specific Edit Numbers and Dispositions for non-OPPS Hospitals**

With the implementation of the July 2018 release of the I/OCE, CMS was able to revisit and re-instate NCCI PTP editing, along with additional editing with disposition into the system logic for non-OPPS hospitals and other non-OPPS provider types.

- NCCI Add-on Code editing with Edits 106, 107, and 108
- Invalid procedure code editing with Edit 6
- Invalid modifier editing with Edit 22
- NCCI PTP editing with Edits 20 and 40

As indicated by the development of the NCCI program, it has always been CMS’s intent that all providers code correctly as we continue to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims regardless of our ability to edit on a pre-payment basis.

Tables 6.3 and 6.4 were updated in the I/OCE CMS Specifications V19.2.R1 Effective 07/01/2018 as found on our website on the OCE Quarterly Release Files July 2018 Quarterly Data file zip file link at [https://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/OCEQtrReleaseSpecs.html](https://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/OCEQtrReleaseSpecs.html).

**6.3 OCE Edits Applied by OPPS Bill Type Table [OPPS Flag =1]**

<table>
<thead>
<tr>
<th>Row #</th>
<th>Provider/Bill Types</th>
<th>Edits Applied (by edit number)</th>
<th>APC Buffer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>12x or 14x with condition code 41</td>
<td>46</td>
<td>Buffer not completed</td>
</tr>
<tr>
<td>2</td>
<td>12x or 14x without condition code 41</td>
<td>1-9, 11-18, 20-23, 25-28, 35-38, 40-45, 47-50, 52-54, 56-58, 60-79, 81-85, 87, 92, 93, 94, 98, 99, 100, 102, 103, 105</td>
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</tr>
<tr>
<td>3</td>
<td>13x with condition code 41</td>
<td>1-9, 11-18, 20-23, 25-28, 29-34, 37, 38, 40-45, 47-50, 52, 54, 56-58, 60-62, 65-80, 82-85, 87, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 105</td>
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<tr>
<td>4</td>
<td>13x without condition code 41</td>
<td>1-9, 11-18, 20-23, 25-28, 35-38, 40-45, 47-50, 52, 54, 56-58, 60-79, 81, 82-85, 87, 92, 93, 94, 98, 99, 100, 101, 102, 103, 105</td>
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</tr>
<tr>
<td>5</td>
<td>76x (CMHC)</td>
<td>1-9, 11-13, 15, 18, 20, 22, 23, 25, 26, 29-34, 38, 40, 41, 43-45, 47-50, 53-55, 61, 65, 69, 71-73, 75, 77-80, 82, 84, 85, 87, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 105</td>
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<tr>
<td>6</td>
<td>34x (HHA) with Vaccine Administration, Antigens, Splints, Casts or NPWT</td>
<td>1-5, 7-9, 11-13, 15, 18, 20, 25-26, 28, 38, 40, 41, 43-45, 47, 49-50, 53-55, 62, 65, 69, 71, 73, 75, 77-79, 82, 84, 85, 87, 92, 93, 94, 98, 99, 100, 105</td>
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</tr>
<tr>
<td>7</td>
<td>34x (HHA) without Vaccine Administration, Antigens, Splints, Casts or NPWT</td>
<td>1-5, 7-9, 11-13, 20, 25, 26, 40-41, 44, 50, 53-55, 65, 69, 94</td>
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<tr>
<td>8</td>
<td>43x (RNHCI)</td>
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<td>9</td>
<td>71x (RHC), 77x (FQHC through v15.2)</td>
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</tr>
<tr>
<td>Row #</td>
<td>Provider/Bill Types</td>
<td>Edits Applied (by edit number)</td>
<td>APC buffer</td>
</tr>
<tr>
<td>-------</td>
<td>---------------------</td>
<td>--------------------------------</td>
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</tr>
<tr>
<td>1</td>
<td>12X or 14X with condition code 41, and OPPS flag = 2</td>
<td>1-3, 5, 6, 8, 9, 11, 12, 15, 17, 20, 22, 23, 24, 25, 26, 28, 40, 41, 50, 53, 54, 61, 65, 67-69, 72, 83, 94, 103, 106, 107, 108</td>
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<tr>
<td>2</td>
<td>12X or 14X without condition code 41, and OPPS flag = 2</td>
<td>1-3, 5, 6, 8, 9, 11, 12, 15, 17, 20, 22, 23, 24, 25, 26, 28, 40, 41, 50, 53, 54, 61, 65, 67-69, 72, 83, 94, 103, 106, 107, 108</td>
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<tr>
<td>3</td>
<td>13X with condition code 41, and OPPS flag = 2</td>
<td>1-3, 5, 6, 8, 9, 11, 12, 15, 17, 20, 22, 23, 24, 25, 26, 28, 40, 41, 50, 54, 61, 65, 67-69, 72, 83, 94, 103, 106, 107, 108</td>
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<tr>
<td>4</td>
<td>13X without condition code 41, and OPPS flag = 2</td>
<td>1-3, 5, 6, 8, 9, 11, 12, 15, 17, 20, 22, 23, 24, 25, 26, 28, 40, 41, 50, 54, 61, 65, 67-69, 72, 83, 94, 103, 106, 107, 108</td>
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</tr>
<tr>
<td>5</td>
<td>85X, and OPPS flag = 2</td>
<td>1-3, 5, 6, 8, 9, 11, 12, 15, 20, 22, 23, 24, 25, 26, 28, 40, 41, 50, 54, 61, 65, 67-69, 72, 74, 83, 94, 106, 107, 108</td>
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</tr>
</tbody>
</table>

**6.4 OCE Edits Applied by Non-OPPS Hospital Bill Type Table [OPPS Flag = 2]**

**DOCUMENT HISTORY**

<table>
<thead>
<tr>
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<th>Description</th>
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<tbody>
<tr>
<td>September 4, 2018</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>
IMRT Planning Services Editing

MLN Matters Number: SE18013
Article Release Date: September 11, 2018

PROVIDER TYPE AFFECTED

This MLN Matters® Special Edition Article is intended for Outpatient Prospective Payment System (OPPS) providers submitting claims for outpatient Intensity-Modulated Radiation Therapy (IMRT) planning to Medicare Administrative Contractors (MACs).

WHAT YOU NEED TO KNOW

IMRT is a procedure that delivers radiation with adjusted intensity to preserve adjoining normal tissue. IMRT is provided in two treatment phases, planning and delivery. Medicare pays hospitals under the OPPS a bundled payment for the planning phase. The bundled payment covers a range of services that may be performed as part of developing an IMRT treatment plan. The bundled payment covers these services regardless of when they are billed.

This article provides a reminder to hospitals that bill for outpatient IMRT planning services to ensure that they bill correctly and avoid overpayments.

BACKGROUND

IMRT also known as conformal radiation, delivers radiation with adjusted intensity to preserve adjoining normal tissue. IMRT can deliver a higher dose of radiation within the tumor while delivering a lower dose of radiation to surrounding healthy tissue. IMRT is provided in two treatment phases, planning and delivery. The planning phase includes simulations.

When IMRT is furnished to beneficiaries in a hospital outpatient department that is paid under the hospital OPPS, hospitals must remember that CPT codes 77014, 77280, 77285, 77290, 77295, 77306 through 77321, 77331, and 77370 are included in the Ambulatory Payment Classification (APC) payment for CPT code 77301 (IMRT planning). You should not report these codes in addition to CPT code 77301, when provided prior to, or as part of, the development of the IMRT plan. The charges for these services should be included in the charge associated with CPT code 77301, even if the individual services associated with IMRT planning are performed on dates of service other than the date on which CPT code 77301 is reported.

ADDITIONAL INFORMATION


MLN Matters Article MM9658, July 2016 Update of the Hospital Outpatient Prospective Payment System (OPPS) also contains these instructions for IMRT and it is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9658.pdf.


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<tr>
<td>September 11, 2018</td>
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</tr>
</tbody>
</table>
**PREVENTIVE SERVICES**

**Prostate Cancer Screenings**

September is Prostate Cancer Awareness Month. Did you know that the average age at the time of diagnosis is about 66? About one in every 41 men will die of prostate cancer. The good news is that although prostate cancer is a serious disease, most men diagnosed with prostate cancer do not die from it. You can access the American Cancer Society for Key Statistics for Prostate Cancer to learn more about this type of cancer.

Discuss prostate cancer screenings with your patients and which may be appropriate for them. Medicare provides coverage for Digital Rectal Exams (DREs) and Prostate Specific Antigen (PSA) blood tests once every 12 months for all male beneficiaries aged 50 and older.

Review the CMS MLN Prostate Cancer Awareness Month article for information on free educational products related to Medicare-covered prostate cancer screenings.

*This document was developed through the A/B Medicare Administrative Contractor Provider Outreach & Education 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.*

**Influenza Virus Vaccine Code Update – January 2019 – Revised**

MLN Matters Number: MM10871 Revised  
Related Change Request (CR) Number: 10871  
Related CR Release Date: September 5, 2018  
Effective Date: January 1, 2019  
Related CR Transmittal Number: R4127CP  
Implementation Date: January 7, 2019

This article was revised on September 6, 2018 to reflect the revised CR10871 issued on September 5. In the article, the CR release date, transmittal number, and the Web address for accessing CR10871 are revised. All other information remains the same.

**PROVIDER TYPE AFFECTED**

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

**PROVIDER ACTION NEEDED**

Change Request (CR) 10871 provides instructions for payment and edits for Medicare’s Common Working File (CWF) and Fiscal Intermediary Shared System (FISS) to include and update new or existing influenza virus vaccine codes. This update includes one new influenza virus vaccine code: 90689. Please make certain your billing staffs are aware of this update.

**BACKGROUND**

Effective for claims processed with Dates of Service (DOS) on or after January 1, 2019, influenza virus vaccine code 90689 (Influenza virus vaccine quadrivalent (IIV4), inactivated, adjuvanted, preservative free, 0.25mL dosage, for intramuscular use) will be payable by Medicare. The short descriptor is VACC IIV4 NO PRSRV 0.25ML IM. This new code will be included on the 2019 Medicare Physician Fee Schedule Database file update and the annual Healthcare Common Procedure Coding System (HCPCS) update.

Except as noted below, MACs will use the Centers for Medicare & Medicaid Services (CMS) Seasonal Influenza Vaccines Pricing webpage: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html to obtain the payment rate for 90689. The new influenza virus vaccine code 90689 is not retroactive to August 1, 2018. No claims should be accepted for influenza virus vaccine code 90689 between the DOS August 1, 2018, and December 31, 2018. If claims are received in January 2019 with code 90689 for DOS between August 1, 2018, and December 31, 2018, MACs will follow their normal course of action for codes billed prior to their effective date.
PREVENTIVE SERVICES

Payment Basis for Institutional Claims
MACs will pay for influenza virus vaccine code 90689 with a Type of Service (TOS) of V based on reasonable cost to
• Hospitals (Type of Bill 12X and 13X)
• Skilled Nursing Facilities (22X and 23X)
• Home Health Agencies (34X)
• Hospital-based renal dialysis facilities (72X)
• Critical Access Hospitals (85X)
MACs will pay for influenza virus vaccine code 90689 with a TOS of V based on the lower of the actual charge or 95 percent of the Average Wholesale Price (AWP), to:
• Indian Service Hospitals (IHS) (12X and 13X)
• Hospices (81X and 82X)
• IHS Critical Access Hospitals (85X)
• Comprehensive Outpatient Rehabilitation Facilities (CORFs) (75X)
• Independent Renal Dialysis Facilities (72X)
Note: In all cases, coinsurance and deductible do not apply.

ADDITIONAL INFORMATION

DOCUMENT HISTORY

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<thead>
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<tr>
<td>September 6, 2018</td>
<td>The article was revised to reflect the revised CR10871 issued on September 5. In the article, the CR release date, transmittal number, and the Web address for accessing CR10871 are revised. All other information remains the same.</td>
</tr>
<tr>
<td>August 6, 2018</td>
<td>Initial article released.</td>
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</table>

Influenza Vaccine Payment Allowances for 2018-2019 Season

MLN Matters Number: MM10914
Related Change Request (CR) Number: 10914
Related CR Release Date: August 31, 2018
Effective Date: August 1, 2018
Related CR Transmittal Number: R4124CP
Implementation Date: No later than October 1, 2018

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

PROVIDER ACTION NEEDED
Change Request (CR) 10914 informs MACs about payment allowances for influenza virus vaccines, which are updated on August 1 of each year. The Centers for Medicare & Medicaid Services (CMS) will post
the payment allowances for influenza vaccines that are approved after the release of CR 10914 at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html. Make sure your billing staffs are aware that the payment allowances are being updated.

BACKGROUND

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

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

The Medicare Part B payment allowances for dates of service of August 1, 2018, through July 31, 2019, are still pending as of the date of CR10914 for CPT codes 90630, 90653, 90654, 90655, 90656, 90657, 90661, 90662, 90672, 90673, 90674, 90682, 90685, 90686, 90687, 90688, 90756, and HCPCS codes Q2035, Q2036, Q2037, and Q2038. Once payment allowances are available, they will be posted at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html.

Payment allowances for codes for which products have not yet been approved will be provided when the products have been approved and pricing information becomes available to CMS.

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

Note: MACs will reprocess any previously processed and paid claims for the current flu season that were paid using influenza vaccine payment allowances other than the allowances published in the influenza vaccine pricing website for the 2018/2019 season, that began on August 1, 2018. This reprocessing should occur by November 1, 2018.

ADDITIONAL INFORMATION


DOCUMENT HISTORY

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<tbody>
<tr>
<td>September 4, 2018</td>
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</table>

Review of Opioid Use During the IPPE and AWV

MLN Matters Number: SE18004
Article Release Date: August 28, 2018

PROVIDER TYPE AFFECTED

This MLN Matters® Special Edition (SE) article 18004 is intended to emphasize the existing policy for eligible health care professionals who furnish the AWV to Medicare beneficiaries.

WHAT YOU NEED TO KNOW

Medicare covers the following services for Medicare patients that meet certain eligibility requirements:

- The Initial Preventive Physical Examination (IPPE) (also known as the “Welcome to Medicare” Preventive Visit)
- The Annual Wellness Visit (AWV).
These preventive benefits allow you to assess your patients’ health on an annual basis to help you determine if they have any risk factors and if they are eligible for other preventive services and screenings that Medicare covers.

These preventive benefits are a great way for you to detect illnesses in their earliest stages when treatment works best. For example, review of opioid use as an important routine aspect of the patient’s medical history is helpful in diagnosing and then treating as appropriate opioid use disorders (OUD). CMS information on reducing opioid misuse is available at https://www.cms.gov/about-cms/story-page/reducing-opioid-misuse.html.

Note: Please check the physician fee schedule for the exact amount of reimbursement for your locality and setting. The physician fee schedule is available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PFSlookup/index.html.

The Initial Preventative Physical Exam IPPE (“Welcome to Medicare” Preventive Visit)

Medicare covers an IPPE for all patients who are newly enrolled in Medicare Part B.

- The patient must receive this service within the first 12 months after the effective date of their Medicare Part B coverage.
- The IPPE is a one-time benefit.
- The IPPE consists of the following:
  - Review the patient’s medical and social history (Medicare would like to emphasize that review of opioid use is a routine component of this element, including OUD. If a patient is using opioids, assess the benefit from other, non-opioid pain therapies instead, even if the patient does not have OUD but is possibly at risk.)
  - Review potential risk factors for depression and other mood disorders
  - Review functional ability and level of safety
  - Measurement of height, weight, BMI, and visual acuity screening
  - End-of-life planning (upon agreement of the individual)
  - Education, counseling and referral based on the review of previous 5 components
  - Education, counseling and referral for other preventive services, including a brief written plan such as a checklist


The AWV or Annual Wellness Visit

Medicare covers an annual AWV for patients:

- Who are no longer within 12 months of the effective date of their first Part B coverage period and
- Who have not gotten either an IPPE or AWV within the previous 12 months.

Medicare pays for only one first AWV. Medicare will pay for a subsequent AWV for each patient annually. Note: The elements in first and subsequent AWVs, and the codes to bill them, are different.

- The first AWV includes the following elements:
  - A health risk assessment
  - Establishment of a current list of provider and suppliers
  - Review of medical and family history (Medicare would like to emphasize that review of opioid use is a routine component of this element, including OUD. If a patient is using opioids, assess the benefit from other, non-opioid pain therapies instead, even if the patient does not have OUD but is possibly at risk.)
  - Measurement of height, weight, BMI, and blood pressure
  - Review of potential risk factors for depression and other mood disorders
• Review of functional ability and level of safety
  • Detection of any cognitive impairment the patient may have
  • Establishment of a written screening schedule (such as a checklist)
  • Establishment of a list of risk factors
  • Provision of personalized health advice and referral to appropriate health education or other preventive services.

• Subsequent AWVs include the following elements:
  • Review of updated health risk assessment;

Update medical and family history (As mentioned above, Medicare would like to include opioid use in the ‘Review of Medical and Family History’ element of the AWV. Providers are encouraged to pay close attention to opioid use during this element of the AWV. If a patient is using opioids, assess the benefit from other, non-opioid pain therapies instead, even if the patient does not have OUD but is possibly at risk.)

  • Update of list of current providers and suppliers;
  • Measurement of weight and blood pressure;
  • Detection of cognitive impairment the patient may have;
  • Update of the written screening schedule (such as a checklist);
  • Update of the list of risk factors; and
  • Provision of personalized health advice and referral to appropriate health education or other preventive services.

ADDITIONAL INFORMATION

The Medicare Learning Network® has published a variety of additional educational material on Medicare-covered Preventive Services, including:


For general information about Medicare-covered preventive services, visit the CMS Prevention page at http://www.cms.gov/Medicare/Prevention/PreventionGenInfo/index.html. For information to share with your Medicare patients, please visit http://www.medicare.gov.


DOCUMENT HISTORY

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<tr>
<td>August 28, 2018</td>
<td>Initial article released.</td>
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</table>
Influenza Resources for Health Care Professionals for 2018 – 2019

MLN Matters Number: SE18015
Article Release Date: September 24, 2018

PROVIDER TYPES AFFECTED
All health care professionals who order, refer, or provide flu vaccines and vaccine administration to Medicare beneficiaries and submit bills for these services to Medicare Administrative Contractors (MACs).

PROVIDER ACTION NEEDED
Special Edition (SE) MLN Matters article SE18015 provides information about influenza (flu) resources for health care professionals and providers relevant to the 2018-2019 flu season. Health care professionals should:

- Keep this article and refer to it throughout the 2018-2019 flu season.
- Take advantage of each office visit as an opportunity to encourage patients to protect themselves from the flu and serious complications by getting a flu shot.
- Continue to provide the flu shot if you have vaccine available, even after the new year.
- Remember to immunize yourself and your staff.

BACKGROUND
The Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that Medicare Part B reimburses health care providers for flu vaccines and their administration (Medicare provides coverage of the flu vaccine without any out-of-pocket costs to the Medicare patient. No deductible or copayment/coinsurance applies).

You can help your Medicare patients reduce their risk for contracting seasonal flu and serious complications by using every office visit as an opportunity to recommend they take advantage of Medicare’s coverage of the annual flu shot. As a reminder, please help prevent the spread of the flu by immunizing yourself and your staff!

Know What to Do About the Flu!

Payment Rates for 2018-2019
Each year, CMS updates the Medicare Healthcare Common Procedure Coding System (HCPCS) and Current Procedure Terminology (CPT) codes and payment rates for personal flu and pneumococcal vaccines. Payment allowance limits for such vaccines are 95 percent of the Average Wholesale Price (AWP), except where the vaccine is furnished in a hospital outpatient department, Rural Health Clinic (RHC), or Federally Qualified Health Center (FQHC). In these cases, the payment for the vaccine is based on reasonable cost.

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

The following table contains the applicable Medicare Part B payment allowances for HCPCS and CPT codes:

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<th>Drug Name</th>
<th>Payment Allowance</th>
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<td>Sanofi Pasteur</td>
<td>Fluzone High-Dose (2018/2019)</td>
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<td>08/01/2018 – 07/31/2019</td>
</tr>
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<td>CPT Code</td>
<td>Manufacturer</td>
<td>Vaccine Description</td>
<td>Amount</td>
<td>Dates of Service</td>
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<tr>
<td>90682</td>
<td>Sanofi Pasteur</td>
<td>Flublok Quadrivalent (2018/2019)</td>
<td>$53.373</td>
<td>08/01/2018 – 07/31/2019</td>
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<tr>
<td>90687</td>
<td>Sanofi Pasteur</td>
<td>Fluzone Quadrivalent Pediatric (2018/2019)</td>
<td>$9.403</td>
<td>08/01/2018 – 07/31/2019</td>
</tr>
<tr>
<td>90756</td>
<td>Seqirus Inc</td>
<td>Flucelvax Quadrivalent (2018/2019)</td>
<td>$22.793</td>
<td>08/01/2018 – 07/31/2019</td>
</tr>
<tr>
<td>Q2035</td>
<td>Seqirus Inc</td>
<td>Afluria (2018/2019)</td>
<td>$18.236</td>
<td>08/01/2018 – 07/31/2019</td>
</tr>
</tbody>
</table>

Payment allowance information is still pending as of the date of this article for other CPT and HCPCS codes. Once payment allowances are available, CMS will post them at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html).

For 2018/2019, there is a new CPT code (90689), for which the applicable Dates of Service (DOS) are January 1, 2019, through July 31, 2019. The payment rate for 90689 is pending. The new influenza virus vaccine code 90689 is not retroactive to August 1, 2018. No claims will be accepted for influenza virus vaccine code 90689 for DOS between August 1, 2018, through December 31, 2018. If MACs receive claims with code 90689 for DOS between August 1, 2018, and December 31, 2018, MACs will follow their normal course of action for codes billed prior to their effective date.


**Note:** MACs will reprocess any previously processed and paid claims for the current flu season that were paid using influenza vaccine payment allowances other than the allowedance published in the influenza vaccine pricing website for the 2018/2019 season that began on August 1, 2018. This reprocessing should occur by November 1, 2018.

**ADDITIONAL INFORMATION**

Educational Products for Health Care Professionals

The Medicare Learning Network® (MLN) has developed a variety of educational resources to help you understand Medicare guidelines for seasonal flu vaccines and their administration.

1. **MLN Influenza Related Products for Health Care Professionals**

PREVENTIVE SERVICES

Network-MLN/MLNProducts/downloads/qr_immun_bill.pdf

Medicare Preventive Services educational tool - https://www.cms.gov/Medicare/Prevention/PreventionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html


2. Other CMS Resources

Provider Resources webpage - https://www.cms.gov/Medicare/Prevention/PreventionGenInfo/ProviderResources.html
Immunizations webpage - https://www.cms.gov/Medicare/Prevention/Immunizations/Overview.html

Prevention Services webpage - http://www.cms.gov/Medicare/Prevention/PreventionGenInfo/index.html


3. Other Resources

The following non-CMS resources are useful information and tools for the 2018 – 2019 flu season:


Centers for Disease Control and Prevention - http://www.cdc.gov/flu


Food and Drug Administration - http://www.fda.gov

Immunization Action Coalition - http://www.immunize.org

Indian Health Services - http://www.ihs.gov

National Alliance for Hispanic Health - http://www.hispanichealth.org

National Foundation For Infectious Diseases - http://www.nfid.org/influenza


National Vaccine Program - http://www.hhs.gov/nvpo


World Health Organization - http://www.who.int/en

DOCUMENT HISTORY

<table>
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<tr>
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<tbody>
<tr>
<td>September 24, 2018</td>
<td>Initial article released.</td>
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</tbody>
</table>
Provider-Based Billing Poster Now Available

Provider-based billing can generate two different bills (Part A: Billed on UB-04 [CMS-1450 Form] and Part B: Billed on CMS-1500 Form) which may cause beneficiaries to have questions as it might appear to them as though they have been billed twice for the same date of service.

To help providers better explain this, we now have a Provider-Based Billing Poster that can be edited to include the logo of the facility being billed for allowing it to be displayed in areas where beneficiaries may have a moment to review the information.

Access the Provider-Based Billing Poster from on the Provider Based Facilities Educational Resources.
Holding Claims for Pricing Based on the October 2018 FISS Release

Effective October 1, 2018, Part A claims with dates of service on/after October 1, 2018 will be placed on a 15 day hold while pricing files are installed into the Fiscal Intermediary Shared System (FISS). This will allow claims to be verified for correct pricing to ensure proper payment.

All claims held during this time will be released no later than October 15, 2018.

MPFSDB – October 2018 Update

MLN Matters Number: MM10898
Related Change Request (CR) Number: 10898
Related CR Release Date: August 10, 2018
Effective Date: January 1, 2018
Related CR Transmittal Number: R4109CP
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) 10898 amends payment files issued to MACs based upon the 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 MPFS Final Rule, published in the Federal Register on November 15, 2017, to be effective for services furnished from January 1, 2018, through December 31, 2018.

CR 10898 presents a summary of the changes for the October update to the 2018 MPFS. Section 1848(c)(4) of the Social Security Act authorizes the Secretary to establish ancillary policies necessary to implement relative value units (RVU) for physicians’ services. Unless otherwise stated, these changes are effective for dates of service on and after January 1, 2018.

The HCPCS codes listed below have been added to the Medicare Physician Fee Schedule Database (MPFSDB) effective for dates of service on and after October 1, 2018.

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>G9978</td>
<td>Non-Facility &amp; Facility PE RVU = 0.23. All other MPFS indicators &amp; RVUs = 99201</td>
</tr>
<tr>
<td>G9979</td>
<td>Non-Facility &amp; Facility PE RVU = 0.42. All other MPFS indicators &amp; RVUs = 99202</td>
</tr>
<tr>
<td>G9980</td>
<td>Non-Facility &amp; Facility PE RVU = 0.60. All other MPFS indicators &amp; RVUs = 99203</td>
</tr>
<tr>
<td>G9981</td>
<td>Non-Facility &amp; Facility PE RVU = 1.01. All other MPFS indicators &amp; RVUs = 99204</td>
</tr>
<tr>
<td>G9982</td>
<td>Non-Facility &amp; Facility PE RVU = 1.32. All other MPFS indicators &amp; RVUs = 99205</td>
</tr>
<tr>
<td>G9983</td>
<td>Non-Facility &amp; Facility PE RVU = 0.20. All other MPFS indicators &amp; RVUs = 99212</td>
</tr>
<tr>
<td>G9984</td>
<td>Non-Facility &amp; Facility PE RVU = 0.41. All other MPFS indicators &amp; RVUs = 99213</td>
</tr>
<tr>
<td>G9985</td>
<td>Non-Facility &amp; Facility PE RVU = 0.62. All other MPFS indicators &amp; RVUs = 99214</td>
</tr>
<tr>
<td>G9986</td>
<td>Non-Facility &amp; Facility PE RVU = 0.88. All other MPFS indicators &amp; RVUs = 99215</td>
</tr>
<tr>
<td>G9987</td>
<td>Non-Facility &amp; Facility PE RVU = 1.06. All other MPFS indicators &amp; RVUs = G9187</td>
</tr>
</tbody>
</table>
The following “Q” codes are effective on or after July 1, 2018 (see CR 10626 for additional information on HCPCS code Q9994 and CR 10624 on HCPCS codes Q5105 and Q5106). HCPCS code Q5108 is effective July 12, 2018. See CR 10834 for more information on HCPCS Q5108:

<table>
<thead>
<tr>
<th>Code</th>
<th>Action</th>
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</thead>
<tbody>
<tr>
<td>Q9994</td>
<td>Procedure Status = X; there are no RVUs, payment policy indicators do not apply.</td>
</tr>
<tr>
<td>Q5105</td>
<td>Procedure Status = E; there are no RVUs, payment policy indicators do not apply.</td>
</tr>
<tr>
<td>Q5106</td>
<td>Procedure Status = E; there are no RVUs, payment policy indicators do not apply.</td>
</tr>
<tr>
<td>Q5108</td>
<td>Procedure Status = E; there are no RVUs, payment policy indicators do not apply.</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.

ADDITIONAL INFORMATION


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<td>August 10, 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 – October 2018

MLN Matters Number: MM10899
Related Change Request (CR) Number: 10899
Related CR Release Date: August 3, 2018
Effective Date: October 1, 2018
Related CR Transmittal Number: R4107CP
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 Medicare Part B drugs provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

Change Request (CR) 10899 provides the quarterly update for Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to the prior quarterly pricing files. CR 10899 instructs MACs to download and implement the October 2018 and, if released, the revised July 2018, April 2018, January 2018, and October 2017 ASP drug pricing files for Medicare Part B drugs. Medicare shall use the October 2018 ASP and Not Otherwise Classified (NOC) drug pricing files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after October 1, 2018 with dates of service October 1, 2018, through December 31, 2018. Make sure your billing staffs are aware of these updates.

BACKGROUND

The ASP methodology is based on quarterly data that manufacturers submit to the Centers for Medicare & Medicaid Services (CMS). CMS supplies MACs with the ASP and 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 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: October 2018 ASP and ASP NOC – effective dates of service: October 1, 2018, through December 31, 2018;
• 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 dates of April 1, 2018, through June 30, 2018;
• File: January 2018 ASP and ASP NOC – effective dates of service: January 1, 2018, through March 31, 2018; and

For any drug or biological not listed in the ASP or NOC drug pricing files, MACs will determine the payment allowance limits in accordance with the policy described in Chapter 17, Section 20.1.3 of the Medicare Claims Processing Manual 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.

MACs will not search and adjust claims that have already been processed unless you bring such claims to your MAC’s attention.

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<td>August 3, 2018</td>
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Clotting Factor Furnishing Fee – Annual Update 2019

MLN Matters Number: MM10918
Related Change Request (CR) Number: 10918
Related CR Release Date: September 7, 2018
Effective Date: January 1, 2019
Related CR Transmittal Number: R4128CP
Implementation Date: January 7, 2019

PROVIDER TYPE AFFECTED

This MLN Matters® Article is intended for physicians, providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs) for services related to the administration of clotting factors provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

CR 10918 announces the clotting factor furnishing fee for 2019 is $0.220 per unit. Make sure that your billing staffs are aware of the update to the annual clotting factor furnishing fee for 2019.

BACKGROUND

The Medicare Modernization Act Section 303(e)(1) added Section 1842(o)(5)(C) of the Social Security Act which requires that a furnishing fee will be paid for items and services associated with clotting factor.
The Centers for Medicare & Medicaid Services includes the clotting factor furnishing fee in the published national payment limits for clotting factor billing codes. When the national payment limit for a clotting factor is not included on the Average Sales Price (ASP) Medicare Part B Drug Pricing File or the Not Otherwise Classified (NOC) Pricing File, the MACs make payment for the clotting factor as well as make payment for the furnishing fee. For dates of service from January 1, 2019, through December 31, 2019, the clotting factor furnishing fee of $0.220 per unit is added to the payment limit for the clotting factor.

**ADDITIONAL INFORMATION**


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<tr>
<td>September 7, 2018</td>
<td>Initial article released.</td>
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Medicare Part A SNF PPS Pricer Update

MLN Matters Number: MM10825
Related Change Request (CR) Number: 10825
Related CR Release Date: July 6, 2018
Effective Date: October 1, 2018
Related CR Transmittal Number: R4084CP
Implementation Date: October 1, 2018

PROVIDER TYPE AFFECTED
This MLN Matters® Article is intended for Skilled Nursing Facilities (SNFs) submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries paid under the Skilled Nursing Facility (SNF) Prospective Payment System (PPS).

PROVIDER ACTION NEEDED
Change Request (CR) 10118 informs MACs about updates to the payment rates under the PPS for SNFs, for Fiscal Year (FY) 2019, as required by statute. Make sure your billing staffs are aware of these changes. Also, be sure your billing staff are aware of the annual updates.

BACKGROUND
Annual updates to the PPS rates are required by Section 1888(e) of the Social Security Act, as amended by the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA), the Medicare, Medicaid, and State Children’s Health Insurance Plan (SCHIP) Benefits Improvement and Protection Act of 2000 (BIPA), and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), relating to Medicare payments and consolidated billing for SNFs.

Each July, the Centers for Medicare & Medicaid Services (CMS) publishes the SNF payment rates for the upcoming FY (that is, October 1, 2018, through September 30, 2019) in the Federal Register, available online at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/List-of-SNF-Federal-Regulations.html. The update methodology is similar to that used in the previous year, which includes a forecast error adjustment whenever the difference between the forecasted and actual change in the SNF market basket exceeds a 0.5-percentage point. The statute mandates an update to the Federal rates using the latest SNF full market basket adjusted for productivity. However, for FY 2019, the SNF payment increase factor is 2.4 percent, as required by Section 53111 of the Bipartisan Budget Act of 2018. The payment rates will be effective October 1, 2018.

ADDITIONAL INFORMATION

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<tr>
<td>July 9, 2018</td>
<td>Initial article released.</td>
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**SNF CB Enforcement of HCPCS Codes – 2018 Annual Update**

**MLN Matters Number:** MM10852  
**Related Change Request (CR) Number:** 10852  
**Related CR Release Date:** July 20, 2018  
**Effective Date:** January 1, 2016  
**Related CR Transmittal Number:** R4093CP  
**Implementation Date:** October 1, 2018

**PROVIDER TYPE AFFECTED**

This MLN Matters® Article is intended for providers who submit claims to Medicare Administrative Contractors (MACs), including Durable Medical Equipment MACs (DME MACs) for services provided in a Skilled Nursing Facility (SNF) to Medicare beneficiaries.

**PROVIDER ACTION NEEDED**

Change Request (CR) 10852 provides updates to the lists of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the Consolidated Billing (CB) provision of the SNF Prospective Payment System (PPS). Changes to Current Procedural Terminology (CPT)/HCPCS codes and Medicare Physician Fee Schedule designations are to revise Common Working File (CWF) edits to allow MACs to make appropriate payments in accordance with policy for SNF CB in the “Medicare Claims Processing Manual”, Chapter 6, Section 20.6. Make sure your billing staffs are aware of these changes.

**BACKGROUND**

CR10852 alerts providers that the Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of HCPCS codes that are excluded from the CB provision of the SNF PPS. Services excluded from SNF PPS and CB may be paid to providers, other than SNFs, for beneficiaries, even when in a SNF stay. Services not appearing on the exclusion lists submitted on claims to MACs, including DME MACs, will not be paid by Medicare to any providers other than a SNF.

For non-therapy services, SNF CB applies only when the services are furnished to a SNF resident during a covered Part A stay; however, SNF CB applies to physical and occupational therapies and speech-language pathology services whenever they are furnished to a SNF resident, regardless of whether Part A covers the stay. In order to assure proper payment in all settings, Medicare systems must edit for services provided to SNF beneficiaries both included and excluded from SNF CB.

The updated lists for institutional and professional billing are available at [http://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/index.html](http://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/index.html). Certain codes are included as services that are not subject to SNF CB. You may submit these codes globally (no modifier), professional component only (modifier 26), or technical component only (modifier TC).

Certain codes are included as services that are not subject to SNF CB. These codes can be submitted globally (no modifier), professional component only (modifier 26), or technical component only (modifier TC). When the codes listed below are submitted globally or just for the technical component, the claims submitted to the MACs (Part B) are being rejected by the CWF. That is to say, they are not allowed to pay separately outside of the consolidated payment that is made to the SNF. When submitted with the 26 modifier for just the professional component, the claims have been allowed to pay. The codes are:

- Codes that should have been added effective January 1, 2016 - 77770, 77771, 77772
- Codes that should have been added effective January 1, 2017 - G0491, G0500, J9034, J9301, Q0083, Q0084, Q0085, 36598, 77385, 77386, 77770, 77771, 77772, 79005, 79101, 79445, 96446, 99151, 99152, 99155, 99156, and 99157
- Codes that should have been added effective January 1, 2018 - 00731, 00732, 00811, 00812, 00813, and 77772

The above errors are occurring because CMS did not add the codes to the appropriate coding lists with the 2016, 2017, and 2018 SNF CB Annual Updates. Therefore, for claims with dates of service on or after January 1, 2016, the MACs (Part B) will re-open and reprocess impacted claims, if you bring those claims to the attention of your MAC. MACs (Part B) will notify providers that if they have already received
payment for these services from the SNF, they need to return that payment to the SNF in order to receive payment from Medicare. Providers may not be paid twice for the same service and such a request could be construed as a fraudulent claim.

The following HCPCS will be added to Major Category 1 (Exclusion of Services Beyond the Scope of a SNF) exclusions retroactive to July 1, 2018:

- Q5105 Injection, epoetin alfa, biosimilar, (Retacrit) (for esrd on dialysis), 100 units
- Q5106 Injection, epoetin alfa, biosimilar, (Retacrit) (for non-esrd use), 1000 units

For claims processed on or after October 1, 2018, HCPCS codes Q5105 and Q5106 will be added to Physician Services for SNF Consolidated Billing with an effective date of July 1, 2018.

Note: MACs will re-open and re-process the claims brought to their attention, for claims with dates of service on or after July 1, 2018, that have previously been denied/rejected prior to the implementation of CR 10852.

ADDITIONAL INFORMATION


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<tr>
<td>July 20, 2018</td>
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Telehealth Billing Requirement Revisions for Distant Site Services – Second Revision

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: R20950TN
Implementation Date: October 1, 2018

This article was revised on September 6, 2018, to correct the effective date of the GT modifier (annotated in red). That date should be October 1, 2018. 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 October 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 October 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>September 6, 2018</td>
<td>This article was revised to correct the effective date of the GT modifier. That date should be October 1, 2018.</td>
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<tr>
<td>Date</td>
<td>Description</td>
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<tr>
<td>June 21, 2018</td>
<td>This article was revised to reflect a revised CR10583 issued on June 20. In</td>
</tr>
<tr>
<td></td>
<td>the article, the criteria that allows the GT modifier to be present on Method</td>
</tr>
<tr>
<td></td>
<td>II CAH claim lines is revised. Also, the CR release date, transmittal number,</td>
</tr>
<tr>
<td></td>
<td>and the Web address of the CR are revised. All other information remains the</td>
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<td></td>
<td>same.</td>
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<tr>
<td>April 27, 2018</td>
<td>Initial article released.</td>
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Implement Operating Rules – Phase III ERA EFT: CORE 360 Uniform Use of CARC, RARC and CAGC Rule – Update from CAQH CORE

MLN Matters Number: MM10904
Related Change Request (CR) Number: 10904
Related CR Release Date: August 24, 2018
Effective Date: January 1, 2019
Related CR Transmittal Number: R4117CP
Implementation Date: January 7, 2019

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

PROVIDER ACTION NEEDED
CR 10904 instructs the MACs and Medicare’s Shared System Maintainers to update their systems based on the Committee on Operating Rules for Information Exchange (CORE) 360 Uniform Use of Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC), and Claim Adjustment Group Code (CAGC) Rule publication. These system updates are based on the CORE Code Combination List to be published on or about October 1, 2018. Make sure that your billing staff is aware of these changes.

BACKGROUND
The Department of Health and Human Services (HHS) 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 amended the Social Security Act by adding Part C—Administrative Simplification—to Title XI, requiring the Secretary of HHS 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.

CR10904 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 October 1, 2018. This update is based on the CARC and RARC updates as posted at the Washington Publishing Company (WPC) website on or about July 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. See: http://www.wpc-edi.com/, for reference for CARC and RARC updates and http://www.caqh.org/sites/default/files/core/phase-iii/code-combinations/CORE-required_CodeCombos.xlsx?token=_29xvBua for CAQH CORE defined code combination updates.

Per the Affordable Care Act mandate, all health plans including Medicare must comply with CORE 360 Uniform Use of CARCs and RARCs (835) rule or CORE developed maximum set of CARC/RARC and CAGC combinations for a minimum set of four business scenarios. Medicare can use any code combination if the business scenario is not one of the four CORE defined business scenarios. With the four CORE defined business scenarios, Medicare must use the code combinations from the lists published by CAQH CORE.

ADDITIONAL INFORMATION
Claim Status Category and Claim Status Codes Update

MLN Matters Number: MM10925
Related Change Request (CR) Number: 10925
Related CR Release Date: August 24, 2018
Effective Date: January 1, 2019
Related CR Transmittal Number: R4115CP
Implementation Date: January 7, 2019

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) 10925 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.

The codes sets are available at http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-category-codes/ and http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-codes/. Included in the code lists are specific details, including the date when a code was added, changed, or deleted.

All code changes approved during the September/October 2018 committee meeting shall be posted on these sites on or about November 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 10925.

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 10925 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


DOCUMENT HISTORY

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
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<tbody>
<tr>
<td>August 24, 2018</td>
<td>Initial article released.</td>
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