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

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

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

Sources for “Medicare A News” Articles

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

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

Quarterly Provider Update from CMS

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

The purpose of the Quarterly Provider Update is to:

- Inform providers about new developments in the Medicare program;
- Assist providers in understanding CMS programs and complying with Medicare regulations and instructions;
• Ensure that providers have time to react and prepare for new requirements;
• Announce new or changing Medicare requirements on a predictable schedule; and

Communicate the specific days that CMS business will be published in the Federal Register. Sign up for the Quarterly Provider Update listserv to receive notification when regulations and program instructions are added throughout the quarter, (electronic mailing list) at http://www.cms.gov/About-CMS/Agency-Information/AboutWebsite/index.html?redirect=/AboutWebsite/EmailUpdates/list.asp. Indicate that you wish to receive the CMS-QPU Listserv on the list of available publications.

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

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

**Unsolicited or Voluntary Refunds Reminder**

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

**Background**

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

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

**Additional Information**


**Effective Date:** January 1, 2005
**Implementation Date:** January 4, 2005
**Sources:** Transmittal 50, CR 3247 dated July 30, 2004; Internet Only Manual (IOM) Medicare Financial Management Manual, Publication 100-06, Chapter 5, Section 410

**Internet-Only Manual, Pub. 100-06, Chapter 3, Section 90 - Provider Liability Revision**

MLN Matters® Number: MM9708
Related Change Request (CR) #: CR 9708
Related CR Release Date: November 18, 2017
Effective Date: February 21, 2017
Related CR Transmittal #: R275FM
Implementation Date: February 21, 2017
FYI

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

What You Need to Know
Change Request (CR) 9708 provides additional criteria for determining when a contractor shall assume a physician, provider, or supplier should have known about a policy or rule. CR9708 updates Chapter 3, Section 90 of the “Medical Financial Management Manual.” Make sure your billing staff is aware of these updates.

Background
Contractors shall assume the provider, physician, or supplier should have known about a policy or rule, if:

• The policy or rule is in the provider, physician, or supplier manual or in Federal regulations;
• The Centers for Medicare & Medicaid Services (CMS) or a CMS contractor provided general notice to the medical community concerning the policy or rule;
• CMS, a CMS contractor, or the Office of Inspector General (OIG) gave written notice of the policy or rule to the particular provider/physician/supplier;

The provider, physician, or supplier was previously investigated or audited as a result of not following the policy or rule;

• The provider, physician, or supplier previously agreed to a Corporate Integrity Agreement as a result of not following the policy or rule;
• The provider, physician, or supplier was previously informed that its claims had been reviewed/denied as a result of the claims not meeting certain Medicare requirements which are related to the policy or rule; or
• The provider, physician, or supplier previously received documented training/outreach from CMS or one of its contractors related to the same policy or rule.

Additional Information
The official instruction, CR9708, issued to your MAC regarding this change is available at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R275FM.pdf. The revised Chapter 3, Section 90, of the manual is attached to CR9708.

Instructions to Process Services Not Authorized by the VA in a Non-VA Facility Reported with VC 42
MLN Matters® Number: MM9818
Related Change Request (CR) #: CR 9818
Related CR Release Date: October 28, 2016
Effective Date: October 1, 2013
Related CR Transmittal #: R3635CP
Implementation Date: April 3, 2017

Provider Types Affected
This MLN Matters® Article is intended for hospitals and skilled nursing facilities who submit inpatient claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed
Change Request (CR) 9818 corrects a misinterpretation of the changes made with CR8198 - Updating the Shared Systems and Common Working File (CWF) to no Longer Create Veteran Affairs (VA) “I” records in the Medicare Secondary Payer (MSP) Auxiliary File. CR9818 clarifies how Medicare contractors will
process inpatient claims for services in a Non-VA facility that were not authorized by the VA. Make sure that your billing staff are aware of these changes.

Background
The Social Security Act (Section 1862(a) (3) precludes Medicare from making payment for services or items that are paid for directly or indirectly by another government entity.

The Centers for Medicare & Medicaid Services (CMS) issued MLN Matters® Special Edition Article (SE) 1517 to provide clarification and coding reminders for billing Medicare when the Department of Veterans Affairs (VA) is involved for a portion of the services.

CMS was recently notified of a scenario where a hospital cannot follow the instructions in SE 1517 to split the claim to bill Medicare for only the non-VA authorized services as instructed in SE 1517.

Currently hospitals submit no pay inpatient claims paid by the VA to Medicare for the purpose of crediting the Part A deductible and coinsurance amounts. This process is not changing.

Medicare is precluded from making payment for services or items that are paid for directly or indirectly by another government entity. For inpatient claims where the VA is the Payer, the covered VA services are exclusions to the Medicare program per Section 1862 of the Social Security Act. If the VA doesn’t approve all the services, any Medicare covered services not considered by the VA may be billed to the Medicare program.

When a VA- eligible beneficiary chooses to receive services in a Medicare Certified Facility for which the VA has not authorized, the facility shall use Condition Code 26 to indicate the patient is a VA eligible patient and chooses to receive services in a Medicare Certified provider instead of a VA facility and Value Code (VC) 42 with the amount of the VA payment for the authorized days.

MACs will accept value code ‘42’ on inpatient claims with type of bill codes 11X, 18X, 21X, 41X and 51X. MACs will calculate the Medicare payment for an inpatient claim when condition code ‘26’ and value code ‘42’ are present on a claim. However, MACs will return the claim to the provider if CC ‘26’ is present without VC ‘42’ or vice versa.

Additional Information


Medicare Deductible, Coinsurance and Premium Rates for 2017
MLN Matters® Number: MM9902
Related Change Request (CR) #: CR 9902
Related CR Release Date: December 2, 2016
Effective Date: January 1, 2017
Related CR Transmittal #: R103GI
Implementation Date: January 3, 2017

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

Provider Action Needed
Change Request (CR) provides instruction for MACs to update the claims processing system with the new Calendar Year (CY) 2017 Medicare deductible, coinsurance, and premium rates. Make sure your billing staffs are aware of these changes.
Background

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

Most individuals age 65 and older, and many disabled individuals under age 65, are insured for Health Insurance (HI) benefits without a premium payment. The Social Security Act provides that certain aged and disabled persons who are not insured may voluntarily enroll, but are subject to the payment of a monthly premium. Since 1994, voluntary enrollees may qualify for a reduced premium if they have 30-39 quarters of covered employment. When voluntary enrollment takes place more than 12 months after a person’s initial enrollment period, a 10 percent penalty is assessed for 2 years for every year they could have enrolled and failed to enroll in Part A.

Under Part B of the Supplementary Medical Insurance (SMI) program, all enrollees are subject to a monthly premium. Most SMI services are subject to an annual deductible and coinsurance (percent of costs that the enrollee must pay), which are set by statute. When Part B enrollment takes place more than 12 months after a person’s initial enrollment period, there is a permanent 10 percent increase in the premium for each year the beneficiary could have enrolled and failed to enroll.

2017 Part A - Hospital Insurance (HI)

- **Deductible**: $1,316.00
- **Coinsurance**
  - $329.00 a day for 61st-90th day
  - $658.00 a day for 91st-150th day (lifetime reserve days)
  - $164.50 a day for 21st-100th day (Skilled Nursing Facility coinsurance)
- **Base Premium (BP)**: $413.00 a month
- **BP with 10 percent surcharge**: $454.30 a month
- **BP with 45 percent reduction**: $227.00 a month (for those who have 30-39 quarters of coverage)
- **BP with 45 percent reduction and 10 percent surcharge**: $249.70 a month

2017 Part B - Supplementary Medical Insurance (SMI)

- **Standard Premium**: $134.00 a month
- **Deductible**: $183.00 a year
- **Pro Rata Data Amount**
  - $125.73 1st month
  - $57.27 2nd month
- **Coinsurance**: 20 percent

Additional Information

Fingerprint-based Background Check Begins August 6, 2014 – Rescinded

MLN Matters® Number: SE1427 Rescinded
This article was rescinded on October 17, 2016. For information on the Fingerprint-based Background Check requirement, view MLN Matters® article SE1417, “Implementation of Fingerprint-Based Background Checks”, available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1417.pdf.

Comprehensive CJR Model: SNF 3-Day Rule Waiver

MLN Matters® Number: SE1626
Article Release Date: December 9, 2016

Provider Types Affected
This MLN Matters® Article is intended for Skilled Nursing Facilities (SNFs) submitting claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries in the Comprehensive Care for Joint Replacement (CJR) model.

What You Need to Know
This purpose of this article is to inform SNFs of the policies surrounding use of the 3-day stay waiver available for use under the CJR Model and to provide instructions on using the demonstration code 75 on applicable CJR claims submitted on or after January 1, 2017. Make sure that your billing staffs are aware of these changes.

Background
Section 1115A of the Social Security Act authorizes the Centers for Medicare & Medicaid Services (CMS) to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care furnished to Medicare, Medicaid, and Children's Health Insurance Program beneficiaries. In accordance with this statutory authority, in November 2015 CMS published a final rule for the creation and testing of a new bundled payment model called the CJR model. The CJR model tests bundled payments for Lower Extremity Joint Replacement (LEJR) episodes at acute care hospitals located in multiple geographic areas. The intent of the model is to promote quality and financial accountability for episodes of care surrounding a LEJR procedure, hereafter referred to as LEJR episodes. The CJR model will test whether bundled payments to acute care hospitals for LEJR episodes of care can reduce Medicare expenditures while preserving or enhancing the quality of care for Medicare beneficiaries. CMS is testing the CJR model over a period of 5 performance years. The CJR model, began April 1, 2016, and will run through December 31, 2020.

Key Points
Under the CJR model, acute care hospitals in certain selected geographic areas take on quality and payment accountability for retrospectively calculated bundled payments for LEJR episodes. All related care within 90 days of hospital discharge from the LEJR procedure is included in the episode of care.

CJR Episodes of Care
Medicare currently pays for LEJR procedures under the Inpatient Prospective Payment System (IPPS) through one of two Medicare Severity Diagnosis Related Groups (MS-DRGs): MS-DRG 469 (major joint replacement or reattachment of lower extremity with major complications or comorbidities (MCC)) or MS-DRG 470 (major joint replacement or reattachment of lower extremity without MCC). Under the CJR model, episodes begin with admission to an acute care hospital for an LEJR procedure that is assigned to MS-DRG 469 or 470 upon beneficiary discharge and paid under the IPPS. Episodes end 90 days after the date of discharge from the acute care hospital. The episode includes the LEJR procedure, inpatient stay, and all related care as defined under the model that is covered under Medicare Parts A and B within the 90 days after discharge, including hospital care, post-acute care, and physician services.
CJR Participant Hospitals
Participant hospitals are the episode initiators (that is, the entity where the episode begins) and bear quality and episode payment accountability under the CJR model. CMS requires all hospitals paid under the IPPS and located in selected geographic areas to participate in the CJR model, with limited exceptions for those hospitals currently participating in Bundled Payments for Care Improvement (BPCI) Models for the LEJR BPCI clinical episodes.

CJR Model Beneficiary Inclusion Criteria
Medicare beneficiaries whose care is included in the CJR model must meet the following criteria upon admission to the anchor hospitalization:

- The beneficiary is enrolled in Medicare Part A and Part B throughout the duration of the episode.
- The beneficiary’s eligibility for Medicare is not on the basis of the End Stage Renal Disease benefit.
- The beneficiary is not enrolled in any managed care plan.
- The beneficiary is not covered under a United Mine Workers of America health plan.
- Medicare is the primary payer.

Skilled Nursing Facility Three-Day Waiver
The CJR model waives certain existing payment system requirements to provide additional flexibilities to hospitals participating in CJR, as well as other providers that furnish services to beneficiaries in CJR episodes. The purpose of such flexibilities is to increase LEJR episode quality and decrease episode spending or provider and supplier internal costs, or both, and to provide better, more coordinated care for beneficiaries and improved financial efficiencies for Medicare, providers, and beneficiaries.

In order to provide more comprehensive care across the post-acute spectrum and support the ability of participant hospitals to coordinate the care of beneficiaries, CMS will conditionally waive the 3-day stay requirement for covered SNF services for beneficiaries in CJR episodes in performance years 2 through 5 of the CJR model (i.e. on or after January 1, 2017).

Under Medicare rules, in order for Medicare to pay for SNF services, a beneficiary must have a qualifying hospital stay of at least 3 consecutive days (counting the day of hospital admission but not the day of discharge). Additional information regarding the Skilled Nursing Facility benefit is available in the “Medicare Benefit Manual” (Pub 100–02), Chapter 8.

CMS waives the SNF 3-day rule for coverage of a SNF stay for a CJR beneficiary following the anchor hospitalization, only if the SNF is identified on the applicable calendar quarter list of qualified SNFs at the time of CJR beneficiary admission to the SNF. CMS will determine all the qualified SNFs for each calendar quarter based on a review of the most recent rolling 12 months of overall star ratings on the Five-Star Quality Rating System for SNFs on the Nursing Home Compare website. All other Medicare rules for coverage and payment of Part A-covered SNF services continue to apply. This will allow payment of claims for SNF services delivered to beneficiaries at eligible sites.

When submitting claims to Medicare that require a waiver of the 3-day hospital stay requirement for Part A SNF coverage, SNF billing staff must enter a “75” in the Treatment Authorization Code Field. This allows MACs to appropriately pay SNFs treating beneficiaries during CJR Model episodes. In order to determine if use of the demonstration code “75” is appropriate, the following circumstances must be met:

- The hospitalization does not meet the prerequisite hospital stay of at least 3 consecutive days for Part A coverage of “extended care” services in a SNF. If the hospital stay would lead to covered SNF services in the absence of the waiver, then the waiver is not necessary for the stay.
- The discharge is from a participant hospital in the CJR model. Participant hospitals are listed on the CMS website this list is shared with the MACs on a monthly basis.
- The beneficiary must have been discharged from the CJR model participant hospital for one of the two specified MS–DRGs (469 or 470) within 30 days prior to the initiation of SNF services.
- The beneficiary meets the criteria for inclusion in the CJR model at the time of SNF admission: That is, he or she is enrolled in Part A and Part B, eligibility is not on the basis of ESRD, is not enrolled in any managed care plan, is not covered under a United Mine Workers of America health plan, and Medicare is the primary payer.
The waiver will apply if the SNF is qualified to admit CJR model beneficiaries under the waiver. A list of qualified SNFs will be sent to the MACs and Medicare Shared Systems Maintainers via a quarterly list, developed by CMS and posted to the CMS website on a quarterly basis. The list will contain those SNFs with an overall star rating of three stars or better for at least 7 of the preceding 12 months of the rolling data used to create the quarterly list.

The SNF must include Demonstration Code 75 in the Treatment Authorization field when submitting claims that qualify for the SNF waiver under the CJR model. Note: The waiver is not valid for swing bed (TOB 18X) stays or Critical Access Hospitals (CAHs).

All other Medicare rules for coverage and payment of Part A-covered SNF services continue to apply.

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


More information on the CJR model is available at [https://innovation.cms.gov/initiatives/CJR](https://innovation.cms.gov/initiatives/CJR). At this page, one can scroll down and open a list of the hospitals participating in this model.

**Holding Claims for Pricing Based on the January 2017 FISS Release**

Effective January 1, 2017, Part A claims with dates of service on/after January 1, 2017 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 January 15, 2017.

**Portal Enhancements Implemented November 4**

In response to provider/supplier feedback, the following changes have been made to the Noridian Medicare Portal (NMP), effective November 4, 2016.

**Part A and Part B Reason Codes**

The applicable reason codes on Part A and Part B Claim Status will display on each claim line. The reason code descriptions are provided below the claim lines. This information assists the provider in understanding why a claim line has been denied.

**Clear Beneficiary Details Button**

A new button titled Clear Beneficiary Details has been added to the inquiry screens. After an inquiry is successful and results display, users can return to the inquiry page and the beneficiary details will still be populated. If the next inquiry is for a different beneficiary, this button may be used to quickly clear the existing information.

**Eligibility Inquiry Requirements Link**

Narrative has been added to the Eligibility Inquiry page to indicate the beneficiary details are required per the CMS HIPAA Eligibility Transaction System (HETS) criteria.

**Registrations Pending More than 21 Days will be Deleted**

After a provider/supplier establishes a username and password, an email is sent which contains a URL that the provider/supplier must click to complete the initial registration process. If that URL is not selected and the registration portion completed in NMP, the system will automatically delete the account on the day 22. A new registration will be required at that time.

**Annual Security Awareness Training**

On an annual basis, all providers/suppliers within NMP are required to complete the Annual Security Awareness training. Forty-five days prior to the provider/supplier initial created date in NMP, the provider/
suppliers will be systematically prompted to complete the additional online training. By selecting Accept, the provider/supplier acknowledges the training and will continue into the NMP. If not accepted, the provider/supplier will not be allowed to enter the NMP.

**DME Additional Documentation Request (ADR) Option Explanations**

On the ADR inquiry page, explanations of the two search options, Request Sent and Response Received/Processing, are now provided.

**Part B Full Remittance Advices Display in Descending Order**

Part B full remittance advices now display in descending order so the newest remittance advices are at the top of the list.

Please continue to share your suggestions for the portal on the website satisfaction survey each time it is presented during website or portal navigation.

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**MLN Connects Provider eNews – October 6, 2016**

MLN Connects® Provider eNews for Thursday, October 6, 2016

View this edition as a PDF

**News & Announcements**

- CMS Finalizes Improvements in Care, Safety, and Consumer Protections for Long-Term Care Facility Residents
- CMS Awards $347 Million to Continue Progress toward a Safer Health Care System
- HH Quality of Patient Care Star Ratings and HH Compare Preview Reports Available
- New Electronic Appeals System: MOD E-File Available
- New EHR Contract Guide and Health IT Playbook
- EHR Incentive Programs: Learn About Important Changes
- EHR Incentive Programs: 2016 CQM Requirements
- October is National Breast Cancer Awareness Month

**Provider Compliance**

- Automatic External Defibrillators: Inadequate Medical Record Documentation

**Claims, Pricers & Codes**

- Billing for Influenza: New CPT Code 90674

**Upcoming Events**

- IMPACT Act: Data Elements and Measure Development Call — October 13
- Physician Compare Public Reporting Information Sessions — October 18 and 19
- 2015 Supplemental QRUR Physician Feedback Program Call — October 20
- Long-Term Care Facilities: Reform of Requirements Call — October 27
- How to Report Across 2016 Medicare Quality Programs Call — November 1

**Medicare Learning Network® Publications & Multimedia**

- Medicare Part B Drug Average Sales Price Reporting by Manufacturers – Blending National Drug Codes MLN Matters® Article — New
- Medicare Parts A & B Appeals Process Booklet — Revised
- Resources for Medicare Beneficiaries Booklet — Revised
MLN Connects Provider eNews – October 13, 2016
MLN Connects® Provider eNews for Thursday, October 13, 2016
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News & Announcements
• New Data to Increase Transparency on Medicare Hospice Payments
• SNF Value-Based Purchasing Program: Confidential Feedback Reports Available
• IMPACT Act Cross-Setting Quality Measure on Major Falls: Comments due October 14
• EHR Incentive Programs: Review Resources on 2016 Program Requirements
• Protect Your Patients from Influenza this Season

Provider Compliance
• Reporting Fraud to the Office of the Inspector General

Upcoming Events
• CMS Rural Health Council Solutions Summit — October 19
• 2015 Supplemental QRUR Physician Feedback Program Call — October 20
• Long-Term Care Facilities: Reform of Requirements Call — October 27
• How to Report Across 2016 Medicare Quality Programs Call — November 1
• Clinical Diagnostic Laboratory Test Payment System: Data Reporting Call — November 2

Medicare Learning Network® Publications & Multimedia
• Medicare Quarterly Provider Compliance Newsletter Educational Tool — New
• Learning Management and Product Ordering System FAQs Booklet — New
• SNF Value-Based Purchasing Program Call: Audio Recording and Transcript — New
• 2015 Annual QRURs Webcast: Audio Recording and Transcript — New
• Medicare Basics: Commonly Used Acronyms Educational Tool — Revised
• Preventive Services Educational Tool — Revised
• Fraud & Abuse Educational Products — Revised
• Screening Pap Tests and Pelvic Examinations Booklet — Reminder
• Give us Your Feedback

MLN Connects Provider eNews Special Edition – October 14, 2016

CMS Finalizes the New Medicare Quality Payment Program
On October 14, HHS finalized its policy implementing the Merit-Based Incentive Payment System (MIPS) and the Advanced Alternative Payment Model (APM) incentive payment provisions in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), collectively referred to as the Quality Payment Program. The new Quality Payment Program will gradually transform Medicare payments for more than 600,000 clinicians across the country, and is a major step in improving care across the entire health care system.

The final rule with comment period offers a fresh start for Medicare by centering payments around the care that is best for the patients, providing more options to clinicians for innovative care and payment approaches, and reducing administrative burden to give clinicians more time to spend with their patients, instead of on paperwork.
Accompanying the announcement is a new Quality Payment Program website, which will explain the new program and help clinicians easily identify the measures most meaningful to their practice or specialty.

For More Information:

- Final Rule and Executive Summary
- Press Release
- Fact Sheet
- Quality Payment Program website

MLN Connects Provider eNews – October 20, 2016

MLN Connects® Provider eNews for Thursday, October 20, 2016

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News & Announcements

- CMS Announces New Initiative to Increase Clinician Engagement
- Medicare’s Investment in Primary Care Shows Progress
- Physician Compare Preview Period Ends November 11
- Value Modifier: Informal Review Request Period Open through November 30
- 2015 Supplemental Quality and Resource Use Reports Available
- Medicare Open Enrollment Information for your Patients

Provider Compliance

- Importance of Documentation

Claims, Pricers & Codes

- October 2016 OPPS Pricer File Update

Upcoming Events

- Long-Term Care Facilities: Reform of Requirements Call — October 27
- How to Report Across 2016 Medicare Quality Programs Call — November 1
- Clinical Diagnostic Laboratory Test Payment System: Data Reporting Call — November 2
- Quality Payment Program Final Rule Call — November 15
- Home Health Quality Reporting Program Provider Training — November 16 and 17

Medicare Learning Network® Publications & Multimedia

- Provider Compliance Fact Sheets — New
- Emergency Preparedness Requirements Call: Audio Recording and Transcript — New
- Evaluation and Management Services Guide — Revised
- Hospice Payment System Booklet — Revised
- Provider Compliance Fact Sheets — Revised
- Continuing Education Credits for Web-Based Training Courses
MLN Connects Provider eNews – October 27, 2016

MLN Connects® Provider eNews for Thursday, October 27, 2016
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News & Announcements
• Quality Payment Program: Additional Opportunities for Clinicians to Join Innovative Care Approaches
• Hospital Compare Updated with VA Hospital Performance Data
• CMS Awards Special Innovation Projects to QIN-QIOs
• Meeting the Health Challenges of Rural America
• IRF and LTCH Quality Reporting Program Data Submission Deadline: November 15
• Revised Home Health Change of Care Notice: Effective January 17, 2017
• Prepare for ESRD QIP PY 2017 Reporting Documents by Updating your Account
• Technical Update to 2016 QRDA I Schematrons for eCQM Reporting
• Check Your Patients Addresses
• Connect with Us on LinkedIn

Provider Compliance
• Duplicate Claims

Upcoming Events
• Social Security Removal Initiative Open Door Forum—November 1
• How to Report Across 2016 Medicare Quality Programs Call—November 1
• Comparative Billing Report on Subsequent Hospital Care Webinar – November 2
• Clinical Diagnostic Laboratory Test Payment System: Data Reporting Call — November 2
• Solutions to Reduce Disparities Webinar — November 14
• Quality Payment Program Final Rule Call — November 15

Medicare Learning Network® Publications & Multimedia
• Implementation of LTCH PPS Based on Specific Clinical Criteria MLN Matters® Article —New
• Provider Compliance Fact Sheets — New
• IMPACT Act Call: Audio Recording and Transcript — New
• PECOS FAQs Fact Sheet — Revised
• DMEPOS Information for Pharmacies Fact Sheet — Revised
• Complying with Documentation Requirements for Laboratory Services Fact Sheet — Reminder
• Electronic Mailing Lists: Keeping Health Care Professionals Informed Fact Sheet — Reminder

MLN Connects Provider eNews Special Edition – November 1, 2016

CMS Provider Education Message:
• CMS Finalizes Hospital OPPS Changes to Better Support Hospitals and Physicians and Improve Patient Care
• Home Health Agencies: Final Payment Changes
CMS Finalizes Hospital OPPS Changes to Better Support Hospitals and Physicians and Improve Patient Care

On November 1, CMS finalized updated payment rates and policy changes in the Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System for CY 2017. CMS is also adding new quality measures to the Hospital Outpatient Quality Reporting Program and the ASC Quality Reporting Program that are focused on improving patient outcomes and experience of care. CMS estimates that the updates in the final rule would increase OPPS payments by 1.7 percent and ASC rates by 1.9 percent in 2017.

Included in the rule:

- Addressing physicians’ concerns regarding pain management
- Focusing payments on patients rather than setting
- Improving patient care through technology

For More Information:

- Final Rule
- Fact Sheet

See the full text of this excerpted CMS Press Release (issued November 1).

Home Health Agencies: Final Payment Changes

On October 31, CMS announced final changes to the Medicare Home Health (HH) Prospective Payment System (PPS) for CY 2017. In the final rule (CMS-1648-F), CMS estimates that Medicare payments to home health agencies in CY 2017 would be reduced by 0.7 percent, or $130 million based on the finalized policies.

Payment policy provisions:

- Rebasing the 60-day episode rate
- Updates to reflect case-mix growth
- Negative Pressure Wound Therapy
- Change in methodology and the fixed-dollar loss ratio used to calculate outlier payments
- Other updates

The final rule also includes:

- Home Health Quality Reporting Program
- Home Health Value-Based Purchasing Model

For More Information:

- Final Rule
- HH PPS website
- HH Value-Based Purchasing Model webpage

See the full text of this excerpted CMS fact sheet (issued October 31).

ESRD PPS: Policies and Payment Rates for End-Stage Renal Disease

On October 28, CMS issued a final rule (CMS 1651-F) that updates payment policies and rates under the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) for renal dialysis services furnished to beneficiaries on or after January 1, 2017. This rule also:

- Finalizes new quality measures to improve the quality of care by dialysis facilities treating patients with ESRD
- Implements the Trade Preferences Extension Act of 2015 provisions regarding the coverage and payment of renal dialysis services furnished by ESRD facilities to individuals with acute kidney injury
- Makes changes to the ESRD Quality Incentive Program (QIP), including Payment Years (PYs) 2019 and
2020

- Makes changes to the scoring methodology for the ESRD QIP for PY 2019 and added one new measure
- Addresses issues related to Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) and the DMEPOS Competitive Bidding Program

The finalized CY 2017 ESRD PPS base rate is $231.55. CMS projects that the updates for CY 2017 will increase the total payments to all ESRD facilities by 0.73 percent compared with CY 2016. For hospital-based ESRD facilities, CMS projects an increase in total payments of 0.9 percent, while for freestanding facilities, the projected increase in total payments is 0.7 percent. Aggregate ESRD PPS expenditures are projected to increase by approximately $80 million from CY 2016 to CY 2017.

Changes to the ESRD PPS:
- Update to the base rate
- Annual update to the wage index and wage index floor
- Update to the outlier policy
- Home and self-dialysis training add-on payment adjustment

Changes to the DMEPOS Competitive Bidding Program:
- Bid surety bond
- State licensure
- Appeals process for breach of contract actions
- Bid limits
- Changes for similar items with different features

For More Information:
- Final Rule

See the full text of this excerpted CMS fact sheet (issued October 28).

MLN Connects Provider eNews Special Edition – November 2, 2016

Medicare Finalizes Substantial Improvements that Focus on Primary Care, Mental Health, and Diabetes Prevention

On November 2, CMS finalized the 2017 Physician Fee Schedule final rule that recognizes the importance of primary care by improving payment for chronic care management and behavioral health. The rule also finalizes many of the policies to expand the Diabetes Prevention Program model test to eligible Medicare beneficiaries, the Medicare Diabetes Prevention Program (MDPP) expanded model, starting January 1, 2018.

The annual Physician Fee Schedule updates payment policies, payment rates, and quality provisions for services provided in CY 2017. In addition to physicians, a variety of practitioners and entities are paid under the physician fee schedule. Additional policies finalized in the 2017 payment rule include:
- Primary care and care coordination
- Mental and behavioral health
- Cognitive impairment care assessment and planning

The 2017 payment rule will also:
- Finalize a data collection strategy for global services with significantly reduced burden for practitioners compared to the proposal
- Finalize a change that will more accurately reflect local costs and significantly increase payments to practitioners in Puerto Rico
- Enhance program integrity and data transparency in the Medicare Advantage program.
MLN Connects Provider eNews – November 3, 2016

MLN Connects® Provider eNews for Thursday, November 3, 2016
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News & Announcements
- Updates to Dialysis Facility Compare: Patient Experience Ratings Available
- Hospital Value-Based Purchasing Program Results for FY 2017
- DMEPOS Competitive Bidding Program: CMS Awards Contracts for Round 1 2017
- 2017 PQRS Results: Submit an Informal Review by November 30
- IRF and LTCH Quality Reporting Program: NHSN Rebaseline Guidance
- Recovery Audit Contractor Awards
- Antipsychotic Drug use in Nursing Homes: Trend Update
- November is Home Care and Hospice Month

Provider Compliance
- Chiropractic Services: High Part B Improper Payment Rate

Claims, Pricers & Codes
- Billing for Influenza: New CPT Code 90674

Upcoming Events
- Quality Payment Program Final Rule Call — November 15
- 2016 Hospital Appeals Settlement Call — November 16
- IRF and LTCH: Transition to NHSN Rebaseline Webinar — November 16
- IRF and LTCH Quality Measure Report Call — December 1
- National Partnership to Improve Dementia Care and QAPI Call — December 6
- CMS 2016 Quality Conference — December 13-15

Medicare Learning Network® Publications & Multimedia
- Provider Compliance Fact Sheets — New
- QRUR Call: Audio Recording and Transcript — New
- Hospital-Acquired Conditions and Present on Admission Indicator Reporting Provision Fact Sheet — Revised
News & Announcements
- Proposed Rule on Fire Safety Requirements for Applicable Dialysis Facilities
- IMPACT Act Cross-Setting Quality Measure on Pressure Ulcers: Comments due November 17
- 2017 PQRS Results: Submit an Informal Review by November 30
- Value Modifier: Informal Review Request Period Open through November 30
- IRF-PAI and LTCH Provider Reports Retention Change: Take Action by December 1
- Open Payments: Physicians and Teaching Hospitals Review Public Data by December 31
- Quality Payment Program Presentations Available
- New Guide Helps Nursing Homes Tackle Antimicrobial Stewardship
- Raising Awareness of Diabetes in November

Provider Compliance
- Compliance Program Basics

Claims, Pricers & Codes
- Re-release of V34 ICD-10 MS-DRG Grouper, Definitions Manual, and Errata Available

Upcoming Events
- Quality Payment Program Final Rule Call — November 15
- 2016 Hospital Appeals Settlement Call — November 16
- Medicare Diabetes Prevention Program Model Expansion Call — November 30
- IRF and LTCH Quality Measure Report Call — December 1
- National Partnership to Improve Dementia Care and QAPI Call — December 6

Medicare Learning Network® Publications & Multimedia
- Inappropriate Billing of Qualified Medicare Beneficiaries MLN Matters® Article — New
- Long-Term Care Call: Audio Recording and Transcript — New
- PECOS for Physicians and Non-Physician Practitioners Fact Sheet — Revised
- Power Mobility Devices Fact Sheet — Revised
- IMPACT Act Videos — Reminder

News & Announcements
- CMS and Indian Health Service Expand Collaboration to Improve Health Care in Hospitals
- CMS to Release a Comparative Billing Report on Knee Orthoses in January
- Recognizing Lung Cancer Awareness Month and the Great American Smokeout
Provider Compliance
• False Claims Act

Claims, Pricers & Codes
• Sunsetting of Section 1011: Emergency Health Services Furnished to Undocumented Aliens
• LTCH: Clarification of Immediately Preceding Hospitals for Exclusion from Site Neutral Payment Rate

Upcoming Events
• Medicare Diabetes Prevention Program Model Expansion Call — November 30
• IRF and LTCH Quality Measure Report Call — December 1
• National Partnership to Improve Dementia Care and QAPI Call — December 6
• 2016 Hospital Appeals Settlement Update Call — December 12
• Comparative Billing Report on Viscosupplementation of the Knee Webinar — December 14

Medicare Learning Network® Publications & Multimedia
• Hard Copy Claims Not Crossing Over Due to Duplicate Diagnosis Codes MLN Matters Article — New
• Medicare Basics: Parts A and B Claims Overview Video — New
• Medicare Quality Programs Call: Audio Recording and Transcript — New
• Clinical Labs Call: Audio Recording and Transcript — New
• Medicare Fraud & Abuse: Prevention, Detection, and Reporting Booklet — Revised

MLN Connects Provider eNews – November 23, 2016

MLN Connects® Provider eNews for Wednesday, November 23, 2016
View this edition as a PDF

News & Announcements
• CMS Launches New Online Tool to Make Quality Payment Program Easier for Clinicians
• 2017 PQRS Results: Submit an Informal Review by November 30
• Value Modifier: Informal Review Request Period Open through November 30
• IMPACT Act Cross-Setting Quality Measures: Comments Due
• Post-Acute Care QRP Data Submission Exceptions for Hurricane Matthew
• New Quality Payment Program Resources Available
• Each Office Visit is an Opportunity to Recommend Influenza Vaccination

Provider Compliance
• Enteral Infusion Pumps

Claims, Pricers & Codes
• Reprocessing of Some IPPS Claims

Upcoming Events
• Medicare Diabetes Prevention Program Model Expansion Call — November 30
• IRF and LTCH Quality Measure Report Call — December 1
• National Partnership to Improve Dementia Care and QAPI Call — December 6
• 2016 Hospital Appeals Settlement Update Call — December 12
• IRF-PAI Therapy Information Data Collection Call — January 12

**Medicare Learning Network® Publications & Multimedia**

• Emergency Preparedness Video Presentation — New
• Inappropriate Billing of Qualified Medicare Beneficiaries for Medicare Cost-Sharing MLN Matters Article — Revised
• Provider Enrollment Requirements for Writing Prescriptions for Medicare Part D Drugs MLN Matters Article — Revised
• Hospital-Acquired Conditions and POA Indicator Reporting Provision Fact Sheet — Reminder
• PAP Devices: Complying with Documentation & Coverage Requirements Fact Sheet — Revised
• Evaluation and Management Services Guide — Reminder
• DMEPOS Quality Standards Booklet—Revised
• Medicare Claim Review Programs Booklet — Revised
• Drug Diversion: Do You Know Where the Drugs Are Going? Web-Based Training Course—Revised
• Hospice Payment System Booklet – Reminder

**MLN Connects Provider eNews – December 1, 2016**

MLN Connects® Provider eNews for Thursday, December 1, 2016

*View this edition as a PDF*

**News & Announcements**

• CMS Finalizes Measures under Consideration List for Pre-rulemaking
• Working to Achieve Health Equity: The CMS Equity Plan for Medicare One Year Later
• Clinical Laboratories: Prepare Now to Report Lab Data January 1- March 31, 2017
• Value Modifier: Informal Review Request Period Extended to December 7
• World AIDS Day is December 1
• National Handwashing Awareness Week: December 4 through 10

**Provider Compliance**

• Billing For Stem Cell Transplants

**Upcoming Events**

• National Partnership to Improve Dementia Care and QAPI Call — December 6
• 2016 Hospital Appeals Settlement Update Call — December 12
• IRF-PAI Therapy Information Data Collection Call — January 12

**Medicare Learning Network® Publications & Multimedia**

• Documentation Requirements for the Hospice Physician Certification/Recertification MLN Matters Article — New
• Sample Hospice Notice of Election Statement MLN Matters Article — New
• Quality Payment Program Call: Audio Recording and Transcript — New
• Hospital Appeals Settlement Call: Audio Recording and Transcript — New
MLN Connects Provider eNews – December 8, 2016

MLN Connects® Provider eNews for Thursday, December 8, 2016

View this edition as a PDF

News & Announcements
• Keeping Medicare’s Promise with MACRA
• Submit Quality Payment Program Comments by December 19
• EHR Incentive Programs: Information on CY 2017 and Stage 3 Program Requirements
• National Influenza Vaccination Week: What Does Medicare Cover?

Provider Compliance
• Billing for Ambulance Transports

Upcoming Events
• 2016 Hospital Appeals Settlement Update Call — December 12
• MIPS Webinar — December 13
• IRF-PAI Therapy Information Data Collection Call — January 12

Medicare Learning Network® Publications & Multimedia
• Exceptions for Late Hospice Notices of Election Delayed by Medicare Systems MLN Matters Article — New
• SNF Quality Reporting Program Video Presentation — New
• Advanced Practice Registered Nurses, Anesthesiologist Assistants, and Physician Assistants Booklet — Revised
• Vaccine and Vaccine Administration Payments under Medicare Part D Fact Sheet — Reminder

MLN Connects Provider eNews – December 15, 2016

MLN Connects® Provider eNews for Thursday, December 15, 2016

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News & Announcements
• CMS Releases Person and Family Engagement Strategy
• Medicare Outpatient Observation Notice CMS-10611 Available
• Quality Payment Program Patient Relationship Categories List: Comment by January 6
• IRF and LTCH QRP Preview Reports Available: Review by January 10
• ICD-10 Code Updates: Impact on Medicare Quality Programs

Provider Compliance
• Compliance Programs and Fraud and Abuse Laws

Claims, Pricers & Codes
• January 2017 Average Sales Price Files Available

Upcoming Events
• MACRA 101 Webinar Series — December 16, 20, and 21
• Quality Payment Program: Electing MIPS vs. APMs Webinar — December 19
• IRF-PAI Therapy Information Data Collection Call — January 12
• ESRD QIP: Payment Year 2020 Final Rule Call — January 17
• Hospice Quality Reporting Program Provider Training — January 18

Medicare Learning Network® Publications & Multimedia
• Comprehensive CJR Model: SNF 3-Day Rule Waiver MLN Matters® Article — New
• Medicare Diabetes Prevention Program Call: Audio Recording and Transcript — New
• IRF and LTCH Quality Reporting Program Call: Audio Recording and Transcript — New
• LTCH Prospective Payment System Booklet — Revised
• Mass Immunizers and Roster Billing Fact Sheet — Reminder

MLN Connects Provider eNews – December 22, 2016
MLN Connects® Provider eNews for Thursday, December 22, 2016
View this edition as a PDF

News & Announcements
• Increased Transparency and Quality Information via New Compare Sites and Data Updates
• Additional Opportunities for Clinicians under the Quality Payment Program
• HHS Finalizes New Medicare Alternative Payment Models
• CMS Releases Second Year of Home Health Utilization and Payment Data
• Hospice Quality Measure Reports Available
• New ST PEPPER Available
• First Two DME Items Subject to Prior Authorization
• Part D Prescribers: Date Change and Phased Enforcement
• 2017 eCQM Logic Flows for Eligible Clinicians Available
• EHR Incentive Programs: Prepare for 2016 Attestation
• EHR Incentive Programs FAQs on 2017 OPPS/ASC Final Rule

Provider Compliance
• Office of Inspector General Exclusion Authorities

Claims, Pricers & Codes
• Pricing and Payment Changes for DME Infusion Drugs Effective January 1, 2017

Upcoming Events
• IRF-PAI Therapy Information Data Collection Call — January 12
• ESRD QIP: Payment Year 2020 Final Rule Call — January 17
• Home Health Groupings Model Technical Report Call — January 18
• Comparative Billing Report Webinar on Knee Orthoses — February 8

Medicare Learning Network® Publications & Multimedia
• Continuation of HH Probe and Educate Medical Review Strategy MLN Matters® Article — New
• Dementia Care and QAPI Call: Audio Recording and Transcript — New
• ICD-9-CM, ICD-10-CM, ICD-10-PCS, CPT, and HCPCS Code Sets Educational Tool — Revised
Ambulance Inflation Factor for 2017 and Productivity Adjustment

MLN Matters® Number: MM9811
Related Change Request (CR) #: CR 9811
Related CR Release Date: October 14, 2016
Effective Date: January 1, 2017
Related CR Transmittal #: R3625CP
Implementation Date: January 3, 2017

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

Provider Action Needed
Change Request (CR) 9811 furnishes the Calendar Year (CY) 2017 Ambulance Inflation Factor (AIF) for determining the payment limit for ambulance services. Make sure that your billing staffs are aware of the change.

Background
CR9811 furnishes the CY 2017 Ambulance Inflation Factor (AIF) for determining the payment limit for ambulance services required by Section 1834(l)(3)(B) of the Social Security Act (the Act).

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

Section 3401 of the Affordable Care Act requires that specific Prospective Payment System (PPS) and Fee Schedule (FS) update factors be adjusted by changes in economy-wide productivity. The statute defines the productivity adjustment to be equal to the 10-year moving average of changes in annual economy-wide private nonfarm business Multi-Factor Productivity (MFP) (as projected by the Secretary of Health and Human Services (the Secretary) for the 10-year period ending with the applicable fiscal year, cost reporting period, or other annual period).

The MFP for CY 2017 is 0.3 percent and the CPI-U for 2017 is 1.0 percent. According to the Affordable Care Act, the CPI-U is reduced by the MFP, even if this reduction results in a negative AIF update. Therefore, the AIF for CY 2017 is 0.7 percent.

Part B coinsurance and deductible requirements apply to payments under the ambulance fee schedule.

Additional Information
ALJ and Federal District Court Amount in Controversy Increase for 2017

Section 1869(b)(1)(E) of the Social Security Act, as amended by Section 940 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), requires an annual reevaluation of the dollar amount in controversy required for an Administrative Law Judge (ALJ) hearing and for Federal District Court review. The amount in controversy is adjusted by the percentage increase in the medical care component of the Consumer Price Index for all urban consumers (U.S. city average) for July 2003 to the July preceding the year involved.

The amount that must remain in controversy for review for an ALJ hearing requested on or before December 31, 2015, is $150. This amount will increase to $160 for ALJ hearing requests filed on or after January 1, 2017. The amount that must remain in controversy for reviews in Federal District Court requested on or before December 31, 2016 is $1,500. This amount will increase to $1,560 for appeals to Federal District Court filed on or after January 1, 2017.

New Educational Resources Now Available for Appeals

New tools have been added to the Part A Appeals Educational Resources to assist in the accurate completion of redetermination requests. Included in these additions are:

- Redetermination/Reopening Tutorial;
- Appointment of Representative Tutorial; and
- Decision Tree

The tutorials provide a detailed explanation of how to correctly complete each of the above listed forms. A hover option offers popup text boxes describing what action should be taken for each field within the form.

The Decision Tree will assist providers in determining if a claim is appealable. This tool contains helpful links to additional resources, as well as information regarding what action to take if a claim is not appealable.

2016 Hospital Appeals Settlement

Acute Care Hospitals and Critical Access Hospitals (CAHs) are encouraged to review the 2016 Hospital Appeals Settlement Process (HASP) Document found on the https://www.CMS.gov website. Participation in this settlement process is advised, if meeting the following criteria: eligible claims have an admission date prior to 10/1/2013 and have been denied due to patient status by pre and post-payment Medicare review contractors. In exchange for the withdrawal of appeals currently residing at the Administrative Law Judge (ALJ) or Departmental Appeals Board (DAB) levels, providers will be reimbursed at 66% of the net allowable amount. Providers with pending investigations or False Claims Act cases may be excluded from this settlement opportunity.

To initiate your participation in the settlement, complete the Expression of Interest Form and return to MedicareAppealsSettlement@cms.hhs.gov by 1/31/2017.

For additional assistance, review the Frequently Asked Questions (FAQs) page.
**ASP Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files - July 2016**

MLN Matters® Number: MM9612
Related Change Request (CR) #: CR 9612
Related CR Release Date: April 22, 2016
Effective Date: July 1, 2016
Related CR Transmittal #: R3494CP
Implementation Date: July 5, 2016

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

**Provider Action Needed**
Change Request (CR) 9612 informs MACs to download and implement the July 2016 Average Sales Price (ASP) drug pricing files and, if released by the Centers for Medicare & Medicaid Services (CMS), the April 2016, January 2016, October 2016 and July 2015, ASP drug pricing files for Medicare Part B drugs. Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after July 5, 2016, with dates of service July 1, 2016, through September 30, 2016. Make sure that your billing staffs are aware of these changes.

**Background**
The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply MACs with the ASP and Not Otherwise Classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the OPPS are incorporated into the Outpatient Code Editor (OCE) through separate instructions that can be located in the “Medicare Claims Processing Manual” (Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)), Section 50 (Outpatient PRICER)).

The following table shows how the quarterly payment files will be applied:

<table>
<thead>
<tr>
<th>Files</th>
<th>Effective Dates of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 2016 ASP and ASP NOC</td>
<td>July 1, 2016, through September 30, 2016</td>
</tr>
<tr>
<td>April 2016 ASP and ASP NOC</td>
<td>April 1, 2016, through June 30, 2016</td>
</tr>
<tr>
<td>January 2016 ASP and ASP NOC</td>
<td>January 1, 2016, through March 31, 2016</td>
</tr>
<tr>
<td>October 2015 ASP and ASP NOC</td>
<td>October 1, 2015, through December 31, 2015</td>
</tr>
<tr>
<td>July 2015 ASP and ASP NOC</td>
<td>July 1, 2015, through September 30, 2015</td>
</tr>
</tbody>
</table>

**Additional Information**
**ASP Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files - October 2016**

MLN Matters® Number: MM9724  
Related Change Request (CR) #: CR 9724  
Related CR Release Date: July 29, 2016  
Effective Date: October 1, 2016  
Related CR Transmittal #: R3573CP  
Implementation October 3, 2016

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

**What You Need to Know**  
Change Request (CR) 9724 provides the October 2016 quarterly update and instructs MACs to download and implement the October 2016 Average Sales Price (ASP) drug pricing files and, if released by CMS, the July 2016, April 2016, January 2016, and October 2015, ASP drug pricing files for Medicare Part B drugs. Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after October 3, 2016, with dates of service October 1, 2016, through December 31, 2016. MACs will not search and adjust claims that have already been processed unless brought to their attention. Make sure your billing staffs are aware of these changes.

**Background**  
The ASP methodology is based on quarterly data submitted to the Centers for Medicare & Medicaid Services (CMS) by manufacturers. CMS will supply MACs with the ASP and Not Otherwise Classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis.

Payment allowance limits under the Outpatient Prospective Payment System (OPPS) are incorporated into the Outpatient Code Editor (OCE) through separate instructions that are in Chapter 4, Section 50 of the “Medicare Claims Processing Manual” at [https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf).

The following table shows how the quarterly payment files will be applied:

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<tbody>
<tr>
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<td>October 1, 2016, through December 31, 2016</td>
</tr>
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<td>July 2016 ASP and ASP NOC</td>
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</tr>
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</tr>
<tr>
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<td>January 1, 2016, through March 31, 2016</td>
</tr>
<tr>
<td>October 2015 ASP and ASP NOC</td>
<td>October 1, 2015, through December 31, 2015</td>
</tr>
</tbody>
</table>

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

MLN Matters® Number: MM9771
Related Change Request (CR) #: CR 9771
Related CR Release Date: October 7, 2016
Effective Date: January 1, 2017
Related CR Transmittal #: R3618CP
Implementation Date: January 3, 2017

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

Provider Action Needed
Change Request (CR) 9771 provides the 2017 annual update to the list of HCPCS codes used by Medicare systems to enforce consolidated billing of home health services. Make sure that your billing staffs are aware of these changes.

Background
The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of HCPCS codes that are subject to the consolidated billing provision of the Home Health Prospective Payment System (HH PPS).

With the exception of therapies performed by physicians, supplies incidental to physician services and supplies used in institutional settings, services appearing on this list that are submitted on claims to Medicare contractors will not be paid separately on dates when a beneficiary for whom such a service is being billed is in a home health episode (that is, under a home health plan of care administered by a home health agency). Medicare will only directly reimburse the primary home health agencies that have opened such episodes during the episode periods. Therapies performed by physicians, supplies incidental to physician services and supplies used in institutional settings are not subject to HH consolidated billing.

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

Section 1842(b)(6) of the Social Security Act requires that payment for home health services provided under a home health plan of care is made to the home health agency.

The HCPCS codes in the table below are being added to the HH consolidated billing therapy code list, effective for services on or after January 1, 2017. These codes replace HCPCS codes: 97001, 97002, 97003, 97004.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>97161</td>
<td>PT EVAL LOW COMPLEX 20 MIN</td>
</tr>
<tr>
<td>97162</td>
<td>PT EVAL MOD COMPLEX 30 MIN</td>
</tr>
<tr>
<td>97163</td>
<td>PT EVAL HIGH COMPLEX 45 MIN</td>
</tr>
<tr>
<td>97164</td>
<td>PT RE-EVAL EST PLAN CARE</td>
</tr>
<tr>
<td>97165</td>
<td>OT EVAL LOW COMPLEX 30 MIN</td>
</tr>
<tr>
<td>97166</td>
<td>OT EVAL MOD COMPLEX 45 MIN</td>
</tr>
<tr>
<td>97177</td>
<td>OT EVAL HIGH COMPLEX 60 MIN</td>
</tr>
<tr>
<td>97168</td>
<td>OT RE-EVAL EST PLAN CARE</td>
</tr>
</tbody>
</table>
G0279 and G0280 are deleted from the HH consolidated billing therapy code list. These codes were replaced with 0019T and should have been removed from the list in earlier updates. Effective January 1, 2015, these codes were redefined for another purpose. MACs will adjust claims denied due to HH consolidated billing with HCPCS codes G0279 and G0280 and line item dates of service on or after January 1, 2015, if brought to their attention.

Additional Information

Issuing Compliance Letters to Specific Providers and Suppliers Regarding Inappropriate Billing of QMBs for Medicare Cost-Sharing – Revised

MLN Matters® Number: MM9817 Revised
Related Change Request (CR) #: CR 9817
Related CR Release Date: November 18, 2016
Effective Date: December 16, 2016
Related CR Transmittal #: R1757OTN
Implementation Date: March 8, 2017

This article was revised on November 18, 2016, to reflect the revised CR9817 issued that same day. In the article, the effective date, CR release date, transmittal number, and the Web address for CR9817 are revised. The sample letters at the end of the article have slight wording changes to show that the Medicaid program also helps low-income beneficiaries pay their Medicare premiums. All other information remains the same.

Provider Types Affected
This MLN Matters® Article is intended for providers submitting claims to Medicare Administrative Contractors (MACs) and Durable Medical Equipment MACs (DME MACs) for services provided to certain Medicare beneficiaries.

Provider Action Needed
Federal law bars Medicare providers from charging individuals enrolled in the Qualified Medicare Beneficiary Program (QMB) for Medicare Part A and B deductibles, coinsurances, or copays. QMB is a Medicaid program that assists low-income beneficiaries with Medicare premiums and cost-sharing. Change Request (CR) 9817 instructs MACs to issue a compliance letter instructing named providers and suppliers to refund any erroneous charges and recall any past or existing billing with regard to improper QMB billing. Please make sure your billing staffs are aware of this aspect of your Medicare provider agreement.

Background
In 2013, approximately seven million Medicare beneficiaries were enrolled in QMB, a Medicaid program that assists low-income beneficiaries with Medicare premiums and cost-sharing.

State Medicaid programs are liable to pay Medicare providers who serve QMB individuals for the Medicare cost sharing. However, federal law permits states to limit provider payment for Medicare cost sharing to the lesser of the Medicare cost sharing amount, or the difference between the Medicare payment and the Medicaid rate for the service provided. Regardless, Medicare providers must accept the Medicare payment and Medicaid payment (if any, and including any permissible Medicaid cost sharing from the beneficiary) as payment in full for services rendered to a QMB individual.

Medicare providers who violate these billing prohibitions are violating their Medicare Provider Agreement and may be subject to sanctions, as described in Sections 1902(n)(3); 1905(p); 1866(a)(1)(A); and 1848(g)(3) of the Social Security Act (the Act).
In July 2015, the Centers for Medicare & Medicaid Services issued a study finding that:

- Erroneous billing of QMB individuals persists
- Confusion about billing rules exists amongst providers and beneficiaries

Note: The study, titled “Access to Care Issues Among Qualified Medicare Beneficiaries (QMB),” is available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Access_to_Care_Issues_Among_Qualified_Medicare_Beneficiaries.pdf.

In September 2016, all Medicare beneficiaries received “Medicare & You 2017,” which contains new language to advise QMB individuals about their billing protections. Also, a toll-free number (1-800-MEDICARE) is available to QMB individuals if they cannot resolve billing problems with their providers. In addition, effective September 17, 2016, Beneficiary Contact Center (BCC) Customer Service Representatives (CSRs) can identify a caller’s QMB status and advise them about their billing rights.

BCC CSRs will begin escalating beneficiary inquiries involving QMB billing problems that the beneficiary has been unable to resolve with the provider to the appropriate MAC. MACs will issue a compliance letter for all inquiries referred. This compliance letter will instruct named providers and suppliers to refund any erroneous charges and recall any past or existing QMB billing (including referrals to collection agencies).

MACs will also send a copy of the compliance letter to the named beneficiary, with a cover letter advising the beneficiary to show the mailing to the named provider and verify that the provider corrected the billing problem. Examples of these letters are included following the “Document History” section of this article.

Additional Information


Example of Cover Letter for affected QMB Individuals sent by MAC

[month] [day], [year]

[address]

[City] ST [Zip]

Reference ID: (NPI, etc.)

Dear [Beneficiary Name]:

You contacted Medicare about a bill you got from [Provider/Supplier Name]. Then we sent [Provider/Supplier Name] the letter on the next page.

You are in the Qualified Medicare Beneficiary (QMB) program. It helps pay your Medicare premiums and costs. Medicare providers cannot bill you for Medicare deductibles, coinsurance, or copays for covered items and services.

The letter tells the provider to stop billing you and to refund you any amounts you already paid. Here’s what you can do:

- Show this letter to your provider to make sure they fixed your bill.
- Tell all of your providers and suppliers you are in the QMB program.
- Show your Medicare and your Medicaid or QMB cards each time you get items or services.

If you have questions about this letter, call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. Call 1-877-486-2048 if you use TTY.

Sincerely,

[Name]

[Title]

[MAC name]
Example of Compliance Letter Sent to Provider by the MAC

[month] [day], [year]

[address]

[City] ST [Zip]

Reference ID: (NPI, etc.)

Dear [Provider/Supplier Name]:

The Centers for Medicare & Medicaid Services (CMS) received information that [Provider/Supplier Name] is improperly billing [Medicare beneficiary name/HICN number] for Medicare cost-sharing.

This beneficiary is enrolled in the Qualified Medicare Beneficiary (QMB) program, a state Medicaid program that helps low-income beneficiaries pay their Medicare premiums and cost-sharing. Federal law says Medicare providers can’t charge individuals enrolled in the QMB program for Medicare Part A and B deductibles, coinsurances, or copays for items and services Medicare covers.

**Promptly review your records for efforts to collect Medicare cost-sharing from [Medicare beneficiary name/HICN number], refund any amounts already paid, and recall any past or existing billing (including referrals to collection agencies) for Medicare-covered items and services**

Ensure that your administrative staff and billing software exempt individuals enrolled in the QMB program from all Medicare cost-sharing billing and related collection efforts

Medicare providers must accept Medicare payment and Medicaid payment (if any) as payment in full for services given to individuals enrolled in the QMB program. Medicare providers who violate these billing prohibitions are violating their Medicare Provider Agreement and may be subject to sanctions. (See Sections 1902(n)(3); 1905(p); 1866(a)(1)(A); 1848(g)(3) of the Social Security Act.)

Finally, please refer to this Medicare Learning Network (MLN) Matters® article for more information on the prohibited billing of QMBs: [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1128.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1128.pdf). If you have questions, please contact [MAC information].

Sincerely,

[Name]

[Title]

[MAC name]

ASP Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files - January 2017

MLN Matters® Number: MM9843

Related Change Request (CR) #: CR 9843

Related CR Release Date: October 28, 2016

Effective Date: January 1, 2017

Related CR Transmittal #: R3640CP

Implementation Date: January 3, 2017

Provider Types Affected

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

What You Need to Know

Change Request (CR) 9843 provides the January 2017 quarterly update and instructs MACs to download and implement the January 2017 ASP drug pricing files and, if released by the Centers for Medicare &
Medicaid Services (CMS), the revised October 2016, July 2016, April 2016, and the January 2016 Average Sales Price (ASP) drug pricing files for Medicare Part B drugs. Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after January 3, 2017 with dates of service January 1, 2017, through March 31, 2017. MACs will not search and adjust claims previously processed unless brought to their attention. Make sure your billing staffs are aware of these changes.

Background

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

The following table shows how the quarterly payment files will be applied:

<table>
<thead>
<tr>
<th>Files</th>
<th>Effective Dates of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 2017 ASP and ASP NOC</td>
<td>January 1, 2017, through March 31, 2017</td>
</tr>
<tr>
<td>October 2016 ASP and ASP NOC</td>
<td>October 1, 2016, through December 31, 2016</td>
</tr>
<tr>
<td>July 2016 ASP and ASP NOC</td>
<td>July 1, 2016, through September 30, 2016</td>
</tr>
<tr>
<td>April 2016 ASP and ASP NOC</td>
<td>April 1, 2016, through June 30, 2016</td>
</tr>
<tr>
<td>January 2016 ASP and ASP NOC</td>
<td>January 1, 2016, through March 31, 2016</td>
</tr>
</tbody>
</table>

Additional Information


MLN Matters® Number: SE1624
Article Release Date: November 22, 2016

Provider Types Affected

This article is intended for providers billing Medicare Administrative Contractors (MACs) for services related to stem cell transplantation.

Provider Action Needed

The Office of the Inspector General (OIG) recently completed a review of Medicare claims related to stem cell transplants. This article is intended to address issues of incorrect billing as a result of the February 2016 OIG report and to clarify coverage of stem cell transplantation. This article does not introduce any new policies. It is intended to clarify the billing for stem cell services.

Background

The Centers for Medicare & Medicaid Services (CMS) has a coverage policy for stem cell transplantation, and the “Medicare National Coverage Determination (NCD) Manual” (Publication 100-03, Section 110.8) states that stem cell transplantation is a process in which stem cells are harvested from either a patient’s or donor’s bone marrow or peripheral blood for intravenous infusion.

Types of Stem Cell Transplants that are covered:

Medicare covers allogeneic and autologous transplants. Allogeneic and autologous stem cell transplants are covered under Medicare for specific diagnoses.
1. Allogeneic Hematopoietic Stem Cell Transplantation (HSCT)

Allogeneic stem cell transplantation is a procedure in which a portion of a healthy donor’s stem cells is obtained and prepared for intravenous infusion to restore normal hematopoietic function in recipients having an inherited or acquired hematopoietic deficiency or defect.

Expenses incurred by a donor are a covered benefit to the recipient/beneficiary but, except for physician services, are not paid separately. Services to the donor include physician services, hospital care in connection with screening the stem cell, and ordinary follow-up care.

2. Autologous Stem Cell Transplantation (AuSCT)

Autologous stem cell transplantation is a technique for restoring stem cells using the patient’s own previously stored cells. Autologous stem cell transplants (AuSCT) must be used to effect hematopoietic reconstitution following severely myelotoxic doses of chemotherapy (High Dose Chemotherapy (HDCT)) and/or radiotherapy used to treat various malignancies.

Medicare policy as stated in Transmittal 1805 states that stem cell transplants are typically performed in the outpatient setting. Should complications occur, then the procedure would be performed on an inpatient basis. However, the OIG report suggests that an inpatient stay of just 1 or 2 days is more likely a miscoded claim as opposed to submitting an outpatient claim to cover stem cell transplantation.

In their February 2016 OIG report, the OIG determined that Medicare paid for many stem cell transplant procedures incorrectly. The main finding was that providers billed these procedures as inpatient when they should have been submitted as outpatient or outpatient with observation services. The key points in the report are as follows:

- **Stem cell transplants are typically performed in the outpatient setting.**
  - Hospitals may have incorrectly thought that stem cell transplantation was on CMS’s list of inpatient-only procedures.
  - Hospitals often billed these services using incorrect Medicare Severity Diagnosis Related Groups (MS-DRGs). Of critical importance, the OIG found that many claims contained an MS-DRG suggesting a Geometric Mean Length of Stay (GMLOS) in the hospital that should have been much longer than the claim actually showed. For example, the following table shows the length of stay one might expect for the given MS-DRGs. Yet, the submitted claims reflected a length of stay of just 1 or 2 days. This suggests the claims should have been billed as outpatient, which is what Medicare policy considers to be the norm for stem cell transplants.

<table>
<thead>
<tr>
<th>MS-DRG</th>
<th>MS-DRG Title</th>
<th>GMLOS</th>
<th>Arithmetic Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>014</td>
<td>ALLOGENEIC BONE MARROW TRANSPLANT</td>
<td>20.0</td>
<td>25.1</td>
</tr>
<tr>
<td>016</td>
<td>AUTOLOGOUS BONE MARROW TRANSPLANT W CC/ MCC</td>
<td>17.5</td>
<td>19.1</td>
</tr>
<tr>
<td>017</td>
<td>AUTOLOGOUS BONE MARROW TRANSPLANT W/O CC/MCC</td>
<td>8.9</td>
<td>12.4</td>
</tr>
</tbody>
</table>

Extracted from Table 5 Acute Inpatient FY 2015 Final Rule

The Two-Midnight Rule

To assist providers in determining whether inpatient admission is reasonable and payable under Medicare Part A, CMS adopted the Two-Midnight rule for admissions beginning on or after October 1, 2013. This rule established Medicare payment policy regarding the benchmark criteria that should be used when determining whether an inpatient admission is reasonable and payable under Medicare Part A.

In general, the Two-Midnight rule states:

- Inpatient admissions will generally be payable under Part A if the admitting practitioner expected the patient to require a hospital stay that crossed two midnights and the medical record supports that reasonable expectation.
- Medicare Part A payment is generally not appropriate for hospital stays not expected to span at least two midnights.
The Two-Midnight rule also specified that all treatment decisions for beneficiaries were based on the medical judgment of physicians and other qualified practitioners. The Two-Midnight rule does not prevent the physician from providing any service at any hospital, regardless of the expected duration of the service.

For stays for which the physician expects the patient to need less than two midnights of hospital care (and the procedure is not on the inpatient-only list or otherwise listed as a national exception), an inpatient admission may be payable under Medicare Part A on a case-by-case basis based on the judgment of the admitting physician. The documentation in the medical record must support that an inpatient admission is necessary, and is subject to medical review.

Additional Information

The OIG report is available at https://oig.hhs.gov/oas/reports/region9/91402037.pdf.


You may want to review the following MLN Matters articles for further information:


Additional information is in a transcript of an MLN Connects® conference call discussing the Two-Midnight rule, which is available at https://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/2-27-14MidnightRuleTranscript.pdf.

Guidance to Physician/Practitioner and Supplier Billing Offices that Submit Hard Copy Claims to Medicare to Help Reduce Incidence of Claims Not Crossing Over Due to Duplicate Diagnosis Codes and Diagnosis Code Pointers

MLN Matters® Number: SE1629
Article Release Date: November 8, 2016
Provider Types Affected
This MLN Matters Special Edition (SE) Article is intended for physician/practitioner and supplier billing offices mailing CMS-1500 claim forms to Medicare Administrative Contractors (MACs) and Durable Medical Equipment MACs (DME MACs) for services provided to Medicare beneficiaries.

Provider Action Needed
This article instructs physician/practitioner and supplier billing offices to correctly submit CMS-1500 claim forms to reduce the number of claims that are not “crossed over,” or transferred electronically to the destination supplemental payer. Make sure your billing staff is aware of this guidance.

Background
Currently, when physician/practitioner and supplier billing offices mail CMS-1500 claim forms to their MAC or DME MAC, the MAC or DME MAC’s shared system uses the resulting adjudication data in the creation of outbound Medicare crossover claims. More specifically, Medicare uses the results from the processing of the incoming hard copy claims to create outbound Health Insurance Portability and Accountability Act (HIPAA) Accredited Standards Committee (ASC) X12-N 837 professional Coordination of Benefits (COB) claims.

After the incoming hard-copy claims have met their Medicare payment floor requirements, MACs and DME MACs then transfer these claims to the Centers for Medicare & Medicaid Services (CMS) Benefits Coordination & Recovery Center (BCRC). The BCRC administers CMS’ Medicare claims crossover process.

Upon receipt at the BCRC, the claims are edited for HIPAA ASC X12-N 837 claims compliance. Claims that pass compliance are “crossed over,” or transferred electronically, to the destination supplemental payer. Claims that fail HIPAA compliance are not crossed over. Instead, the BCRC submits an electronic report to the associated MAC or DME MAC advising why the claims were not crossed over. MACs and DME MACs then create a notification letter that is mailed to the physician/practitioner or supplier’s correspondence address of record, which is on file with the MAC or DME MAC. It is within the context of this process that CMS is creating SE1629.

Diagnosis Coding on Claims and Processing and Editing of Those Claims
Beginning in October 2015, billing vendors for physicians and medical practitioners and suppliers in the healthcare industry have been including International Classification of Diseases, Clinical Modifications, Version 10 (ICD-CM-10), on healthcare claims submitted to Medicare in association with specified Service-From Date requirements.

- Example: If a claim’s Service-From Date is October 15, 2015, physicians/practitioners and suppliers are to bill the claim to Medicare using an ICD-10, rather than ICD-9, diagnosis code.

CMS MACs and DME MACs have either a front-end Contractor Common Edits Module (CCEM) or Common Electronic Data Interchange (CEDI) module that activates when ICD diagnosis code versions are incorrectly used for claim service dates. Additionally, the MAC and DME MAC CCEM and CEDI have logic that activates when incoming electronically-submitted claims contain duplicate ICD-10 diagnosis codes, as well as duplicate diagnosis code pointers.

MACs and DME MACs currently do not have established Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) that may be used through Medicare’s unprocessable claims procedure to advise physician/practitioners or suppliers that they have either incorrectly:

1. Included a duplicate ICD-10 diagnosis code on an incoming CMS-1500 Claim; or
2. Included a diagnosis code pointer reference more than once (for example, “1, 1”) on such claims.

CMS is providing the informational guidance to physicians/practitioners and medical suppliers in the hopes that they will have fewer issues with Medicare crossing their claims over to supplemental payers.

BCRC Editing and Claims Failing to Cross Over
Prior to and after the implementation of ICD-10 diagnosis reporting in October 2015, representatives from the Medicare supplemental payer community informed CMS and its BCRC that the ICD-10-CM, Version 5010 Manual provides direction to users regarding the inappropriateness of reporting ICD-10-CM diagnosis codes more than once. The guidance is as follows:
Within Section B, “General Coding Guidelines, number 12, page 19,” the Manual states, “12. Reporting Same Diagnosis Code More Than Once: Each unique ICD-10-CM diagnosis code may be reported only once per encounter. This also applies to bilateral conditions when there are no distinct codes identifying laterally or two different conditions classified to the same ICD-10-CM diagnosis code.”

CMS has determined that the above guidance has influenced many healthcare plans, payers, and clearinghouses to create edits that will activate if the same ICD-10 diagnosis code is duplicated on claims. The BCRC, at the discretion of CMS, has also done so, to ensure that supplemental payers will not reject Medicare crossover claims with this characteristic upon receipt. Therefore, any claims that MACs and DME MACs transmit to the BCRC that contain duplicate ICD-10 diagnosis codes are encountering the following error:

- **H54271** – “ICD-10 codes cannot be duplicated.”

Since MACs and DME MACs have duplicate diagnosis code editing included in their CCEM or CEDI front-end editing routines, incoming electronic HIPAA ASC X12-N 837 claims with these characteristics are being rejected through Medicare’s 277-CA process. This means it is primarily incoming hard copy (CMS-1500) claims that are now encountering the H54271 edit rejection.

Additionally, guidance in the HIPAA Technical Report Version 3 (TR-3) Guide governing 837 professional claims transactions makes reference to use of distinct diagnosis pointers to differentiate among multiple diagnosis codes when included on healthcare claims. It appears Medicare’s CCEM or CEDI routines catch situations where diagnosis code pointer references are used more than once. However, there is no available CARC or RARC that can be used to identify this situation as part of Medicare’s unprocessable claims procedure. Because of this, claims where a diagnosis pointer reference is duplicated, such as “1, 1,” are encountering the following error at the BCRC:

- **H25670** – “Diagnosis code pointers should not be duplicated.”

**Next Steps to Remediate This Issue**

CMS recognizes it is possible for a physician/practitioner or supplier to reference a given reported diagnosis code, through a diagnosis code pointer, more than once when billing Medicare for multiple services on the same claim. However, vendors or physician/practitioner and supplier offices that create CMS-1500 claims can obtain better Medicare claims crossover results if they:

- Cease reporting the same ICD-9 or ICD-10 diagnosis more than once and
- Cease reporting a diagnosis code pointer reference more than once (for example, 1, 1, or 2, 2)

**Additional Information**

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

**Interim Billing Instructions for Common Procedure Terminology (CPT) Code 90674 - Influenza Virus Vaccine, Quadrivalent (ccIIV4), Derived from Cell Cultures, Subunit, Preservative and Antibiotic Free, 0.5 mL Dosage, for Intramuscular Use**

**Effective:** For dates of service on or after August 1, 2016 and only up to and including December 31, 2016.

The American Medical Association issued a new Current Procedural Terminology (CPT) code for influenza vaccine Flucelvax Quadriivalent®, CPT 90674, effective August 1, 2016 for Medicare claims. However, the Medicare claims processing systems will not be able to accept this new code until January 1, 2017 for non-institutional claims (Part B), and not until February 20, 2017 for institutional claims (Part A).

CMS has instructed that Medicare Administrative Contractors (MACs) may direct use of a Not Other Classified (NOC) code to allow billing for the vaccine for dates of service on or after August 1, 2016 through December 31, 2016, after which time the new 90674 will be recognized by the Medicare claims systems.

Until January 1, 2017, you may therefore either:
BILLING

- Hold claims containing CPT 90674, or
- Alternatively, submit claims using the Not Other Classified (NOC) code Q2039

Procedure code Q2039 is described as influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (not otherwise specified). It is technically correct that the 90674 vaccine is not a “split virus”, but this is the closest NOC code available and therefore the most suitable for this short-term purpose.

Enter “Q2039 = 90674” in Item 19 of the CMS-1500 claim form or its electronic equivalent when billing for this vaccine for non-institutional claims.

Enter “Q2039 = 90674” in Form Locator (FL) 80 of the CMS 1450 (UB-04) claim form or its electronic equivalent when billing for this vaccine for institutional claims.

Note: Institutional claims submitted with 90674 after January 1, 2017 will be held by Noridian until February 20, 2017 when the Shared System can be updated. Claims submitted after January 1, 2017 must be submitted with CPT 90674 for this vaccine.

Effective for dates of service on or after August 1, 2016, MACs are using 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](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html).

Coinsurance and deductible do not apply to flu vaccines, including CPT codes 90674 and Q2039.

CERT

CERT RC Contract Awarded

On August 16, 2016, the CMS awarded the Comprehensive Error Rate Testing (CERT) Review Contractor (RC) work to AdvanceMed, an NCI company. This new contract eliminates the current CERT Documentation Contractor (DC), Livanta, as of October 13, 2016. The work that is currently being performed by the incumbent DC will be transitioned to the RC and fully operational on October 14, 2016.

Important information for this transition is as follows:

- October 6, 2016 is the last day that the current CERT DC will be receiving medical records and CERT inquiries at their location
- Beginning with October 7, 2016, all CERT inquiries and medical records should be addressed to the new contact information provided below

Contact Information

<table>
<thead>
<tr>
<th>Method</th>
<th>Prior to October 7, 2016</th>
<th>Effective October 7, 2016 and After</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mailing Address</td>
<td>CERT – DC Operations</td>
<td>CERT Documentation Center</td>
</tr>
<tr>
<td></td>
<td>9090 Junction Dr. Suite 9</td>
<td>1510 East Parham Road</td>
</tr>
<tr>
<td></td>
<td>Annapolis Junction, MD 20701</td>
<td>Henrico, VA 23228</td>
</tr>
<tr>
<td>Fax</td>
<td>240-568-6222</td>
<td>804-261-8100</td>
</tr>
<tr>
<td>Phone Number</td>
<td>301-957-2380</td>
<td>443-663-2699</td>
</tr>
<tr>
<td>Toll Free Phone Number</td>
<td>888-779-7477</td>
<td>888-779-7477</td>
</tr>
<tr>
<td>Email</td>
<td><a href="mailto:CERTMail@livanta.com">CERTMail@livanta.com</a></td>
<td><a href="mailto:CERTMail@admedcorp.com">CERTMail@admedcorp.com</a></td>
</tr>
</tbody>
</table>

If documentation is sent to Livanta on/after October 14, 2016, it will be processed as indicated below.

<table>
<thead>
<tr>
<th>Method</th>
<th>Processing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fax</td>
<td>Fax will fail</td>
</tr>
<tr>
<td>USPS ground mail</td>
<td>Forwarded for six months</td>
</tr>
</tbody>
</table>
CERT Provider Website
The current CERT Provider Website will remain at the same; however, it will be temporarily unavailable for address updates from October 6-13, 2016. Point of Contact (POC) information will not need to be re-entered if previously submitted to this website.

To ensure the correct individual, or department, is in receipt of CERT requests for documentation and CERT Findings Letters, we (Noridian) encourage providers to review their POC information on/after October 14, 2016.

Please send any inquiries to the appropriate email address below.

<table>
<thead>
<tr>
<th>Line of Business</th>
<th>Email Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part A</td>
<td><a href="mailto:CERTPartAQuestion@noridian.com">CERTPartAQuestion@noridian.com</a></td>
</tr>
<tr>
<td>Part B</td>
<td><a href="mailto:CERTQuestion@noridian.com">CERTQuestion@noridian.com</a></td>
</tr>
<tr>
<td>DME JA</td>
<td><a href="mailto:JADMECERT@noridian.com">JADMECERT@noridian.com</a></td>
</tr>
<tr>
<td>DME JD</td>
<td><a href="mailto:JDDMECERT@noridian.com">JDDMECERT@noridian.com</a></td>
</tr>
</tbody>
</table>

CLAIM REVIEWS

Targeted Probe & Educate with Extrapolation
CMS has authorized Jurisdiction F to conduct the Targeted Probe and Educate with Extrapolation (TPEE) Pilot review process. This is a required process for providers targeted by Medical Review. The TPEE review process includes three rounds of a prepayment probe review with education. If there are continued high denials after the first three rounds, Noridian has the option to perform a fourth round, which will include a post payment review with extrapolation.

View the Targeted Probe & Educate with Extrapolation webpage for complete details.

CODING

New Revenue Code 0815 for Allogeneic Stem Cell Acquisition Services
MLN Matters® Number: MM9674
Related Change Request (CR) #: CR 9674
Related CR Release Date: July 29, 2016
Effective Date: January 1, 2017
Related CR Transmittal #: R3571CP
Implementation Date: January 3, 2017

Provider Types Affected
This MLN Matters® Article is intended for physicians, other providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs) for stem cell transplant services provided to Medicare beneficiaries.
**CODING**

**What You Need to Know**

Medicare systems will accept revenue code 0815 (Allogeneic Stem Cell Acquisition/Donor Services), recently created by the National Uniform Billing Committee (NUBC), effective January 1, 2017, when submitted on hospital claims (Types of Bill (TOB) 011x, 012x, 013x, or 085x). Make sure that your billing staffs are aware of this change.

**Background**

Hematopoietic stem cell transplantation (HSCT) is a process that includes mobilization, harvesting, and transplant of stem cells and the administration of high dose chemotherapy and/or radiotherapy prior to the actual transplant. During the process stem cells are harvested from either the patient (autologous) or a donor (allogeneic) and subsequently administered by intravenous infusion to the patient.

Payment for these acquisition services is included in the Outpatient Prospective Payment System Ambulatory Payment Classification (OPPS APC) payment for the allogeneic stem cell transplant when the transplant occurs in the hospital outpatient setting, and in the Medicare Severity-Diagnosis Related Group (MS-DRG) payment for the allogeneic stem cell transplant when the transplant occurs in the inpatient setting. MACs do not make separate payments for these acquisition services, because hospitals may bill and receive payment only for services provided to the Medicare beneficiary who is the recipient of the stem cell transplant and whose illness is being treated with the stem cell transplant. Unlike the acquisition costs of solid organs for transplant (for example, hearts and kidneys), which are paid on a reasonable cost basis, acquisition costs for allogeneic stem cells are included in the prospective payment.

Acquisition charges for stem cell transplants apply only to allogeneic transplants, for which stem cells are obtained from a donor (other than the recipient himself or herself). Acquisition charges do not apply to autologous transplants (transplanted stem cells are obtained from the recipient himself or herself), because autologous transplants involve services provided to the beneficiary only (and not to a donor), for which the hospital may bill and receive payment. (See the “Medicare Claims Processing Manual,” Chapter 3, Section 90.3 and Chapter 4, Section 231, for information regarding billing for autologous stem cell transplants.)

Currently, when the allogeneic stem cell transplant occurs in the outpatient setting, the hospital identifies stem cell acquisition charges for allogeneic bone marrow/stem cell transplants separately in FL 42 of Form CMS-1450 (or electronic equivalent) by using revenue code 0819 (Other Organ Acquisition). Revenue code 0819 charges should include all services required to acquire stem cells from a donor, as defined above, and should be reported on the same date of service as the transplant procedure in order to be appropriately packaged for payment purposes.

Stakeholders have expressed concern that the acquisition costs are not being accurately reflected in the transplant procedure as Revenue Code 0819 maps to cost center code 086XX (Other organ acquisition where XX is “00” through “19”) and is reported on line 112 (or applicable subscripts of line 112) of the Form CMS-2552-10 cost report.

The Centers for Medicare & Medicaid Services (CMS) requested and NUBC approved a new Revenue Code 0815 to be used when the hospital identifies stem cell acquisition charges for allogeneic bone marrow/stem cell transplants separately.

**Additional Information**


**Editing of Therapy Services to Reflect Coding Changes**

MLN Matters® Number: MM9698
Related Change Request (CR) #: CR 9698
Related CR Release Date: December 1, 2016
Effective Date: January 1, 2017
Related CR Transmittal #: R3670CP
Implementation Date: April 3, 2017
CODING

Provider Types Affected
This MLN Matters® Article is intended for providers submitting claims to Medicare Administrative Contractors (MACs) for physical and occupational therapy services provided to Medicare beneficiaries.

Provider Action Needed
Change Request (CR) 9698 instructs the MACs to apply certain coding edits to the new Current Procedural Terminology (CPT) codes that are used to report physical and occupational therapy evaluations and re-evaluations, effective January 1, 2017. Make sure your billing staffs are aware of these coding changes.

Background
Original Medicare claims processing systems contain edits to ensure claims for the evaluative procedures furnished by rehabilitative therapy clinicians – including physical therapists, occupational therapists and speech-language pathologists – are coded correctly. These edits ensure that when the codes for evaluative services are submitted, the therapy modifier (GP, GO or GN) that reports the type of therapy plan of care is consistent with the discipline described by the evaluation or re-evaluation code. The edits also ensure that Functional Reporting occurs, that is, that functional G-codes, along with severity modifiers, always accompany codes for therapy evaluative services.

For calendar year (CY) 2017, eight new CPT codes (97161-97168) were created to replace existing codes (97001-97004) to report physical therapy (PT) and occupational therapy (OT) evaluations and re-evaluations. The new CPT code descriptors include specific components that are required for reporting as well as the typical face-to-face times. In another recent issuance, CR9782, the Centers for Medicare & Medicaid Services (CMS) described the new PT and OT code sets, each comprised of three new codes for evaluation – stratified by low, moderate, and high complexity – and one code for re-evaluation. CR 9782 designated all eight new codes as “always therapy” (always require a therapy modifier) and added them to the 2017 therapy code list located at http://www.cms.gov/Medicare/Billing/TherapyServices/index.html.

For a complete listing of the new codes, their CPT long descriptors, and related policies, see the article related to CR 9782 at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9782.pdf.

CR 9698 applies the coding requirements for certain evaluative procedures that are currently outlined in the “Medicare Claims Processing Manual,” Chapter 5 to the new codes for PT and OT evaluations and re-evaluations. These coding requirements include the payment policies for evaluative procedures that (a) require the application of discipline-specific therapy modifiers and (b) necessitate Functional Reporting using G-codes and severity modifiers. The new codes are also added to the list of evaluation codes that CMS will except from the caps after the therapy caps are reached when an evaluation is necessary, for example, to determine if the current status of the beneficiary requires therapy services.

This notification implements the following payment policies related to claims for therapy services for the new codes for physical therapy (PT) and occupational therapy (OT) evaluative procedures – claims without the required information will be returned as unprocessable:

**Therapy modifiers.** The new PT and OT codes are added to the current list of evaluative procedures that require a specific therapy modifier to identify the plan of care under which the services are delivered to be on the claim for therapy services. Therapy modifiers GP, GO or GN are required to report the type of therapy plan of care – PT, OT, or speech language pathology (SLP), respectively. This payment policy requires that each new PT evaluative procedure code – 97161, 97162, 97163 or 97164 – to be accompanied by the GP modifier; and, (b) each new code for an OT evaluative procedure – 97165, 97166, 97167 or 97168 – be reported with the GO modifier.

**Functional Reporting.** In addition to other Functional Reporting requirements, current payment policy requires Functional Reporting, using G-codes and severity modifiers, when an evaluative procedure is furnished and billed. CR9698 adds the eight new codes for PT and OT evaluations and re-evaluations – 97161, 97162, 97163, 97164, 97165, 97166, 97167, and 97168 – to the procedure code list of evaluative procedures that necessitate Functional Reporting. A severity modifier (CH – CN) is required to accompany each functional G-code (G8978-G8999, G9158-9176, and G9186) on the same line of service.

For each evaluative procedure code, Functional Reporting requires either two or three functional G-codes and related severity modifiers be on the same claim. Two G-codes are typically reported on specified claims throughout the therapy episode. However, when an evaluative service is furnished that represents a one-time therapy visit, the therapy clinician reports all three G-codes in the functional limitation set –
G-codes for Current Status, Goal Status and Discharge Status.

For the documentation requirements related to Functional Reporting, please refer to the “Medicare Benefits Policy Manual,” Chapter 15, Section 220.4.

CMS coding requirements for Functional Reporting applied through CR9698 ensure that at least two G-codes in a functional set and their corresponding severity modifiers are present on the same claim with any one of the codes on this evaluative procedure code list. The required reporting of G-codes includes: (a) G-codes for Current Status and Goal Status; or, (b) G-codes for Discharge Status and Goal Status. Remember that your MAC will Return to the Provider (RTP):

1. Claims you submit for the new therapy evaluative procedures, HCPCS codes 97161-97168, without including one of the following pairs of G-codes/severity modifiers required for Functional Reporting: (a) A current status G-code/severity modifier paired with a goal status G-code/severity modifier; or, (b) A goal status G-code/severity modifier paired with a discharge status G-code/severity modifier.

2. Institutional outpatient claims reporting HCPCS codes 97161, 97162, 97163, and 97164 that you submit without including modifier GP.

3. Institutional outpatient claims reporting HCPCS codes 97165, 97166, 97167, and 97168, that you submit without including modifier GO.

Additional Information

The official instruction, CR9698, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3670CP.pdf. The updated “Medicare Claims Processing Manual,” Chapter 5 (Part B Outpatient Rehabilitation and CORF/OPT Services), Sections 10.3.2 (Exceptions Process), 10.6 (Functional Reporting), and 20.2 (Reporting of Service Units with HCPCS) is attached to CR9698.

New Physician Specialty Code for Hospitalist – Revised

MLN Matters® Number: MM9716 Revised
Related Change Request (CR) #: CR 9716
Related CR Release Date: November 25, 2016
Effective Date: April 1, 2017
Related CR Transmittal #: R3637CP and R276FM
Implementation Date: April 3, 2017

This article was updated on November 28, 2016, to reflect a revised CR9716, issued on November 25. 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) 9716 announces that the Centers for Medicare & Medicaid Services (CMS) has established a new physician specialty code for Hospitalist. The new code for Hospitalist is C6. Make sure your billing staffs are aware of this physician specialty code.

Background

When they enroll in the Medicare program, physicians self-designate their Medicare physician specialty on the Medicare enrollment application (CMS-855I or CMS-855O), or in the Internet-based Provider Enrollment, Chain and Ownership System (PECOS). CMS uses these Medicare physician specialty codes,
which describe the specific/unique types of medicine that physicians (and certain other suppliers) practice, for programmatic and claims processing purposes.

Medicare will also recognize the new code of C6 as a valid specialty for the following edits:

- Ordering/certifying Part B clinical laboratory and imaging, durable medical equipment (DME), and Part A home health agency (HHA) claims
- Critical Access Hospital (CAH) Method II Attending and Rendering claims
- Attending, operating, or other physician or non-physician practitioner listed on CAH claims

Additional Information

New POS Code for Telehealth and Distant Site Payment Policy
MLN Matters® Number: MM9726
Related Change Request (CR) #: CR 9726
Related CR Release Date: August 12, 2016
Effective Date: January 1, 2017 - Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the effective date for nonmedical data code sets, of which the POS code set is one, is the code set in effect the date the transaction is initiated. It is not date of service.
Related CR Transmittal #: R3586CP
Implementation Date: January 3, 2017

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

Provider Action Needed
CR 9726 updates the Place of Service (POS) code set by creating a new code (POS 02) for Telehealth services, effective January 1, 2017. You should ensure that your billing staffs are aware of this new POS code.

Background
As an entity covered under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Medicare must comply with standards, and their implementation guides, adopted by regulation under this statute. The currently adopted professional implementation guide for the ASC X12N 837 standard requires that each electronic claim transaction include a Place of Service (POS) code from the POS code set that the Centers for Medicare & Medicaid Services (CMS) maintains. The POS code set provides setting information necessary to appropriately pay Medicare and Medicaid claims.

As a payer, Medicare must be able to recognize, as valid, any valid code from the POS code set that appears on the HIPAA standard claim transaction. Further, unless prohibited by national policy to the contrary, Medicare not only recognizes such codes, but also adjudicates claims that contain these codes.

At times, Medicaid has had a greater need for code specificity than has Medicare; and many of the new codes, over the past few years, have been developed to meet Medicaid’s needs. While Medicare does not always need this greater specificity in order to appropriately pay claims, it nevertheless adjudicates claims with the new codes to ease coordination of benefits and to give Medicaid and other payers the setting information they require.
Effective January 1, 2017, CMS is creating a new POS code 02 for use by the physician or practitioner furnishing telehealth services from a distant site. CR 9726 updates the current POS code set by adding this new code (POS 02: Telehealth), with a descriptor of “The location where health services and health related services are provided or received, through telecommunication technology.”

Medicare will pay for these services using the Medicare Physician Fee Schedule (MPFS), including the use of the MPFS facility rate for Method II Critical Access Hospitals billing on type of bill 85x. This Telehealth POS code would not apply to originating site facilities billing a facility fee.

**Remember that under HIPAA, the effective date for nonmedical data code sets, of which the POS code set is one, is the code set in effect the date the transaction is initiated. It is not date of service.**

Modifiers GT (via interactive audio and video telecommunications systems) and GQ (via an asynchronous telecommunications system) are still required when billing for Medicare Telehealth services. If you bill for Telehealth services with POS code 02, but without the GT or GQ modifier, your MAC will deny the service with the following messages:

- Group Code CO
- Claim Adjustment Reason Code (CARC) 4 (The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present)
- Remittance Advice Remarks Code (RARC) MA130 (Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information)

Conversely, if you bill for Telehealth services with modifiers GT or GQ, but without POS code 02, your MAC will deny the service with the following messages:

- Group Code CO
- CARC 5 (The procedure code/bill type is inconsistent with the place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present)
- RARC M77 (Missing/incomplete/invalid/inappropriate place of service)

**Additional Information**


**Coding Revisions to NCDs – Revised**

**MLN Matters® Number:** MM9751 Revised  
**Related Change Request (CR) #:** CR 9751  
**Related CR Release Date:** November 17, 2016  
**Effective Date:** January 1, 2017 - Unless otherwise noted  
**Related CR Transmittal #:** R1753OTN  
**Implementation Date:** January 3, 2017

This article was revised on November 17, 2016 to reflect the revised CR9571 issued on the same day. CR9571 was revised to change the NCD180.1 effective date in spreadsheet history to 1/1/16, in NCD160.18, remove reactivation of MCS 012L from spreadsheet history and business requirement, and in NCD220.6.20 to remove reference to ‘primary diagnosis’ regarding diagnosis code Z00.6 in spreadsheet, and reference FISS new RC for value code D4 in spreadsheet history. In the article, the CR release date, transmittal number and the Web address for CR9571 are revised. All other information remains the same.
Provider Types Affected
This MLN Matters® Article is intended for physicians and other providers submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed
Change Request (CR) 9751 is the 9th maintenance update of International Classification of Diseases, Tenth Revision (ICD-10) conversions and other coding updates specific to national coverage determinations (NCDs). The majority of the NCDs included are a result of feedback received from previous ICD-10 NCD CRs, specifically CR7818, CR8109, CR8197, CR8691, CR9087, CR9252, CR9540, and CR9631; while others are the result of revisions required to other NCD-related CRs released separately. MLN Matters® Articles MM7818, MM8109, MM8197, MM8691, MM9087, MM9252, MM9540, and MM9631 contain information pertaining to these CR’s.

Background
The translations from ICD-9 to ICD-10 are not consistent 1-1 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 the 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 as of October 1, 2015.

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. Edits to ICD-10 and other coding updates specific to NCDs will be included in subsequent, quarterly releases as needed.

CR9751 makes adjustments to the following NCDs:
- NCD 20.7 Percutaneous Transluminal Angioplasty (PTA)
- NCD 20.19 Ambulatory Blood Pressure Monitoring (ABPM)
- NCD 20.33 Transcatheter Mitral Valve Repair (TMVR) Therapy
- NCD 40.1 Diabetes Self-Management Training (DSMT)
- NCD 160.18 Vagus Nerve Stimulation (VNS)
- NCD 180.1 Medical Nutrition Therapy (MNT)
- NCD 190.3 Cytogenetic Studies
- NCD 220.6.17 FDG PET for Solid Tumors
- NCD 220.6.20 PET Beta Amyloid in Dementia/Neurological/ Disorders
- NCD 230.18 Sacral Nerve Stimulation (SNS) for Urinary Incontinence
- NCD 260.1 Adult Liver Transplants


Remember that coding and payment are areas of the Medicare Program that are separate and distinct 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.

Your MACs will 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 - This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered; with
- Claim Adjustment Reason Codes (CARC)
- 50 - These are non-covered services because this is not deemed a “medical necessity” by the payer;
- 96 - Non-covered charge(s); or
- 119 Benefit maximum for this time period has been reached.

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).

Additional Information

Claim Status Category and Claim Status Codes Update
MLN Matters® Number: MM9769
Related Change Request (CR) #: CR 9769
Related CR Release Date: November 18, 2016
Effective Date: April 1, 2017
Related CR Transmittal #: R3661CP
Implementation Date: April 3, 2017

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

Provider Action Needed
Change Request (CR) 9769 informs MACs about system changes to update, 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 that your billing staffs are aware of these changes.

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

The National Code Maintenance Committee meets at the beginning of each ASC X12 trimester meeting (January/February, June, and September/October) and makes decisions about additions, modifications, and retirement of existing codes. The Committee has decided to allow the industry 6 months for implementation of newly added or changed codes. The codes sets are available on the Washington Publishing Company website 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 January 2017 committee meeting shall be posted on these sites on or about February 1, 2017. Your MAC will complete entry of all applicable code text changes and new codes, and terminated use of deactivated codes, by the implementation date of CR 9769.

These code changes are to be used in editing of all ASC X12 276 transactions processed on or after the date of implementation and to be reflected in the ASC X12 277 transactions issued on and after the date of implementation of CR 9769.
Additional Information

New Influenza Virus Vaccine Code – Implementation – Revised
MLN Matters® Number: MM9793 Revised
Related Change Request (CR) #: CR 9793
Related CR Release Date: September 30, 2016
Effective Date: August 1, 2016
Related CR Transmittal #: R3617CP
Implementation Date: January 3, 2017

This article was revised on October 21, 2016, to correct a date on page 2 in bold. The dates should have read, “.... from August 1, 2016, through December 31, 2016. All other information is unchanged.

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

Provider Action Needed
Change Request (CR) 9793 which informs MACs about the changes to instructions for payment and edits for the Common Working File (CWF) to include influenza virus vaccine code 90674 (Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use) as payable for claims with dates of service on or after August 1, 2016, processed on or after January 3, 2017. Make sure that your billing staffs are aware of these changes.

Background
CR9793 provides instructions for payment and edits to include influenza virus vaccine code 90674. Medicare waives coinsurance and deductibles for code 90674. Medicare will pay for code 90674 based on reasonable cost when submitted by:

• Hospitals on Type of Bill (TOB) 12X and 13X
• Skilled Nursing Facilities on TOB 22X and 23X
• Home Health Agencies on TOB 34X
• Hospital-Based Renal Dialysis facilities on 72X, and
• Critical Access Hospitals (CAHs) on TOB 85X

MACs will pay for influenza virus vaccine code 90674 based on the lower of the actual charge or 95 percent of the Average Wholesale Price (AWP) to:

• Indian Health Services (IHS) hospitals submitting claims on TOB 12X and 13X
• IHS CAHs submitting claims on TOB 85X
• Comprehensive Outpatient Rehabilitation Facilities using TOB 75X, and
• Independent Renal Dialysis Facilities using TOB 72X

It is important to note that MACs will hold institutional claims with code 90674 with dates of service on or after January 1, 2017, through February 20, 2017, until the Fiscal Intermediary Shared System (FISS) changes are implemented on February 20, 2017. Medicare will issue further instructions on how to handle claims for code 90674 with dates of service from August 1, 2016, through December 31, 2016.

Medicare will use the Centers for Medicare & Medicaid Services (CMS) Seasonal Influenza Vaccines Pricing webpage at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/)
McrPartBDrugAvgSalesPrice/VaccinesPricing.html to determine the payment rate for influenza virus vaccine code 90674. This applies to professional claims with dates of service on or after August 1, 2016. Coinsurance and deductible do not apply.

Additional Information

Preventive Services - HCPCS Code Update
MLN Matters® Number: MM9888
Related Change Request (CR) #: CR 9888
Related CR Release Date: December 2, 2016
Effective Date: January 1, 2017
Related CR Transmittal #: R3669CP
Implementation Date: January 3, 2017

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

Provider Action Needed
Change Request (CR) 9888, announces that, effective for dates of service on and after January 1, 2017, CPT code 76706 replaces HCPCS code G0389. MACs will apply all editing that was applied to HCPCS code G0389 to CPT code 76706, including the waiver of deductible and coinsurance. Make sure that your billing staffs are aware of these changes.

Background
Section 5112 of the Deficit Reduction Act of 2005 allows for only one ultrasound screening test for an abdominal aortic aneurysm by Medicare. CPT code 76706 replaces HCPCS code G0389 as of January 1, 2017, for billing this service. CR9888 also updates the “Medicare Claims Processing Manual,” Chapter 9, to show the current CPT codes for smoking cessation. The revised Chapter 9 is attached to CR9888.

Additional Information
Changes to the Laboratory NCD Edit Software for January 2017 – Revised

MLN Matters® Number: MM9806 Revised
Related Change Request (CR) #: CR 9806
Related CR Release Date: November 16, 2016
Effective Date: October 1, 2016
Related CR Transmittal #: R3656CP
Implementation Date: December 5, 2016

This article was revised on November 17, 2016, to reflect the revised CR issued on November 16. In the article, the implementation date is now December 5, 2016. Also, the CR release date, transmittal number and the Web address for accessing the CR are revised. All other information remains the same.

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

Provider Action Needed
Change Request (CR) 9806 announces changes that will be included in the January 2017 quarterly release of the edit module for clinical diagnosis laboratory services. Make sure your billing staffs are aware of these changes to ensure proper billing to Medicare.

Background
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. Medicare developed nationally uniform software that was 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 United States effective April 1, 2003.

CR9806 communicates requirements to Medicare system maintainers and the MACs regarding changes to the NCD code lists used for laboratory claims edit software for January 2017. 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 ICD-10-CM codes. Please see Section II (Business Requirements Table) of CR9806 for the lengthy list of codes added or deleted. Note that where codes are deleted, the effective date of deletion is September 30, 2016 and the effective date for codes added is October 1, 2016.

Additional Information

Implantable Infusion Pumps for Chronic Pain – R1

The following Medicare Coverage Article has been revised under contract numbers 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) 03601 (WY)

Medicare Coverage Article Number: A55323
Article Title: Implantable Infusion Pumps for Chronic Pain
Effective Date: September 1, 2016
Summary of Article:
- Change in verbiage from “may” to “must” regarding intraspinal opioid or non-opioid drug administration.
- Replacement of CPT code 62318 with 62325 and 62319 with 62327

View the locally hosted Noridian Medicare Coverage Articles webpage:
- Go to https://med.noridianmedicare.com/web/jfa/policies/coverage-articles
Intraocular Bevacizumab Coding/Billing Guidelines – R3 and R4

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

Revision 3

Summary of Changes: The Part A article (A53010) is retired effective 9/30/2016. Part A contract numbers are added to the Part B article (A53009) so that both Part A and Part B articles will have the same MCD numbers. Coverage remains the same with the exception of the code additions and deletions noted below due to annual ICD-10 code updates.


**Effective Date:** 10/01/16
Revision 4

Summary of Changes: The article is revised to remove diagnoses including unspecified eye in the description which were added in error due to the annual ICD-10 code update. Coding to the highest level of specificity is required and codes for right and left eye are included for each indication where appropriate.


Effective Date: 10/01/16

View the complete Noridian coverage article.

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

Go to the Noridian Medicare Coverage Articles webpage to:

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

Intraocular Bevacizumab Coding/Billing Guidelines – R5

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

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

- Added New ICD-10 Codes
  - H34.8110 - Central retinal vein occlusion, right eye, with macular edema
  - H34.8111 - Central retinal vein occlusion, right eye, with retinal neovascularization
  - H34.8112 - Central retinal vein occlusion, right eye, stable
  - H34.8120 - Central retinal vein occlusion, left eye, with macular edema
  - H34.8121 - Central retinal vein occlusion, left eye, with retinal neovascularization
  - H34.8122 - Central retinal vein occlusion, left eye, stable
  - H34.8130 - Central retinal vein occlusion, bilateral, with macular edema
  - H34.8131 - Central retinal vein occlusion, bilateral, with retinal neovascularization
  - H34.8132 - Central retinal vein occlusion, bilateral, stable
  - H34.8310 - Tributary (branch) retinal vein occlusion, right eye, with macular edema
  - H34.8311 - Tributary (branch) retinal vein occlusion, right eye, with retinal neovascularization
  - H34.8312 - Tributary (branch) retinal vein occlusion, right eye, stable
− H34.8320 - Tributary (branch) retinal vein occlusion, left eye, with macular edema
− H34.8321 - Tributary (branch) retinal vein occlusion, left eye, with retinal neovascularization
− H34.8322 - Tributary (branch) retinal vein occlusion, left eye, stable
− H34.8330 - Tributary (branch) retinal vein occlusion, bilateral, with macular edema
− H34.8331 - Tributary (branch) retinal vein occlusion, bilateral, with retinal neovascularization
− H34.8332 - Tributary (branch) retinal vein occlusion, bilateral, stable
− H35.3210 - Exudative age-related macular degeneration, right eye, stage unspecified
− H35.3211 - Exudative age-related macular degeneration, right eye, with active choroidal neovascularization
− H35.3212 - Exudative age-related macular degeneration, right eye, with inactive choroidal neovascularization
− H35.3213 - Exudative age-related macular degeneration, right eye, with inactive scar
− H35.3220 - Exudative age-related macular degeneration, left eye, stage unspecified
− H35.3221 - Exudative age-related macular degeneration, left eye, with active choroidal neovascularization
− H35.3222 - Exudative age-related macular degeneration, left eye, with inactive choroidal neovascularization
− H35.3223 - Exudative age-related macular degeneration, left eye, with inactive scar
− H35.3230 - Exudative age-related macular degeneration, bilateral, stage unspecified
− H35.3231 - Exudative age-related macular degeneration, bilateral, with active choroidal neovascularization
− H35.3232 - Exudative age-related macular degeneration, bilateral, with inactive choroidal neovascularization
− H35.3233 - Exudative age-related macular degeneration, bilateral, with inactive scar

• Deleted ICD-10 codes due to 2017 ICD-10 code updates effective 9/30/2016 but not noted in previous revision history
− E10.321 - Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema
− E10.329 - Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema
− E10.331 - Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema
− E10.339 - Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema
− E10.341 - Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema
− E10.349 - Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema
− E10.351 - Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema
− E10.359 - Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema

Effective Date: October 1, 2016

View the complete Noridian coverage article.

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

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

**Medical Necessity of Therapy Services - R2**

The Medical Necessity of Therapy Services coverage article has been revised and published 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) New Number:** A52775

**Effective Date:** January 1, 2017

**Summary of Changes:** This final article, effective 01/01/2017, combines JFA A52762 into the JFB A52775 article so that both JFA and JFB contract numbers will have the same final MCD article number with the 2017 CPT updates. In addition, the following CPT/HCPCS codes were added or deleted effective January 1, 2017.

- **New/Revised CPT/HCPCS**
  - **97161** - Physical therapy evaluation: low complexity, requiring these components:
    - A history with no personal factors and/or comorbidities that impact the plan of care;
    - An examination of body system(s) using standardized tests and measures addressing 1-2 elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions;
    - A clinical presentation with stable and/or uncomplicated characteristics; and
    - Clinical decision making of low complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, **20 minutes** are spent face-to-face with the patient and/or family.
  - **97162** - Physical therapy evaluation: moderate complexity, requiring these components:
    - A history of present problem with 1-2 personal factors and/or comorbidities that impact the plan of care;
    - An examination of body systems using standardized tests and measures in addressing a total of 3 or more elements from any of the following body structures and functions, activity limitations, and/or participation restrictions;
    - An evolving clinical presentation with changing characteristics; and
    - Clinical decision making of moderate complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, **30 minutes** are spent face-to-face with the patient and/or family.
  - **97163** - Physical therapy evaluation: high complexity, requiring these components:
    - A history of present problem with 3 or more personal factors and/or comorbidities that impact the plan of care;
    - An examination of body systems using standardized tests and measures addressing a total of 4 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions;
    - A clinical presentation with unstable and unpredictable characteristics; and
• Clinical decision making of high complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, **45 minutes** are spent face-to-face with the patient and/or family.

- **97165** - Occupational therapy evaluation, low complexity, requiring these components:
  • An occupational profile and medical and therapy history, which includes a brief history including review of medical and/or therapy records relating to the presenting problem;
  • An assessment(s) that identifies 1-3 performance deficits (i.e., relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and
  • Clinical decision making of low complexity, which includes an analysis of the occupational profile, analysis of data from problem-focused assessment(s), and consideration of a limited number of treatment options. Patient presents with no comorbidities that affect occupational performance. Modification of tasks or assistance (e.g., physical or verbal) with assessment(s) is not necessary to enable completion of evaluation component. Typically, **30 minutes** are spent face-to-face with the patient and/or family.

- **97166** - Occupational therapy evaluation, moderate complexity, requiring these components:
  • An occupational profile and medical and therapy history, which includes an expanded review of medical and/or therapy records and additional review of physical, cognitive, or psychosocial history related to current functional performance;
  • An assessment(s) that identifies 3-5 performance deficits (i.e., relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and
  • Clinical decision making of moderate analytic complexity, which includes an analysis of the occupational profile, analysis of data from detailed assessment(s), and consideration of several treatment options. Patient may present with comorbidities that affect occupational performance. Minimal to moderate modification of tasks or assistance (e.g., physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, **45 minutes** are spent face-to-face with the patient and/or family.

- **97167** - Occupational therapy evaluation, high complexity, requiring these components:
  • An occupational profile and medical and therapy history, which includes review of medical and/or therapy records and extensive additional review of physical, cognitive, or psychosocial history related to current functional performance;
  • An assessment(s) that identify 5 or more performance deficits (i.e., relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and
  • A clinical decision-making is of high analytic complexity, which includes an analysis of the patient profile, analysis of data from comprehensive assessment(s), and consideration of multiple treatment options. Patient presents with comorbidities that affect occupational performance. Significant modification of tasks or assistance (e.g., physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, **60 minutes** are spent face-to-face with the patient and/or family.

• Deleted Codes Effective January 1, 2017.
  - **97001** - Physical therapy evaluation
  - **97002** - Physical therapy re-evaluation
  - **97003** - Occupational therapy evaluation
  - **97004** - Occupational therapy re-evaluation

View the complete Noridian coverage article.

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

Go to the Noridian Medicare Coverage Articles webpage to:
Ocular Photodynamic Therapy (OPT) with Verteporfin – R2

The following JF Local Coverage Article 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: A52769

Effective Date: October 1, 2016

Article Summary of Changes: This Article has been updated to add ICD-10 codes:

- New/Revised ICD-10 codes:
  - H35.3211 - Exudative age-related macular degeneration, right eye, with active choroidal neovascularization to Group 1
  - H35.3221 - Exudative age-related macular degeneration, left eye, with active choroidal neovascularization to Group 1
  - B39.5 - Histoplasmosis duboisii to Group 2
  - B39.9 - Histoplasmosis, unspecified to Group 2

- Deleted ICD-10 codes:
  - H35.32 - Exudative age-related macular degeneration from Group 1.

Go to the Noridian National Coverage Determination (NCD) webpage to:

- View the locally hosted Noridian Active Medicare Coverage Articles
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).

Outpatient Drugs Administration Orders - Revised

This article, last published in April of 2016, has been revised to update the second sentence regarding physician signature documentation.

Coverage for outpatient drugs requires that documentation must support that services were properly authenticated or intended by the physician. When a physician order is not signed, the physician must clearly document in the medical record his or her intent that the service or test be performed.

View the “Outpatient Drugs Administration Orders” section of the newly created “Browse by Topic” Drugs, Biologicals and Injections webpage for a listing of practitioners who may sign orders.

Routine Dental Services – R1

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

Effective Date: October 1, 2016

Summary of Changes: Article was reformatted and non-covered diagnoses were removed from Limitations of Coverage and added to the appropriate diagnosis field. This article now includes Part A contract numbers effective 10/1/16.

- Added as excluded due to the ICD-10 annual update effective 10/1/16
- K02.52, K02.53, K04.01, K04.02, K05.211, K05.212, K05.213, K05.219, K05.221, K05.222, K05.223, K05.229, K05.311, K05.312, K05.313, K05.319, K05.321, K05.322, K05.323, K05.329, K06.3, K06.8, K06.9, K08.111, K08.112, K08.113, K08.114, K08.119, K08.121, K08.122, K08.123, K08.124, K08.129, K08.131, K08.132, K08.133, K08.134, K08.139, K08.191, K08.192, K08.193, K08.194, K08.199, K08.411, K08.412, K08.413, K08.414, K08.421, K08.422, K08.423, K08.424, K08.431, K08.432, K08.433, K08.434, K08.491, K08.492, K08.493, K08.494, K08.539, K08.81, K08.82, K08.89 and M26.219.

- Deleted due to the ICD-10 annual update effective 9/30/16
  - K04.0, K05.21, K05.22, K05.31, K05.32 and K08.8.

- Deleted effective 9/30/16

- However, Providers must have documentation available for review to support these services are reasonable and necessary and not routine dental services.

View the complete Noridian coverage article.

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

Go to the Noridian Medicare Coverage Articles webpage to:

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

Self-Administered Drug Exclusion List – R8

The Self-Administered Drug Exclusion List coverage article has been revised and/or published for notice under contract numbers: 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601 (WY) in the CMS Medicare Coverage Database (MCD) and on our (Noridian) website.

Effective Date: December 6, 2016

Summary of Changes: Added HCPCS Codes J3590, C9399 for Etanercept-SZZS (Erelzi™).

Added Saxenda® brand name to include in HCPCS code J3490 Liraglutide GLP-1, Victoza®. The effective date remains 09/30/2013.

View the complete Noridian Self-Administered Drug Exclusion List.

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

Go to the Noridian Medicare Coverage Articles webpage to:

- View complete list of Noridian coverage articles
- Access the CMS MCD to view a comprehensive revision history for this corresponding article
  - Scroll to bottom of webpage
  - Select state/contract of interest from Active, Future or Retired column (This link will redirect you to the CMS website.)
  - Once in the CMS MCD, select corresponding article title
Self-Administered Drug Exclusion List – R9

The Self-Administered Drug Exclusion List coverage article has been revised and/or published for notice under contract numbers: 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601 (WY) in the CMS Medicare Coverage Database (MCD) and on our (Noridian) website.

**Effective Date:** October 1, 2016

**Summary of Changes:** J2502 removed from the SAD list with an exclusion end date of 10/1/2016.

- J2502 – Injection, Pasireotide long acting, 1 MG

View the complete Noridian Self-Administered Drug Exclusion List.

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

Go to the Noridian Medicare Coverage Articles webpage to:

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

Testopel Coverage – R3

The following Medicare Coverage Article has been revised under contract numbers 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) 03601 (WY)

**Medicare Coverage Article Number:** A55057

**Article Title:** Testopel Coverage

**Effective Date:** July 12, 2016

**Summary of Article:** Submitted claim form information verbiage was changed to: Enter drug dosage given (include milligrams delivered only) in Item 19 of CMS-1500 paper claim form or Loop 2400/SV101-7 for electronic claims.

View the locally hosted Noridian Medicare Coverage Articles webpage:

- Go to [https://med.noridianmedicare.com/web/ifa/policies/coverage-articles](https://med.noridianmedicare.com/web/ifa/policies/coverage-articles)
- 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

Therapeutic Apheresis for Familial Hypercholesterolemia – R2

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

**Effective Date:** 10/01/16
Summary of Changes: The article has been updated to include and/or remove ICD-10 codes.

- Deleted ICD-10 code:
  - E78.0 – Pure hypercholesterolemia
- New ICD-10 codes:
  - E78.00 - Pure hypercholesterolemia, unspecified
  - E78.01 - Familial hypercholesterolemia

View the complete Noridian coverage article.

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

Go to the Noridian Medicare Coverage Articles webpage to:

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

Therapy Evaluation Coding

The Therapy Evaluation Coding coverage article has been revised and published 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) New Number: A55367

Effective Date: January 1, 2017

Summary of Changes: This final article, effective 01/01/2017, combines JFA A52761 into the JFB A55367 article so that both JFA and JFB contract numbers will have the same final MCD article number with the 2017 CPT updates. In addition, the following new and deleted CPT/HCPCS codes effective January 1, 2017.

- New/Revised CPT/HCPCS
  - 97161 - Physical therapy evaluation: low complexity, requiring these components:
    - A history with no personal factors and/or comorbidities that impact the plan of care;
    - An examination of body system(s) using standardized tests and measures addressing 1-2 elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions;
    - A clinical presentation with stable and/or uncomplicated characteristics; and
    - Clinical decision making of low complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 20 minutes are spent face-to-face with the patient and/or family.
  - 97162 - Physical therapy evaluation: moderate complexity, requiring these components:
    - A history of present problem with 1-2 personal factors and/or comorbidities that impact the plan of care;
    - An examination of body systems using standardized tests and measures in addressing a total of 3 or more elements from any of the following body structures and functions, activity limitations, and/or participation restrictions;
- An evolving clinical presentation with changing characteristics; and
- Clinical decision making of moderate complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, **30 minutes** are spent face-to-face with the patient and/or family.

- **97163** - Physical therapy evaluation: high complexity, requiring these components:
  - A history of present problem with 3 or more personal factors and/or comorbidities that impact the plan of care;
  - An examination of body systems using standardized tests and measures addressing a total of 4 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions;
  - A clinical presentation with unstable and unpredictable characteristics; and
  - Clinical decision making of high complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, **45 minutes** are spent face-to-face with the patient and/or family.

- **97164** - Reevaluation of physical therapy established plan of care, requiring these components:
  - An examination including a review of history and use of standardized tests and measures is required; and
  - Revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, **20 minutes** are spent face-to-face with the patient and/or family.

- **97165** - Occupational therapy evaluation, low complexity, requiring these components:
  - An occupational profile and medical and therapy history, which includes a brief history including review of medical and/or therapy records relating to the presenting problem;
  - An assessment(s) that identifies 1-3 performance deficits (i.e., relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and
  - Clinical decision making of low complexity, which includes an analysis of the occupational profile, analysis of data from problem-focused assessment(s), and consideration of a limited number of treatment options. Patient presents with no comorbidities that affect occupational performance. Modification of tasks or assistance (e.g., physical or verbal) with assessment(s) is not necessary to enable completion of evaluation component. Typically, **30 minutes** are spent face-to-face with the patient and/or family.

- **97166** - Occupational therapy evaluation, moderate complexity, requiring these components:
  - An occupational profile and medical and therapy history, which includes an expanded review of medical and/or therapy records and additional review of physical, cognitive, or psychosocial history related to current functional performance;
  - An assessment(s) that identifies 3-5 performance deficits (i.e., relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and
  - Clinical decision making of moderate analytic complexity, which includes an analysis of the occupational profile, analysis of data from detailed assessment(s), and consideration of several treatment options. Patient may present with comorbidities that affect occupational performance. Minimal to moderate modification of tasks or assistance (e.g., physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, **45 minutes** are spent face-to-face with the patient and/or family.

- **97167** - Occupational therapy evaluation, high complexity, requiring these components:
  - An occupational profile and medical and therapy history, which includes review of medical and/or therapy records and extensive additional review of physical, cognitive, or psychosocial history related to current functional performance;
• An assessment(s) that identify 5 or more performance deficits (i.e., relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and

• A clinical decision-making is of high analytic complexity, which includes an analysis of the patient profile, analysis of data from comprehensive assessment(s), and consideration of multiple treatment options. Patient presents with comorbidities that affect occupational performance. Significant modification of tasks or assistance (e.g., physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 60 minutes are spent face-to-face with the patient and/or family.

  – 97168 - Reevaluation of occupational therapy established plan of care, requiring these components:
    • An assessment of changes in patient functional or medical status with revised plan of care;
    • An update to the initial occupational profile to reflect changes in condition or environment that affect future interventions and/or goals; and
    • A revised plan of care. A formal reevaluation is performed when there is a documented change in functional status or a significant change to the plan of care is required. Typically, 30 minutes are spent face-to-face with the patient and/or family.

• Deleted Codes Effective January 1, 2017.
  – 97001 - Physical therapy evaluation
  – 97002 - Physical therapy re-evaluation
  – 97003 - Occupational therapy evaluation
  – 97004 - Occupational therapy re-evaluation

View the complete Noridian coverage article.

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

Go to the Noridian Medicare Coverage Articles webpage to:

• Access the CMS MCD to view the Future article and comprehensive revision history for this corresponding article
  – Scroll to bottom of webpage
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  – Once in the CMS MCD, select corresponding article title

Zika Virus Testing by PCR and ELISA Methods

The Zika Virus Testing by PCR and ELISA Methods 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 of Changes: The article does not address medical necessity but the appropriate ICD-10 CM coding for claims submission.

Effective Date: October 1, 2016

Go to the Noridian https://med.noridianmedicare.com/web/jfa/policies/coverage-articles Webpage to:

• View complete list of Noridian coverage articles

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

• Access the CMS MCD to view a comprehensive revision history for this corresponding article
  – Scroll to bottom of webpage
- Select state/contract of interest from Active, Future or Retired column (This link will redirect you to the CMS website.)
- Once in the CMS MCD, select corresponding article title

**MolDX: Corus CAD Test Billing and Coding Guidelines – R3**

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

**Summary of Changes:** The Part A article (A54430) is retired and Part A contract numbers are added to the Part B article (A54431) so that they will have the same MCD number. All references to “Z-code Identifier” were replaced with “unique identifier”.

This article has been updated to include and/or remove ICD-10 codes.

**New ICD-10 Codes:**
- E78.00 - Pure hypercholesterolemia, unspecified
- E78.01 - Familial hypercholesterolemia

**Deleted ICD-10 Codes:**
- E78.0 - Pure hypercholesterolemia

**Effective Date:** 10/01/16

View the complete Noridian coverage article.

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

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**MolDX: Progensa PCA3 Assay Billing and Coding Guidelines – R2**

The MolDX: Progensa PCA3 Assay Billing and Coding Guidelines coverage article has been revised and published for notice under contract numbers: 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601 (WY) in the CMS Medicare Coverage Database (MCD) and on our (Noridian) website.

**Summary of Changes:** The Part A article (A54490) is retired and Part A contract numbers are added to the Part B article (A54492) so that they will have the same MCD number. All references to “Z-code Identifier” were replaced with “unique identifier”.

This article has been updated to include and/or remove ICD-10 codes.

**New ICD-10 Codes:**
- R31.21 - Asymptomatic microscopic hematuria
- R31.29 - Other microscopic hematuria
- R97.20 - Elevated prostate specific antigen (PSA)
Deleted ICD-10 Codes:

- R97.2 - Elevated prostate specific antigen (PSA)

**Effective Date:** 10/01/16

View the complete Noridian coverage article.

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

**MolDX: ResponseDX Tissue of Origin Billing and Coding Guidelines – R1**

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

**Summary of Changes:** The Part A article (A54495) is retired and Part A contract numbers are added to the Part B article (A54496) so that they will have the same MCD number. The article title is revised to change “Coding and Billing” to “Billing and Coding” to be consistent with all Noridian MolDX billing and coding articles. All references to “Z-code Identifier” were replaced with “unique identifier”.

This article has been updated to include and/or remove ICD-10 codes.

**New ICD-10 Codes:**

- D49.511 - Neoplasm of unspecified behavior of right kidney
- D49.512 - Neoplasm of unspecified behavior of left kidney

**Deleted ICD-10 Codes:**

- D49.5 - Neoplasm of unspecified behavior of other genitourinary organs

**Effective Date:** 10/01/16

View the complete Noridian coverage article.

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

Go to the Noridian Medicare Coverage Articles webpage to:

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  - Scroll to bottom of webpage
  - Select state/contract of interest from Active, Future or Retired column (This link will redirect you to the CMS website.)
  - Once in the CMS MCD, select corresponding article title
Chemotherapy Administration Local Coverage Article – R4 and R5

The Chemotherapy Administration coverage article 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: A52991

Effective Date: January 1, 2017

Summary of Changes: This article has been updated to include updates effective on January 1, 2016 or July 1, 2016 as detailed below and to add CPT/HCPCS codes effective January 1, 2017.

- Effective dates of service (DOS) January 1, 2016
  - HCPCS G0498 - Chemotherapy administration, intravenous infusion technique; initiation of infusion in the office/other outpatient setting using office/other outpatient setting pump/supplies, with continuation of the infusion in the community setting (e.g., home, domiciliary, rest home or assisted living) using a portable pump provided by the office/other outpatient setting, includes follow up office/other outpatient visit at the conclusion of the infusion replaces CPT® 96549 – unlisted chemotherapy procedure for the use of the non-disposable external infusion pump for continuation of chemotherapy in the community setting per CR9749.

- Effective DOS July 1, 2016
  - Added atezolizumab (Tecentriq™) billed with J3590 - Unclassified biologic for non-institutional claims or C9399 - unclassified drug or biologic for institutional claims are processed as an Intramuscular and subcutaneous injections per labeled indications.
  - Added reslizumab (Cinqair®) billed with J3590 - Unclassified biologic for non-institutional claims or C9399 - unclassified drug or biologic for institutional claims are processed as a Non-Chemotherapy Infusion per labeled indications.

- New Drugs added effective January 1, 2017
  - Added olaratumab (Lartruvo™) billed with J3490 - Unclassified drugs for non-institutional claims or C9399 - unclassified drug or biologic for institutional claims processed as Infusions Chemotherapy

- New/Revised CPT/HCPCS codes effective January 1, 2017
  - J2182 - Injection, mepolizumab, 1 mg
  - J2786 - Injection, reslizumab, 1 mg
  - J9034 - Injection, bendamustine hcl (Bendeka™), 1 mg
  - J9145 - Injection, daratumumab, 10 mg
  - J9176 - Injection, elotuzumab, 1 mg
  - J9205 - Injection, irinotecan liposome, 1 mg
  - J9295 - Injection, necitumumab, 1 mg
  - J9325 - Injection, talimogene laherparepvec, per 1 million plaque forming units
  - J9352 - Injection, trabectedin, 0.1 mg.

View the complete Noridian coverage article.

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

Go to the Noridian Medicare Coverage Articles webpage to:

- Access the CMS MCD to view the Future article and comprehensive revision history for this corresponding article
  - Scroll to bottom of webpage
  - Select state/contract of interest the Future column (This link will redirect you to the CMS website.)
  - Once in the CMS MCD, select corresponding article title
2017 JF Part A Quarterly Ask-the-Contractor Teleconferences

Below is the listing of the 2017 Part A Quarterly Ask-the-Contractor Teleconferences (ACTs).

- January 18, 2017
- May 17, 2017
- September 20, 2017

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

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

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

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

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

We look forward to your participation in these important calls.

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

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<tr>
<th>ACT</th>
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<tr>
<td>JD DME</td>
<td><a href="https://med.noridianmedicare.com/web/iddme/education/act">https://med.noridianmedicare.com/web/iddme/education/act</a></td>
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<td>JA DME</td>
<td><a href="https://med.noridianmedicare.com/web/jadme/education/act">https://med.noridianmedicare.com/web/jadme/education/act</a></td>
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Comprehensive Model CJR Provider Education – Revised

MLN Matters® Number: MM9533 Revised
Related Change Request (CR) #: CR 9533
Related CR Release Date: February 19, 2016
Effective Date: April 1, 2016
Implementation Date: April 4, 2016
Related CR Transmittal #: R140DEMO

This article was revised on November 9, 2016, to correct a typo in the list of G-codes in the lower half of page 6. The original article mentioned code G9499 and it should have stated G9489. 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 Comprehensive CJR services provided to Medicare beneficiaries.

What You Need to Know
Change Request (CR) 9533 supplies information to providers about the CJR model. The intent of the CJR model is to promote quality and financial accountability for episodes of care surrounding a Lower-Extremity Joint Replacement (LEJR) or reattachment of a lower extremity procedure. CJR will test whether bundled payments to certain acute care hospitals for LEJR episodes of care will reduce Medicare expenditures while preserving or enhancing the quality of care for Medicare beneficiaries. Make sure that your billing staffs are aware of these changes.

Background
Section 1115A of the Social Security Act (the Act) authorizes the Centers for Medicare & Medicaid Services (CMS) to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care furnished to Medicare, Medicaid, and Children’s Health Insurance Program beneficiaries. Under this authority, CMS published a rule to implement a new five year payment model called the Comprehensive Care for Joint Replacement (CJR) model on April 1, 2016.

Under the CJR model, acute care hospitals in certain selected geographic areas will take on quality and payment accountability for retrospectively calculated bundled payments for LEJR episodes. Episodes will begin with admission to an acute care hospital for an LEJR procedure that is paid under the Inpatient Prospective Payment System (IPPS) through Medical Severity Diagnosis-Related Group (MS-DRG) 469 (Major joint replacement or reattachment of lower extremity with MCC) or 470 (Major joint replacement or reattachment of lower extremity without MCC) and end 90 days after the date of discharge from the hospital.

Key Points of CR9533

CJR Episodes of Care
LEJR procedures are currently paid under the IPPS through: MS-DRG 469 or MS-DRG 470. The episode will include the LEJR procedure, inpatient stay, and all related care covered under Medicare Parts A and B within the 90 days after discharge. The day of discharge is counted as the first day of the 90-day bundle.

CJR Participant Hospitals
The model requires all hospitals paid under the IPPS in selected geographic areas to participate in the CJR model, with limited exceptions. A list of the selected geographic areas and participant hospitals is available at https://innovation.cms.gov/initiatives/cjr on the Internet. Participant hospitals initiate episodes when an LEJR procedure is performed within the hospital and will be at financial risk for the cost of the services included in the bundle. Eligible beneficiaries who elect to receive care at these hospitals will automatically be included in the model.

CJR Model Beneficiary Inclusion Criteria
Medicare beneficiaries whose care will be included in the CJR model must meet the following criteria upon admission to the anchor hospitalization:

- The beneficiary is enrolled in Medicare Part A and Part B;
- The beneficiary’s eligibility for Medicare is not on the basis of the End-Stage Renal Disease benefit;
- The beneficiary is not enrolled in any managed care plan;
- The beneficiary is not covered under a United Mine Workers of America health plan; and
- Medicare is the primary payer.

If at any time during the episode the beneficiary no longer meets all of these criteria, the episode is canceled.
CJR Performance Years
CMS will implement the CJR model for 5 performance years, as detailed in the table below. Performance years for the model correlate to calendar years with the exception of performance year 1, which is April 1, 2016, through December 31, 2016.

CJR Model: 5 Performance Years

<table>
<thead>
<tr>
<th>Performance Year</th>
<th>Date for Episodes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance Year 1 (calendar year 2016)</td>
<td>Episodes that start on or after April 1, 2016, and end on or before December 31, 2016</td>
</tr>
<tr>
<td>Performance Year 2 (calendar year 2017)</td>
<td>Episodes that end between January 1, 2017, and December 31, 2017, inclusive</td>
</tr>
<tr>
<td>Performance Year 3 (calendar year 2018):</td>
<td>Episodes that end between January 1, 2018, and December 31, 2018, inclusive</td>
</tr>
<tr>
<td>Performance Year 4 (calendar year 2019):</td>
<td>Episodes that end between January 1, 2019, and December 31, 2019, inclusive</td>
</tr>
<tr>
<td>Performance Year 5 (calendar year 2020):</td>
<td>Episodes that end between January 1, 2020, and December 31, 2020, inclusive</td>
</tr>
</tbody>
</table>

CJR Episode Reconciliation Activities
CMS will continue paying hospitals and other providers and suppliers according to the usual Medicare fee-for-service payment systems during all performance years. After completion of a performance year, Medicare will compare or “reconcile” actual claims paid for a beneficiary during the 90 day episode to an established target price. The target price is an expected amount for the total cost of care of the episode. Hospitals will receive separate target prices to reflect expected spending for episodes assigned to MS-DRGs 469 and 470, as well as hip fracture status. If the actual spending is lower than the target price, the difference will be paid to the hospital, subject to certain adjustments, such as for quality. This payment will be called a reconciliation payment. If actual spending is higher than the target price, hospitals will be responsible for repayment of the difference to Medicare, subject to certain adjustments, such as for quality.

Identifying CJR Claims
To validate the retroactive identification of CJR episodes, CMS is associating the Demonstration Code 75 with the CJR initiative. This code will also be utilized in future CRs to operationalize a waiver of the three-day stay requirement for covered Skilled Nursing Facility (SNF) services, effective for CJR episodes beginning on or after January 1, 2017.

Medicare will automatically apply the CJR demonstration code to claims meeting the criteria for inclusion in the demonstration. Participant hospitals need not include demonstration code 75 on their claims. Instructions for submission of claims for SNF services rendered to beneficiaries in a CJR episode of care will be communicated once the waiver of the three-day stay requirement is operationalized.

Waivers and Amendments of Medicare Program Rules
The CJR model waives certain existing payment system requirements to provide additional flexibilities to hospitals participating in CJR, as well as other providers that furnish services to beneficiaries in CJR episodes. The purpose of such flexibilities would be to increase LEJR episode quality and decrease episode spending or provider and supplier internal costs, or both, and to provide better, more coordinated care for beneficiaries and improved financial efficiencies for Medicare, providers, and beneficiaries.

Post-Discharge Home Visits
In order for Medicare to pay for home health services, a beneficiary must be determined to be “home bound.” A beneficiary is considered to be confined to the home if the beneficiary has a condition, due to an illness or injury, that restricts his or her ability to leave home except with the assistance of another individual or the aid of a supportive device (that is, crutches, a cane, a wheelchair or a walker) or if the beneficiary has a condition such that leaving his or her home is medically contraindicated. Additional information regarding the homebound requirement is available in the “Medicare Benefit Policy Manual,” Chapter 7, Home Health Services, Section 30.1.1, Patient Confinement to the Home.
Medicare policy allows physicians and Non-Physician Practitioners (NPPs) to furnish and bill for visits to any beneficiary’s home or place of residence under the Medicare Physician Fee Schedule (MPFS). Medicare policy also allows such physicians and practitioners to bill Medicare for services furnished incident to their services by licensed clinical staff. Additional information regarding the “incident to” requirements is available in 42 CFR 410.26.

For those CJR beneficiaries who could benefit from home visits by licensed clinical staff for purposes of assessment and monitoring of their clinical condition, care coordination, and improving adherence with treatment, CMS will waive the “incident to” direct physician supervision requirement to allow a beneficiary who does not qualify for Medicare home health services to receive post-discharge visits in his or her home or place of residence any time during the episode, subject to the following conditions:

- Licensed clinical staff will provide the service under the general supervision of a physician or NPP. These staff can come from a private physician office or may be either an employee or a contractor of the participant hospital.

- Services will be billed under the MPFS by the supervising physician or NPP or by the hospital or other party to which the supervising physician has reassigned his or her billing rights.

- Up to 9 post discharge home visits can be billed and paid per beneficiary during each CJR episode, defined as the 90-day period following the anchor hospitalization.

- The service cannot be furnished to a CJR beneficiary who has qualified, or would qualify, for home health services when the visit was furnished.

- All other Medicare rules for coverage and payment of services incident to a physician’s service continue to apply.

As described in the “Medicare Claims Processing Manual”, Chapter 12, Sections 40-40.4, Medicare policy generally does not allow for separate billing and payment for a postoperative visit furnished during the global period of a surgery when it is related to recovery from the surgery. However, for CJR, CMS will allow the surgeon or other practitioners to bill and be paid separately for a post-discharge home visit that was furnished in accordance with these conditions. All other Medicare rules for global surgery billing during the 90 day post-operative period continue to apply.

CMS expects that the post-discharge home visits by licensed clinical staff could include patient assessment, monitoring, assessment of functional status and fall risk, review of medications, assessment of adherence with treatment recommendations, patient education, communication and coordination with other treating clinicians, and care management to improve beneficiary connections to community and other services.

The service will be billed under the MPFS with a HCPCS G-code (G9490) specific to the CJR post-discharge home visit, as listed in Attachment A. The post-discharge home visit HCPCS code will be payable for CJR model beneficiaries beginning April 1, 2016, the start date of the first CJR model performance year. Claims submitted for post-discharge home visits for the CJR model will be accepted only when the claim contains the CJR specific HCPCS G-Code. Although CMS is associating the Demonstration Code 75 with the CJR initiative, no demonstration code is needed or required on Part B claims submitted with the post-discharge home visit HCPCS G-Code.

Additional information on billing and payment for the post-discharge home visit HCPCS G-Code will be available in the April 2016 release of the MPFS Recurring Update. Future updates to the relative value units (RVUs) and payment for this HCPCS code will be included in the MPFS final rules and recurring updates each year.

Billing and Payment for Telehealth Services

Medicare policy covers and pays for telehealth services when beneficiaries are located in specific geographic areas. Within those geographic areas, beneficiaries must be located in one of the health care settings that are specified in the statute as eligible originating sites. The service must be on the list of approved Medicare telehealth services. Medicare pays a facility fee to the originating site and provides separate payment to the distant site practitioner for the service. Additional information regarding Medicare telehealth services is available in the “Medicare Benefit Policy Manual,” Chapter 15, Section 270 and the “Medicare Claims Processing Manual,” Chapter 12, Section 190.
Under CJR, CMS will allow a beneficiary in a CJR episode in any geographic area to receive services via telehealth. CMS also will allow a home or place of residence to be an originating site for beneficiaries in a CJR episode. This will allow payment of claims for telehealth services delivered to beneficiaries at eligible originating sites or at their residence, regardless of the geographic location of the beneficiary. CMS will waive these telehealth requirements, subject to the following conditions:

- Telehealth services cannot substitute for in-person home health visits for patients under a home health episode of care.
- Telehealth services performed by social workers for patients under a home health episode of care will not be covered under the CJR model.
- The telehealth geographic area waiver and the allowance of home as an originating site under the CJR model does not apply for instances where a physician or allowed NPP is performing a face-to-face encounter for the purposes of certifying patient eligibility for the Medicare home health benefit.
- The principal diagnosis code reported on the telehealth claim cannot be one that is specifically excluded from the CJR episode definition.
- If the beneficiary is at home, the physician cannot furnish any telehealth service with a descriptor that precludes delivering the service in the home (for example, a hospital visit code).
- If the physician is furnishing an evaluation and management visit via telehealth to a beneficiary at home, the visit must be billed by one of nine unique HCPCS G-codes developed for the CJR model that reflect the home setting.
- For CJR telehealth home visits billed with HCPCS codes G9484, G9485, G9488, and G9489, the physician must document in the medical record that auxiliary licensed clinical staff were available on site in the patient’s home during the visit or document the reason that such a high-level visit would not require such personnel.
- Physicians billing distant site telehealth services under these waivers must include the GT modifier on the claim, which attests that the service was furnished in accordance with all relevant coverage and payment requirements.
- The facility fee paid by Medicare to an originating site for a telehealth service will be waived if the service was originated in the beneficiary’s home.

The telehealth home visits will be billed under the MPFS with one of nine HCPCS G-code specific to the CJR telehealth home visits. Those codes are G9481, G9482, G9483, G9484, G9485, G9586, G9487, G9488, and G9489. Attachment A of CR9533 provides the long descriptors of these codes. The telehealth home visit HCPCS codes will be payable for CJR model beneficiaries beginning April 1, 2016, the start date of the first CJR model performance year. Claims submitted for telehealth home visits for the CJR model will be accepted only when the claim contains one of nine of the CJR specific HCPCS G-Code. Although CMS is associating the Demonstration Code 75 with the CJR initiative, no demonstration code is needed or required on Part B claims submitted with the post-discharge home visit HCPCS G-Code. Additional information on billing and payment for the telehealth home visit HCPCS codes will be available in the April 2016 release of the MPFS Recurring Update. Future updates to the RVUs and payment for these HCPCS codes will be included in the MPFS final rules and recurring updates each year.

**Additional Information**


**HMS Awarded Region 4 Recovery Audit Contract**

On October 31st, 2016, CMS awarded HMS Federal Solutions (HMS), a wholly owned subsidiary of HMS Holdings Corporation, the Region 4 Recovery Audit Contractor (RAC) contract. As the Region 4 RAC, HMS will perform postpayment reviews to identify improper payments (overpayments and underpayments) that were made on all Part A and Part B Medicare claims for all provider types.

Additional updates related to Region 4 RAC reviews will be posted to the Region D website ([https://racinfo.healthdatainsights.com](https://racinfo.healthdatainsights.com)), as HMS implements the RAC Program in Region 4.
EDUCATIONAL

508 Title: Medicare Fee-for-Service RAC Regions
508 Narrative: This image shows the states included in the five RAC regions.

**Medicare Fee-for-Service RAC Regions**

CMS Recent updates on the RAC Program may also be found at: [https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Recent_Updates.html](https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Recent_Updates.html)

Note: Both HMS Federal Solutions and HealthDataInsights (HDI) are wholly owned subsidiaries of HMS Holdings Corporation.

**Mammography Certification Reminder**

Providers and suppliers that furnish film, digital or 3-D mammography services and bill Medicare for these services must have their Mammography Certification up to date in order for claims for these mammography services to process.

For more information on this certification, view the Mammography Certification page on the Noridian website.

**New ST PEPPER now available**

A new release of the Short-Term (ST) Program for Evaluating Payment Patterns Electronic Report (PEPPER), with statistics through the third quarter of fiscal year 2016, is available for short-term acute care hospitals nationwide. PEPPER files were recently distributed through a QualityNet secure file exchange to hospital QualityNet Administrators and user accounts with the PEPPER recipient role.
ENROLLMENT

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

1. “Return service requested” envelopes are used for all hardcopy remittance advices starting October 1, 2002. These envelopes will be used for all providers.
2. “Return service requested” envelopes will not be used for beneficiary correspondence, such as Medicare Summary Notices (MSNs) or for overpayment demand letters.
3. 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.

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About PEPPER

PEPPER summarizes hospital-specific data statistics for Medicare severity diagnosis-related groups and discharges at risk for improper payments. It is distributed by TMF® Health Quality Institute under contract with the Centers for Medicare & Medicaid Services. Visit PEPPERresources.org to access resources for using PEPPER, including the PEPPER user’s guide, recorded training sessions, information about QualityNet accounts, frequently asked questions and examples of how other hospitals are using PEPPER.

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   - 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.
4. 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.

5. 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

Certification Statement Signature and Contact Person Requirements – Revised

MLN Matters® Number: MM9776 Revised
Related Change Request (CR) #: CR 9776
Related CR Release Date: December 9, 2016
Effective Date: January 9, 2017
Related CR Transmittal #: R689PI
Implementation Date: January 9, 2017

This article was revised on December 22, 2016, to clarify certain information in the bullet points on pages 3 and 4. All other information remains the same.

Provider Types Affected
This MLN Matters® Article is intended for physicians, non-physician practitioners, other providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed
Change Request (CR) 9776 clarifies the certification statement signature requirements for the Internet-based Provider Enrollment, Chain and Ownership System (PECOS) and paper Medicare enrollment applications, and addresses contact person requirements.

CR9776 does not involve any legislative or regulatory policies. Make sure that you are familiar with these requirements.

Background
CR9776 informs the MACs that the Centers for Medicare & Medicaid Services (CMS) is updating Chapter 15 of the “Medicare Program Integrity Manual” in order to clarify the certification statement signature requirements for online and paper Medicare enrollment submissions, and to address contact person requirements. The main points of the updates are summarized below; and you can find the details in the manual’s updated Chapter 15 (Medicare Enrollment), which is an attachment to CR9776.
Certification Signature Requirements

A. Paper Submissions

A signed certification statement shall accompany all paper CMS-855 applications, which your MAC will only accept if the signature date is within 120 days of the receipt date of the application. If the provider submits an invalid certification statement or fails to submit a certification statement, your MAC will still proceed with processing the application, however, a valid certification statement will be solicited as part of the development process. This includes certification statements that are: (a) unsigned; (b) undated; (c) contains a copied or stamped signature; (d) was signed (as reflected by the date of signature) more than 120 days prior to the date on which the MAC received the application; (e) for paper Form CMS-855I and Form CMS-855O submissions, someone other than the physician or non-physician practitioner signed the form, except as noted in Section 15.5.14.1; or (f) missing certification statements. The MAC will send one development request to include a list of all of the missing required data/documentation, including the certification statement. The MAC may reject the provider’s application if the provider fails to furnish the missing information on the enrollment application - including all necessary documentation - within 30 calendar days from the date the MAC requested the missing information or documentation. The certification statement may be returned via scanned email, fax or mail to the MAC (as long as an original certification statement signature exist on file).

B. Internet-based PECOS Submissions

A signed certification statement shall accompany all web submitted CMS-855 applications. You may choose to electronically sign the application or submit the paper certification statement to your MAC. Paper certification statements may be submitted by email, fax, or mail (as long as an original certification statement signature exists on file).

You should note that your MAC will not compare the signature on the application with the same provider, authorized or delegated official’s signature on file to ensure that it is the same person; nor will they request the submission of a driver’s license or passport to verify a signature.

Specific form signature requirements follow:

- The enrolling or enrolled physician or non-physician practitioner is the only person who can sign the Form CMS-855I or the Form CMS-855O. (This applies to initial enrollments, changes of information, reactivations, revalidations, voluntary withdrawals, etc.) This includes solely-owned entities listed in section 4A of the Form CMS-855I. A physician or non-physician practitioner may not delegate the authority to sign the Form CMS-855I or Form CMS-855O on his/her behalf to any other person. Note: Exceptions to the above policy may apply in the following scenarios: (1) in the case of death (an executor of the estate), may sign on behalf of the deceased provider, or (2) if an employer is terminating an employment arrangement with a physician assistant, the Authorized or Delegated Official of the organization may sign the application. These situations would only apply to change of information applications.

- Form CMS-855R (Medicare Enrollment Application - Reassignment of Medicare Benefit), submitted for initial applications, must be signed and dated by the physician or non-physician practitioner and the authorized or delegated official of the provider or supplier; while those submitted to change and/or update the provider or supplier’s Medicare enrollment data (to include updates to the primary practice location) may be signed by either the physician or non-physician practitioner or the authorized or delegated official of the provider or supplier.

- Form CMS-855A (Medicare Enrollment Application - Institutional Providers), CMS-855B (Medicare Enrollment Application - Clinics/Group Practices and Certain Other Suppliers), and CMS-855S (Medicare Enrollment Application - Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers), submitted for initial applications, must be signed and dated by an authorized official of the provider or supplier; while those submitted to change, update and/or revalidate the provider or supplier’s Medicare enrollment data may be signed and dated by the authorized or delegated official of the provider or supplier.

The certification statement for the CMS-855A, CMS-855B and CMS-855S Medicare enrollment applications must be signed by an individual who has the authority to bind the provider or supplier, both legally and financially, to the requirements set forth in 42 CFR 424.510. This person must also have an ownership or control interest in the provider or supplier, such as, the general partner, chairman of
ENROLLMENT

the board, chief financial officer, chief executive officer, president, or hold a position of similar status and authority within the provider or supplier organization. The signature attests that the information submitted is accurate; and that the provider or supplier is aware of, and abides by, all applicable statutes, regulations, and program instructions.

Your MAC will verify and validate all information collected on the enrollment application, provided that a data source is available. You should remember that:

1. For paper CMS-855 submissions, if you submit an invalid certification statement or do not submit a certification statement, your MAC will treat this as missing information and will request that you submit a correct certification statement, preferably via e-mail or fax. The certification statement may be returned via scanned email, fax or mail to the contractor (as long as an original certification statement signature exist on file).

2. For Internet-based PECOS submissions, if you choose to submit your certification statement via paper rather than through e-signature, you may do so by email, fax or mail (as long as an original certification statement signature exist on file). You must submit the paper certification statement within 20 calendar days of the date on which you submitted your Internet-based PECOS application, otherwise the MAC may reject your application.

3. When submitting the certification statement, only the signature page is required, you do not have to include the additional page containing the certification terms.

4. MACs will not request a driver’s license or passport to verify the signature.

5. Your MAC will send approval letters to the contact person listed on the application via email (if there is no contact person on file, they will send the approval letter to the provider or supplier at their correspondence address).

Contact Person Requirement Clarifications
MACs will accept end dates to contact persons via phone, scanned email, fax or mail from the individual provider, the Authorized or Delegated Official or a current contact person. This is an interim process until the Form CMS-855s can be updated to delete contact persons.

If any contact person listed on a provider or supplier’s enrollment record requests a copy of their Medicare approval letter or revalidation notice, MACs will send it to the contact person via email, fax or mail.

Additional Information
While the above provides the key points of CR9776, providers may wish to review the entire revision to Chapter 15, which is attached to CR9776. CR9776 is available at [https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R689PI.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R689PI.pdf).

42 CFR 424.5120 is available at [http://www.ecfr.gov/cgi-bin/text-idx?SID=7abb0c441a8cabde659a609fd194c5&mrc=true&node=se42.3.424_1510&rgn=div8](http://www.ecfr.gov/cgi-bin/text-idx?SID=7abb0c441a8cabde659a609fd194c5&mrc=true&node=se42.3.424_1510&rgn=div8).

Provider Enrollment Requirements for Writing Prescriptions for Medicare Part D Drugs – Revised
MLN Matters® Number: SE1434 Revised
Revised Article Release Date: November 16, 2016

The article was revised on November 16, 2016, to show a phased approach to enforcement that will begin in the second calendar quarter of 2017 and end with full implementation and enforcement of the Part D prescriber enforcement requirement on January 1, 2019.

Provider Types Affected
This MLN Matters® Special Edition is intended for physicians, dentists, and other eligible professionals who write prescriptions for Medicare beneficiaries for Medicare Part D drugs. The article is also directed to Medicare Part D plan sponsors.
Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) finalized CMS-4159-F, “Medicare Program; Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs” on May 23, 2014. CMS later published CMS-6107-IFC, “Medicare Program; Changes to the Requirements for Part D Prescribers,” an interim final rule with comment (“IFC”), that made changes to the Final Rule (CMS-4159-F), on May 6, 2015. Together, these rules require virtually all physicians and other eligible professionals, including dentists, who write prescriptions for Part D drugs to be enrolled in an approved status or to have a valid opt-out affidavit on file for their prescriptions to be coverable under Part D, except in very limited circumstances. To allow sufficient time for the prescribers to enroll in Medicare and the Part D sponsors and the Pharmacy Benefit Managers (PBMs) to make the complex system enhancements needed to comply with the prescriber enrollment requirements, CMS announced a delay in enforcement of this rule until February 1, 2017.

While the full implementation date is January 2019, CMS encourages all providers who prescribe Part D drugs, but are not yet enrolled or validly opted out of Medicare, to enroll in the Medicare Program. Enrollment information is available at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Part-D-Prescriber-Enrollment-About.html.

While CMS is committed to the implementation of the prescriber enrollment requirements, CMS also recognizes the need to minimize the impact on the beneficiary population and ensure beneficiaries have access to the care they need. To strike this balance, CMS will implement a multifaceted, phased approach which will align full enforcement of the Part D prescriber enrollment requirements with other ongoing CMS initiatives. Full enforcement of the Part D prescriber enrollment requirement is January 1, 2019.

In the lead-up to the January 1, 2019 full implementation date, CMS will undertake the following incremental strategic actions designed to increase on-going prescriber enrollment, while protecting beneficiaries and the Medicare program.

- **Precluded Providers** - Prescriptions will be denied at the point of sale from sanctioned providers including, but not limited to, providers that are currently excluded by the OIG, revoked by the Medicare program and non-enrolled providers with a felony conviction within the last 10 years. (Implementation in Second Quarter 2017)

- **Easy Enroll Application Process** - CMS will make an easy enrollment application process to enable providers to quickly enroll in Medicare. This process will allow providers to review, update, electronically sign and submit a pre-populated enrollment application online. (Implementation in Second Quarter 2017)

- **Targeted Risk-Based Prescriber Outreach** - CMS will begin targeted, prioritized risk-based outreach and education. This prioritized approach will include direct mailings and coordination with the Part D plans to enroll these prescribers. (Implementation in Second Quarter 2017)

- **Direct Mailing to all Non-Enrolled Providers** - CMS will target and send direct mailings via email and/or paper to all prescribers that are not enrolled in the program. In addition, direct mailing notifications will be triggered for unenrolled providers based on PDE events. (Implementation in Third Quarter 2017)

- **Current Education and Outreach** - CMS will continue with the current education and outreach efforts including such activities as stakeholder meetings and conferences, assembly meetings, and presentations. (Continuously on-going)

The purpose of these rules are to ensure that Part D drugs are prescribed only by physicians and eligible professionals who are qualified to do so under state law and under the requirements of the Medicare program and who do not pose a risk to patient safety. By implementing these rules, CMS is improving the integrity of the Part D prescription drug program by using additional tools to reduce fraud, waste, and abuse in the Medicare program. Prescribers who are determined to have a pattern or practice of prescribing Part D drugs that are abusive and represents a threat to the health and safety of Medicare enrollees or fails to meet Medicare requirements will have their billing privileges revoked under 42 USC 424.535 (a)(14).

**Background**

If you write prescriptions for covered Part D drugs and you are not already enrolled in Medicare in an approved status or have a valid record of opting out, you should submit an enrollment application or an opt-out affidavit to your Medicare Administrative Contractor (MAC) as soon as possible, so that
the prescriptions you write for Part D beneficiaries are coverable as Medicare begins to enforce this requirement on February 1, 2017 with full implementation and enforcement slated for January 1, 2019.

To enroll in Medicare for the limited purpose of prescribing:
You may submit your enrollment application electronically using the Internet-based Provider Enrollment, Chain, and Ownership System (PECOS) located at https://www.cms.gov/medicare/provider-enrollment-and-certification/medicareproviderenroll/internetbasedpecos.html or by completing the paper CMS-855O application, which is available at https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms855o.pdf, which you must submit to the MAC that services your geographic area. Note that there is no application fee required for your application submission. For step-by-step instructions, refer to the PECOS how-to guide, available at http://go.cms.gov/orderreferhowtoguide or watch an instructional video at http://go.cms.gov/videotutorial.

The CMS-855O is a shorter, abbreviated form and takes minimal time to complete. While the CMS-855O form states it is for physicians and non-physician practitioners who want to order and certify, it is also appropriate for use by prescribers, who want to enroll to also prescribe Part D drugs. (CMS is in the process of updating the CMS-855O form). If you do not see your specialty listed on the application, please select the Undefined Physician/Non-Physician Type option and identify your specialty in the space provided.

**Note:** Dentists are recognized by Medicare as physicians and should select the “Part B Physician Specialties” option and specify General Dentist in the free form text box.

The average processing time for CMS-855O applications submitted online is 45 days versus paper submissions which is 60 days. However, your application could be processed sooner depending on the MAC’s current workload.

To enroll to bill for services (and prescribe Part D drugs):
To enroll in Medicare to bill for your services, you may complete the CMS-855I application. The CMS-855R should also be completed if you wish to reassign your right to bill the Medicare program and receive Medicare payments for some or all of the services you render to Medicare beneficiaries. All actions can be completed via PECOS or the paper enrollment application. For more information on enrolling in Medicare to bill for services refer to https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedEnroll_PECOS_PhysNonPhys_FactSheet_ICN903764.pdf.

If you are a physician or non-physician practitioner who wants to opt-out of Medicare, you must submit an opt-out affidavit to the MAC that services your geographic area. Physicians and non-physician practitioners should be aware that if they choose to opt-out of Medicare, they are not permitted to participate in a Medicare Advantage Plan. In addition, once a physician or non-physician practitioner has opted out they are not permitted to terminate their opt-out affidavit early. Section 1802(b)(3)(B)(ii) of the Act establishes the term of the opt-out affidavit. The Act does not provide for early termination of the opt-out term. Under CMS regulations, physicians and practitioners who have not previously submitted an opt-out affidavit under Section 1802(b)(3) of the Act, may choose to terminate their opt-out status within 90 days after the effective date of the opt-out affidavit, if the physician or practitioner satisfies the requirements of 42 CFR § 405.445(b). No other method of terminating opt-out status before the end of the two year opt-out term is available.

Prior to enactment of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), physician/practitioner opt-out affidavits were only effective for 2 years. As a result of changes made by MACRA, valid opt-out affidavits signed on or after June 16, 2015, will automatically renew every 2 years. If physicians and practitioners that file affidavits effective on or after June 16, 2015, do not want their opt-out to automatically renew at the end of a two year opt-out period, they may cancel the renewal by notifying all MACs with which they filed an affidavit in writing at least 30 days prior to the start of the next opt-out period. Valid opt-out affidavits signed before June 16, 2015 will expire 2 years after the effective date of the opt out. If physicians and practitioners that filed affidavits effective before June 16, 2015, want to extend their opt out, they must submit a renewal affidavit within 30 days after the current opt-out period expires to all MACs with which they would have filed claims absent the opt-out. For more information on the opt-out process, refer to MLN Matters® article SE1311, titled “Opting out of Medicare and/or Electing to Order and Certify Items and Services to Medicare Beneficiaries,” which is available at http://www.cms.gov/Outreach-
CMS would like to highlight the following limitations that apply to billing and non-billing providers:

- A resident is defined in 42 CFR § 413.75 as an intern, resident, or fellow who participates in an approved medical residency program, including programs in osteopathy, dentistry, and podiatry, as required in order to become certified by the appropriate specialty board. Interns, residents, and fellows may enroll in Medicare to prescribe if the state licenses them. Licensure can include a provisional license or similarly-regulated credential. Un-licensed interns, residents, and fellows must specify the teaching physician who is enrolled in Medicare as the authorized prescriber on a prescription for a Part D drug (assuming this is consistent with state law). Licensed residents have the option to either enroll themselves or use the teaching physician's name on prescriptions for Part D drugs, unless state law specifies which name is to be used. CMS strongly encourages teaching physicians and facilities to ensure that the NPI of the lawful prescriber under state law is included on prescriptions to assist pharmacies in identifying the correct prescriber and avoid follow up from the pharmacies, which experience rejected claims from Medicare Part D plans due to missing or wrong prescriber NPIs on the claims.

- Other authorized prescribers” are exempt from the Medicare Part D prescriber enrollment requirement. In other words, prescriptions written by “other authorized prescribers” are still coverable under Part D, even if the prescriber is not enrolled in or opted out of Medicare. For purposes of the Part D prescriber enrollment requirement only, “other authorized prescribers” are defined as individuals other than physicians and eligible professionals who are authorized under state or other applicable law to write prescriptions but are not in a provider category that is permitted to enroll in or opt-out of Medicare under the applicable statutory language. CMS believes “other authorized prescribers” are largely pharmacists who are permitted to prescribe certain drugs in certain states, but based on the applicable statute, pharmacists are not able to enroll in or opt-out of Medicare.

If you believe you are an “other authorized prescriber” and are not a pharmacist, please contact providerenrollment@cms.hhs.gov. In addition, CMS strongly recommends that pharmacists in particular make sure that their primary taxonomy associated with their NPI in the National Plan & Provider Enumeration System (NPPES) reflects that they are a pharmacist. To review and update your NPPES information, please go to the National Plan & Provider Enumeration System webpage at https://nppes.cms.hhs.gov/NPPES/Welcome.do. Upon enforcement of the regulation, Part D plans will need to be able to determine if the prescriber is a pharmacist in order to properly adjudicate the pharmacy claim at point-of-sale.

In an effort to prepare the prescribers and Part D sponsors for the first phase February 1, 2017 enforcement date, CMS has made available an enrollment file that identifies physician and eligible professional who are enrolled in Medicare in an approved or opt-out status. However, the file does not specify if a particular prescriber is eligible to prescribe, as prescribing authority is largely determined by state law. The enrollment file is available at https://data.cms.gov/dataset/Medicare-Individual-Provider-List/u8u9-2upx. The file contains production data but is considered a test file since the Part D prescriber enrollment requirement is not yet applicable. An updated enrollment file will be generated every two weeks, with a purposeful goal of providing updates twice a week by the date of enforcement.

The file displays physician and eligible professional eligibility on and after November 1, 2014, (that is, currently enrolled, new approvals, or changes from opt-out to enrolled as of November 1, 2014). Any periods, prior to November 1, 2014, for which a physician or eligible professional was not enrolled in an approved or opt-out status will not be displayed on the enrollment file. However, any gaps in enrollment
ENROLLMENT

after November 1, 2014, for which a physician or eligible professional was not enrolled in an approved or opt-out status will be reflected on the file with its respective effective and end dates for that given provider. For opted out providers, the opt-out flag will display a Y/N (Yes/No) value to indicate the periods the provider was opted out of Medicare. The file will include the provider’s:

- (NPI)
- First and Last Names
- Effective and End Dates
- Opt-out Flag

Example 1– Dr. John Smith’s effective date of enrollment is January 1, 2014. Since he was enrolled prior to the generation of the test file, his effective date will display as November 1, 2014. Dr. Smith submits an enrollment application to voluntarily withdraw from Medicare effective December 15, 2014. Dr. Smith will appear on the applicable file as:

<table>
<thead>
<tr>
<th>NPI</th>
<th>First Name</th>
<th>Last Name</th>
<th>Effective Date</th>
<th>End Date</th>
<th>Opt-out Flag</th>
</tr>
</thead>
<tbody>
<tr>
<td>123456789</td>
<td>John</td>
<td>Smith</td>
<td>11/01/2014</td>
<td>12/15/2014</td>
<td>N</td>
</tr>
</tbody>
</table>

Example 2 - Dr. Mary Jones submits an affidavit to opt-out of Medicare, effective December 1, 2014. Since she has opted out after the generation of the test file, her effective date will display as December 1, 2014. After the 2 year opt-out period expires, Dr. Jones decides she wants to enroll in Medicare to bill, order, and certify, or to write prescriptions. The enrollment application is received on January 31, 2017, and the effective date issued is January 1, 2017. Dr. Jones will display on the applicable file as:

<table>
<thead>
<tr>
<th>NPI</th>
<th>First Name</th>
<th>Last Name</th>
<th>Effective Date</th>
<th>End Date</th>
<th>Opt-out Flag</th>
</tr>
</thead>
<tbody>
<tr>
<td>987654321</td>
<td>Mary</td>
<td>Jones</td>
<td>12/01/2014</td>
<td>12/01/2016</td>
<td>Y</td>
</tr>
<tr>
<td>987654321</td>
<td>Mary</td>
<td>Jones</td>
<td>01/01/2017</td>
<td>N</td>
<td></td>
</tr>
</tbody>
</table>

After the enforcement date of February 1, 2017, the applicable effective dates on the file will be adjusted to February 1, 2017, and it will no longer be considered a test file. All inactive periods prior to February 1, 2017, will be removed from the file and it will only contain active and inactive enrollment or opt-out periods as of February 1, 2017, and after. The file will continue to be generated every two weeks, with a purposeful goal of providing updates twice a week by the date of enforcement. Part D sponsors may utilize the file to determine a prescriber’s Medicare enrollment or opt-out status when processing Part D pharmacy claims. The file will not validate the provider’s ability to prescribe under applicable laws. Please submit questions or issues encountered in accessing the file to providerenrollment@cms.hhs.gov.
ESRD Facility Claim (Type of Bill 72X) to Accommodate Dialysis Furnished to Beneficiaries with AKI

MLN Matters® Number: MM9598
Related Change Request (CR) #: CR 9598
Related CR Release Date: December 6, 2016
Effective Date: January 1, 2017
Related CR Transmittal #: R1759OTN
Implementation Date: January 3, 2017

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

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

Background
On June 29, 2015, The Trade Preferences Extension Act of 2015 was enacted in which Section 808 amended Section 1861(s)(2)(F) of the Social Security Act (42 U.S.C. 1395x(s)(2)(F)) by extending renal dialysis services paid under Section 1881(b)(14) to beneficiaries with AKI effective January 1, 2017.

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

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

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

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

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

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

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

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

**Applicability of Other ESRD and CMS Adjustments**

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

**ESRD Quality Incentive Program (QIP)**
The ESRD QIP is not applicable for beneficiaries with AKI at this time.

**Sequestration Adjustments**
The 2 percent sequestration adjustment is applicable to claims for beneficiaries with AKI. This is global CMS adjustments and applies to AKI claims.

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

**Low Volume Payment Adjustment (LVPA)**
AKI dialysis treatments count toward the LVPA threshold when determining total number of treatments provided when a facility prepares the low volume attestation to determine eligibility for the LVPA.

**Additional Information**


42 CFR 413.171 is available at http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=3233ff9c843c3f74275c ab5dcbf088c&mc=true&n=pt42.2.413&r=PART&ty=HTML#se42.2.413_1171.

42 CFR 494 is available at http://www.ecfr.gov/cgi-bin/text-idx?SID=0cf1f211399c42665d1bfb2ed9b6783a &mc=true&tpl=/ecfrbrowse/Title42/42cfr494_main_02.tpl.

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


ESRD PPS and Payment for Dialysis Furnished for AKI in ESRD Facilities - 2017 Implementation of Changes

MLN Matters® Number: MM9807
Related Change Request (CR) #: CR 9807
Related CR Release Date: November 4, 2016
Effective Date: January 1, 2017
Related CR Transmittal #: R229BP
Implementation Date: January 3, 2017

Provider Types Affected
This MLN Matters® Article is intended for End-Stage Renal Disease (ESRD) facilities submitting claims to Medicare Administrative Contractors (MACs) for ESRD services provided to Medicare beneficiaries.

Provider Action Needed
This article is based on Change Request (CR) 9807 which implements the CY 2017 rate updates for the ESRD Prospective Payment System (PPS) and implements the payment for renal dialysis services furnished to beneficiaries with Acute Kidney Injury (AKI) in ESRD facilities for CY 2017. Make sure that your billing staffs are aware of these changes.

Background
The Centers for Medicare & Medicaid Services (CMS) implemented the ESRD PPS (effective January 1, 2011) based on the requirements of the Social Security Act (Section1881(b)(14)) as amended by the Medicare Improvements for Patients and Providers Act (MIPPA; Section 153(b)).

The Social Security Act (Section 1881(b)(14)(F)), as added by MIPPA (Section 153(b)) and amended by the Patient Protection and Affordable Care Act (Section 3401(h)), established that beginning CY 2012 (and each subsequent year), CMS will annually increase payment amounts by an ESRD market basket increase factor, reduced by the productivity adjustment described in the Social Security Act (Section 1886(b)(3)(B)(ix)).

The ESRD bundled (ESRDB) market basket increase factor minus the productivity adjustment will update the ESRD PPS base rate. The Protecting Access to Medicare Act of 2014 (PAMA; Section 217(b)(2)) included a provision that dictated how the market basket should be reduced for CY 2017.

Beginning CY 2017, in accordance with the Trade Preferences Extension Act of 2015 (TPEA; Section 808(b)), CMS will pay ESRD facilities for furnishing renal dialysis services to Medicare beneficiaries with AKI. CR 9598 implemented the payment for renal dialysis services and provides detailed information regarding payment policies.

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

**CY 2017 ESRD PPS Updates**

**ESRD PPS base rate:**
1. A 0.55 percent update to the CY 2016 payment rate. ($230.39 x 1.0055 = $231.66).
2. A wage index budget-neutrality adjustment factor of 0.999781. ($231.66 x 0.999781 = $231.61)
3. A home dialysis training budget-neutrality adjustment factor of 0.999737. Therefore, the CY2017 ESRD PPS base rate is $231.55 ($230.39 x 1.0055 x 0.999781 x 0.999737 = $231.55).

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

**Labor-related share:**
- The labor-related share will remain at 50.673.

**Home Dialysis Training Add-On Payment:**
- The home dialysis training add-on payment will increase from $50.16 to $95.60.

**Outlier Policy:**
CMS made the following updates to the adjusted average outlier service Medicare Allowable Payment (MAP) amount per treatment:
1. For adult patients, the adjusted average outlier service MAP amount per treatment is $45.00.
2. For pediatric patients, the adjusted average outlier service MAP amount per treatment is $38.29.

CMS made the following updates to the fixed dollar loss amount that is added to the predicted MAP to determine the outlier threshold:
1. The fixed dollar loss amount is $82.92 for adult patients.
2. The fixed dollar loss amount is $68.49 for pediatric patients.

CMS made the following changes to the list of outlier services:
1. Renal dialysis drugs that are oral equivalents to injectable drugs are based on the most recent prices retrieved from the Medicare Prescription Drug Plan Finder, are updated to reflect the most recent mean unit cost. In addition, CMS will add or remove any renal dialysis items and services that are eligible for outlier payment. (See Attachment A in CR 9807.)
2. The mean dispensing fee of the National Drug Codes (NDCs) qualifying for outlier consideration is revised to $0.88 per NDC per month for claims with dates of service on or after January 1, 2017. (See Attachment A in CR 9807.)

**Consolidated Billing Requirements:**
The consolidated billing requirements for drugs and biologicals included in the ESRD PPS is updated by:
1. Adding the following Healthcare Common Procedure Coding System (HCPCS) codes to the bone and mineral metabolism category:
   - J0620 - Injection, calcium glycerophosphate and calcium lactate, per 10 ml, and
   - J3489 - Injection, zoledronic acid, 1 mg.
2. J0620 and J3489 are drugs that are used for bone and mineral metabolism. Bone and mineral metabolism is an ESRD PPS functional category where drugs and biologicals that fall in this category are always considered to be used for the treatment of ESRD. ESRD facilities will not receive separate payment for J0620 and J3489 with or without the AY modifier and the claims will process the line item as covered with no separate payment under the ESRD PPS.
3. Adding HCPCS J0884 – Injection, argatroban, 1 mg (for ESRD on dialysis) to the access management category.
There is a new HCPCS J0883 for argatroban for non-ESRD use. This code will not be permitted on the ESRD type of bill 072x.

4. J0884 is a drug that is used for access management. Access management is an ESRD PPS functional category where drugs and biologicals that fall in this category are always considered to be used for the treatment of ESRD. ESRD facilities will not receive separate payment for J0884 with or without the AY modifier and the claims will process the line item as covered with no separate payment under the ESRD PPS.

5. In accordance with 42 CFR 413.237(a)(1), HCPCS J0620, J3489, and J0884 are considered to be eligible outlier services. Drugs and biologicals are included in the outlier calculation when the manufacturer submits Average Sales Price (ASP) data to CMS. Details regarding submitting ASP data can be found on the CMS website: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/index.html

6. Adding the following HCPCS to the composite rate drugs and biologicals category since these drugs meet the definition of a composite rate drug in Pub. 100-02, Chapter 11, Section 20.3.F and are renal dialysis services:
   - J0945 - Injection, brompheniramine maleate, per 10 mg.
   - J3265 - Injection, torsemide, 10 mg/ml
   - J7131 - Hypertonic saline solution, 1 ml

7. HCPCS J0945, J3265, and J7131 do not meet the definition of an outlier service and therefore do not qualify for an outlier payment. In accordance with CR8978, ESRD facilities should report J0945, J3265, and J7131 along with any other composite rate drugs listed in Attachment B in CR9807 (See related MLN Matters article MM8978).

8. Removing HCPCS J3487 – Injection, zoledronic acid (zometa), 1 mg from the bone and mineral metabolism category. This code was terminated December 31, 2013, and replaced by J3489 effective January 1, 2014.

9. Removing HCPCS C9121 – Injection, argatroban, per 5 mg from the access management category. This code is terminated effective December 31, 2016, and will be replaced by J0884 (Injection, Argatroban, 1 mg (for ESRD on dialysis), effective January 1, 2017.

10. Removing J0635 – calcitriol. This code is no longer an active code.

11. Removing HCPCS S0169 – calcitriol. S codes are not payable under Medicare. Attachment B in CR9807 reflects the items and services that are subject to the ESRD PPS consolidated billing requirements.

**CY 2017 AKI Dialysis Payment Rate for Renal Dialysis Services**


2. The labor-related share is 50.673.

3. The AKI dialysis payment rate will be adjusted for wages using the same wage index that is used under the ESRD PPS.

4. The AKI dialysis payment rate is not reduced for the ESRD QIP.

**Additional Information**

Network Fee Reduction for AKI Services Submitted on Type of Bill 72x

MLN Matters® Number: MM9814
Related Change Request (CR) #: CR 9814
Related CR Release Date: October 27, 2016
Effective Date: January 1, 2017
Related CR Transmittal #: R1738OTN
Implementation Date: April 3, 2017

Provider Types Affected
This MLN Matters® Article is intended for providers at End Stage Renal Disease (ESRD) facilities who submit claims to Part A Medicare Administrative Contractors (MACs) for services related to Acute Kidney Injury (AKI) provided to Medicare beneficiaries.

Provider Action Needed
Change Request (CR) 9814, from which this article was developed, advises providers of the removal of the 50-cent ESRD network fee reduction from claims submitted by ESRD facilities for AKI services. Please make sure your billing staff is aware of this fee reduction removal.

Background
On June 29, 2015, the Trade Preference Extension Act (TPEA) of 2015 was enacted. Section 808 of the TPEA amended Section 1861(s)(2)(F) of the Social Security Act (the Act) (42 U.S.C. 1395x(s)(2)(F)) by extending renal dialysis services paid under Section 1861(b)(14) of the Act to beneficiaries with AKI, effective January 1, 2017.

Policy
Beginning January 1, 2017, ESRD facilities will be able to furnish dialysis to AKI patients. The AKI provision was signed into law on June 29, 2015. The pertinent section is available online at https://www.congress.gov/bill/114th-congress/house-bill/1295/text#toc-HEE69B51CC87340E2B2AB6A4FA73D2A82.

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

Renal dialysis services as defined in 42 CFR, Section 413.171 would be considered to be renal dialysis services for patients with AKI. As such, no separate payment would be made for renal dialysis drugs, biologicals, laboratory services, and supplies that are included in the ESRD PPS base rate when they are furnished by an ESRD facility to an individual with AKI. Other items and services that are furnished to beneficiaries with AKI that are not considered to be renal dialysis services but are related to their dialysis as a result of their AKI would be separately payable. This includes drugs, biologicals, laboratory services, and supplies that ESRD facilities are certified to furnish and that would otherwise be furnished to a beneficiary with AKI in a hospital outpatient setting.

For payment under Medicare, ESRD facilities will report all items and services furnished to beneficiaries with AKI by submitting Type of Bill (TOB) 72X with Condition Code 84 (Dialysis for Acute Kidney Injury (AKI)) on a monthly basis. Since ESRD facilities bill Medicare for renal dialysis services by submitting TOB 72X for ESRD beneficiaries, Condition Code 84 will differentiate an ESRD PPS claim from an AKI claim.

AKI claims will require one of the following diagnosis codes:

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

In addition, ESRD facilities must include revenue code 082X, 083X, 084X, or 085X for the modality of dialysis furnished with the Current Procedural Terminology (CPT) code G0491:

- Long descriptor: Dialysis procedure at a Medicare certified ESRD facility for Acute Kidney Injury without ESRD
- Short descriptor: dialysis Acu Kidney no ESRD

AKI claims will not have limits on how many treatments can be billed for the monthly billing cycle, however, there will only be payment for one treatment per day across settings, except in the instance of uncompleted treatments:

- If a dialysis treatment is started, that is, a patient is connected to the machine and a dialyzer and blood lines are used, but the treatment is not completed for some unforeseen, but valid, reason, for example, a medical emergency when the patient must be rushed to an emergency room, the facility is paid based on the full base rate. This is a rare occurrence and must be fully documented to the MAC’s satisfaction.

CR9598 implemented the majority of the claims processing changes for this policy; however, the 50-cent ESRD network fee reduction was not considered in the implementation of that CR. This CR implements the removal of that fee from AKI claims.

The content of this CR was finalized in the CY 2017 ESRD PPS Final Rule is available at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/End-Stage-Renal-Disease-ESRD-Payment-Regulations-and-Notices-Items/CMS-1651-F.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/End-Stage-Renal-Disease-ESRD-Payment-Regulations-and-Notices-Items/CMS-1651-F.html).

MACs will adjust all 72X TOBs with AKI with dates of service from January 1, 2017, to March 31, 2017, within 45 days of implementation of CR9814.

Additional Information
LTCH PPS Based on Specific Clinical Criteria – Implementation – Revised

MLN Matters® Number: MM9015 Revised
Related Change Request (CR) #: CR 9015
Effective Date: Discharges in Cost Reporting Periods on or after October 1, 2015
Related CR Release Date: September 22, 2015
Related CR Transmittal #: R1544OTN
Implementation Date: October 5, 2015

This article was revised on October 19, 2016, to include a link to MLN Matters Article SE1627, which contains clarifying information. This link is in the Additional Information section of this article.

Provider Types Affected
This MLN Matters® Article is intended for Long-Term Care Hospitals (LTCHs) that submit claims to Medicare Administrative Contractors (MACs) for Long-Term Care Hospital services provided to Medicare beneficiaries.

Provider Action Needed
This article is based on Change Request (CR) 9015, which informs you that Section 1206(a) of Public Law 113–67 (2013 Bipartisan Budget Act) amended Section 1886(m) of the Social Security Act (the Act) to establish patient-level criteria for standard payments under the LTCH PPS for implementation beginning for cost reporting periods beginning on or after October 1, 2015.

This revision to payments under the existing LTCH Prospective Payment System (PPS) will establish two separate payment categories for LTCH patients: Standard and Site Neutral. See the Background and Policy Sections below for details. Make sure that your billing staffs are aware of these changes.

Background
Medicare currently pays for inpatient hospital services for LTCH discharges under the LTCH PPS.

- Under this payment system, the Centers for Medicare & Medicaid Services (CMS) largely sets payment rates prospectively for inpatient stays based on the patient’s diagnosis and severity of illness. A hospital generally receives a single payment for the case based on the payment classification, that is, the MS-LTC-DRGs assigned at discharge.
- LTCHs are required to meet the same Medicare Conditions of Participation (COPs) as acute care hospitals that are paid under the Inpatient Prospective Payment System (IPPS). Under existing law, the primary criteria for a hospital to be designated as an LTCH for Medicare payment purposes is a “greater than 25 day average length of stay” requirement.

Until the enactment of the 2013 Bipartisan Budget Act (Public Law 113-67), however, there were no clinical criteria concerning the patients treated in LTCHs. Specifically, Section 1206 of this Act establishes two distinct payment categories under the LTCH PPS:

- “Standard” payments for patient discharges meeting specific clinical criteria; and
- “Site Neutral” payments for those discharges that do not meet the specified clinical criteria.

This revision to payments under the existing LTCH PPS will establish two separate payment categories for LTCH patients:

- Upon discharge, LTCH cases meeting specific clinical criteria will be paid a standard LTCH PPS payment (that is, what is generally paid under existing LTCH PPS policy); and
- Upon discharge, those cases not meeting specific clinical criteria will be paid based on a “site neutral” basis, which is the lesser of an “IPPS-comparable” payment amount or 100 percent of the estimated cost of the case.

In order to be paid at the standard LTCH PPS amount, an LTCH patient must either:
• Have been admitted directly from an IPPS hospital during which at least 3 days were spent in an Intensive Care Unit (ICU) or Coronary Care Unit (CCU), but the discharge must not be assigned to a psychiatric or rehabilitation MS-LTC-DRG in the LTCH; or
  – Have been admitted directly from an IPPS hospital and the LTCH discharge includes the procedure code for ventilator services of at least 96 hours (ICD-10-CM procedure code 5A1955Z) but must not be assigned to a psychiatric or rehabilitation MS-LTC-DRG in the LTCH.

Existing LTCH PPS policies, such as the Short-Stay Outlier (SSO) policy and the Interrupted Stay policy, will continue to apply in determining the standard LTCH PPS payment for those discharges meeting specific clinical criteria.

The “site neutral” amount will be paid for patients discharged from the LTCH that do not meet one or both of the above criteria. Where a site neutral payment is made, MACs will place Remittance Advice Remarks Code N741 (This is a site neutral payment.) on the remittance advice.

Site Neutral payments shall not change the beneficiary’s out of pocket costs. Coinsurance, if applicable, is payable by the beneficiary for the number of days used. The hospital subtracts the coinsurance amount from the Medicare payment. Days after benefits are exhausted are not charged against the beneficiary’s utilization whether or not the hospital receives the full MS-LTC-DRG payment.

If there is at least 1 day of utilization left at the time of admission and that day is also a day of entitlement (for example, a day before the beneficiary discontinued voluntary Part A entitlement by not paying the premium), if a site neutral payment is made, the remaining “inlier” days of the stay will be considered covered until the site neutral high cost outlier is reached even though the beneficiary is not using any Medicare covered days. The beneficiary shall not be responsible for non-utilization days. Once the beneficiary reaches the site neutral high cost outlier threshold, the beneficiary may choose to use life-time reserve days.

Additional Information


SSP ACO Qualifying Stay Edits – Second Revision

MLN Matters® Number: MM9568 Revised
Related Change Request (CR) #: CR 9568
Related CR Release Date: December 16, 2016
Effective Date: January 1, 2017
Related CR Transmittal #: R1763OTN
Implementation Date: January 3, 2017

This article was revised on December 16, 2016, due to a revised CR9568 issued on that date. As a result, the transmittal number, CR release date, and link to the CR are revised in this article. All other information remains the same.

Provider Types Affected

This MLN Matters® Article is intended for Hospitals and Skilled Nursing Facilities (SNFs) working with Accountable Care Organizations (ACOs) participating in the Medicare Shared Savings Program (SSP) and submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.
HOSPITAL

Provider Action Needed
CR 9568 allows the processing of SNF claims without having to meet the 3-day hospital stay requirement for certain designated SNFs that have a relationship with an ACO participating in the SSP. Make sure that your SNF is clear on whether or not it is eligible to participate in this initiative and that your billing staffs are aware of these changes.

Background
The Medicare SNF benefit is for beneficiaries who require a short-term intensive stay in a SNF, requiring skilled nursing and/or rehabilitation care. Pursuant to Section 1861(i) of the Social Security Act (the Act), beneficiaries must have a prior inpatient hospital stay of no fewer than 3 consecutive days in order to be eligible for Medicare coverage of inpatient SNF care. This has become known as the SNF 3-day rule.

The Centers for Medicare & Medicaid Services (CMS) understands that, in certain circumstances, it could be medically appropriate for some patients to receive skilled nursing care and/or rehabilitation services provided in a SNF without prior hospitalization or with an inpatient hospital length of stay of less than 3 days.

Section 3022 of the Affordable Care Act amended Title XVIII of the Act by adding a new Section 1899 to establish the Medicare SSP. Under Section 1899(f), the Secretary of Health and Human Services is permitted to waive “such requirements of . . . title XVIII of this Act as may be necessary to carry out the provisions of this section.” As a result, CMS proposed and finalized through rulemaking (80 FR 32692 at http://www.gpo.gov/fdsys/pkg/FR-2015-06-09/pdf/2015-14005.pdf) a waiver of the prior 3-day inpatient hospitalization requirement in order to provide Medicare SNF coverage when certain beneficiaries assigned to SSP ACOs in Track 3 are admitted to designated SNF affiliates either directly from an inpatient hospital stay or after fewer than 3 inpatient hospital days, starting in January 2017. The waiver will be available for SSP ACOs in Track 3 that demonstrate the capacity and infrastructure to identify and manage patients who would be either directly admitted to a SNF or admitted to a SNF after an inpatient hospital stay of fewer than 3 days, for services otherwise covered under the Medicare SNF benefit.

To identify the beneficiaries eligible to receive the SNF 3-Day Waiver, CMS provides ACOs with a prospective beneficiary assignment list for the performance year. ACOs will receive the prospective assignment list close to the start of each performance year.

To identify the SNFs eligible to use the SNF 3-Day Waiver, ACOs designate SNFs (as SNF affiliates) eligible to participate in the SNF 3-Day Waiver with the ACO.

CMS will reimburse designated SNFs (specifically, SNF affiliates participating in Track 3 SSP ACOs), for the Medicare SNF benefit without the required 3-day in-patient hospitalization for beneficiaries that are prospectively assigned to the Track 3 ACO.

Additional Information

You can learn more about the SSP by visiting our website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html. To learn more about the SNF 3-Day Waiver, visit the SSP webpage and click on Statutes/Regulations/Guidance.

IPPS and LTCH PPS Changes - 2017

MLN Matters® Number: MM9723
Related Change Request (CR) #: CR 9723
Related CR Release Date: October 19, 2016
Effective Date: October 1, 2016
Related CR Transmittal #: R3626CP
Implementation Date: October 3, 2016
Provider Types Affected
This MLN Matters® Article is intended for hospitals that submit claims to Medicare Administrative Contractors (MACs) for inpatient hospital services provided to Medicare beneficiaries by short-term acute care and long-term care hospitals (LTCHs).

Provider Action Needed
This article is based on Change Request (CR) 9723 which implements policy changes for FY 2017 Inpatient Prospective Payment System (IPPS) and LTCH PPS and covers services effective for hospital discharges occurring on or after October 1, 2016, through September 30, 2017, unless otherwise noted. Failure to adhere to these new policies could affect payment of Medicare claims. Make sure that your billing staff is aware of these IPPS and LTCH PPS changes for FY 2017.

Background
The Social Security Amendments of 1983 (P.L. 98-21) provided for establishment of a Prospective Payment system (PPS) for Medicare payment of inpatient hospital services. In addition, the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA), as amended by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), required that a budget neutral, per discharge PPS for LTCHs based on Diagnosis-Related Groups (DRGs) be implemented for cost reporting periods beginning on or after October 1, 2002. The Centers for Medicare & Medicaid Services (CMS) is required to make updates to these prospective payment systems annually.

CMS displayed the following policy changes for FY 2017 in the Federal Register on August 2, 2016, with a publication date of August 22, 2016. All items covered in CR9723 are effective for hospital discharges occurring on or after October 1, 2016, through September 30, 2017, unless otherwise noted.

IPPS FY 2017 Update
FY 2017 IPPS Rates and Factors
Table 1--FY 2017 IPPS Rates and Factors

<table>
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<th>Standardized Amount Applicable Percentage Increase</th>
<th>1.0165 if Quality = ‘1’ and EHR = ‘blank’ in Provider Specific File (PSF); or 1.00975 if Quality = ‘0’ and EHR = ‘blank’ in PSF; or 0.99625 if Quality = ‘1’ and EHR = ‘Y’ in PSF 0.9895 if Quality = ‘0’ and EHR = ‘Y’ in PSF</th>
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<tr>
<td>Common Fixed Loss Cost Outlier Threshold</td>
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<td>Federal Capital Rate</td>
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Operating Rates for Wage Index > 1

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<tr>
<th>Hospital Submitted Quality Data and is a Meaningful Electronic Health Record (EHR) User (Update = 1.65 Percent)</th>
<th>Hospital Did NOT Submit Quality Data and is a Meaningful EHR User (Update = 0.975 Percent)</th>
<th>Hospital Submitted Quality Data and is NOT a Meaningful EHR User (Update = -0.375 Percent)</th>
<th>Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User (Update = -1.05 Percent)</th>
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</thead>
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<tr>
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<td>Nonlabor</td>
<td>Labor</td>
<td>Nonlabor</td>
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<tr>
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<td>PR National</td>
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<td>$3,839.23</td>
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Operating Rates Wage Index < or = 1
**Hospital Submitted Quality Data and is a Meaningful EHR User (Update = 1.65 Percent)**

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<td>$3,420.01</td>
<td>$2,096.13</td>
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<tr>
<td>PR</td>
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**Hospital Did NOT Submit Quality Data and is a Meaningful EHR User (Update = 0.975 Percent)**

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**Hospital Submitted Quality Data and is NOT a Meaningful EHR User (Update = -0.375 Percent)**

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**Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User (Update = -1.05 Percent)**

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<tr>
<td>PR</td>
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<td>$2,096.13</td>
</tr>
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**MS-DRG Grouper and Medicare Code Editor (MCE) Changes**

For discharges occurring on or after October 1, 2016, the Fiscal Intermediary Shared System (FISS) calls the appropriate GROUPER based on discharge date. For discharges occurring on or after October 1, 2016, the MCE selects the proper internal code edit tables based on discharge date. Medicare contractors should have received the MCE documentation in August 2016. Note that the MCE version continues to match the Grouper version.

Effective October 1, 2016, MS-DRGs 228 through 230 (Other cardiothoracic procedures w MCC, w CC and w/o CC/MCC, respectively) are collapsed from three severity levels to two severity levels by deleting MS-DRG 230 and revising MS-DRG 229, as follows:

- MS-DRG 229 Other cardiothoracic procedures w/o MCC
- MS-DRG 230 Other cardiothoracic procedures w/o CC/MCC

Effective October 1, 2016, the title for MS-DRG 884 (Organic Disturbance and Mental Retardation) is revised to MS-DRG 884 (Organic Disturbances and Intellectual Disability).

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

No new MS-DRGs will be added to the list of MS-DRGs subject to the post-acute care transfer policy and special payment policy. See Table 5 of the FY 2017 IPPS/LTCH PPS Final Rule for a listing of all Post-acute and Special Post-acute MS-DRGs at [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html). Then click on the link on the left side of the screen titled, “FY 2017 IPPS Final Rule Home Page” or “Acute Inpatient Files for Download.”

**New Technology Add-On**

The following items will continue to be eligible for new-technology add-on payments in FY 2017:

1. **Name of Approved New Technology: CardioMEMSTM HF Monitoring System**
   - Maximum Add on Payment: $8,875
   - Identify and make new technology add-on payments with ICD-10-PCS procedure code 02HQ30Z or 02HR30Z

2. **Name of Approved New Technology: Blinatumomab (BLINCYTOSTM)**
   - Maximum Add on Payment: $27,017.85
   - Identify and make new technology add-on payments with ICD 10 PCS procedure code XW03351 or XW04351

3. **Name of Approved New Technology: LUTONIX® Drug Coated Balloon (DCB) Percutaneous Transluminal Angioplasty (PTA) and IN.PACTSTMAdmiralSTM Paclixel Coated Percutaneous Transluminal Angioplasty (PTA) Balloon Catheter**
   - Maximum Add on Payment: $1,035.72
   - Identify and make new technology add-on payments with any of the following ICD-10-PCS procedure codes: 047K041, 047K0D1, 047K0Z1, 047K341, 047K3D1, 047K3Z1, 047K441, 047K4D1, 047K4Z1, 047L041, 047L0D1, 047L0Z1, 047L341, 047L3D1, 047L3Z1, 047L441, 047L4D1, 047L4Z1,
The following items will be eligible for new-technology add-on payments in FY 2017:

1. Name of Approved New Technology: MAGEC® Spinal Bracing Distraction system
   - Maximum Add on Payment: $15,750
   - Identify and make new technology add-on payments with ICD-10-PCS procedure codes XNS0032, XNS0432, XNS3032, XNS3432, XNS4032 or XNS4432

2. Name of Approved New Technology: GORE IBE device system
   - Maximum Add on Payment: $5,250
   - Identify and make new technology add-on payments with ICD-10-PCS procedure codes: 04VC0EZ; 04VC0FZ; 04VC3EZ; 04VC3FZ; 04VC4EZ; 04VC4FZ; 04VD0EZ; 04VD0FZ; 04VD3EZ; 04VD3FZ; 04VD4EZ; or 04VD4FZ

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

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

5. Name of Approved New Technology: Vistogard™
   - Maximum Add on Payment: $37,500
   - Identify and make new technology add-on payments with any of the following ICD-10-PCS diagnosis codes T45.1X1A, T45.1X1D, T45.1X1S, T45.1X5A, T45.1X5D, and T45.1X5S in combination with ICD-10-PCS procedure code XW0DX82

Cost of Living Adjustment (COLA) Update for IPPS PPS

The IPPS incorporates a COLA for hospitals located in Alaska and Hawaii. There are no changes to the COLAs for FY 2017, and are the same COLAs established for FY 2014. These COLAs are shown in the following table:

Table 2: FY 2017 Cost-of-Living Adjustment Factors (COLAs):

<table>
<thead>
<tr>
<th>Alaska Hospitals</th>
<th>Cost of Living Adjustment Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Alaska</strong></td>
<td></td>
</tr>
<tr>
<td>City of Anchorage and 80-kilometer (50-mile) radius by road</td>
<td>1.23</td>
</tr>
<tr>
<td>City of Fairbanks and 80-kilometer (50-mile) radius by road</td>
<td>1.23</td>
</tr>
<tr>
<td>City of Juneau and 80-kilometer (50-mile) radius by road</td>
<td>1.23</td>
</tr>
<tr>
<td>Rest of Alaska</td>
<td>1.25</td>
</tr>
</tbody>
</table>

Table 2: FY 2017 Cost-of-Living Adjustment Factors (COLAs):

<table>
<thead>
<tr>
<th>Hawaii Hospitals</th>
<th>Cost of Living Adjustment Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hawaii</strong></td>
<td></td>
</tr>
<tr>
<td>City and County of Honolulu</td>
<td>1.25</td>
</tr>
<tr>
<td>County of Hawaii</td>
<td>1.19</td>
</tr>
</tbody>
</table>
HOSPITAL

<table>
<thead>
<tr>
<th></th>
<th>Cost of Living Adjustment Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>County of Kauai</td>
<td>1.25</td>
</tr>
<tr>
<td>County of Maui and County of Kalawao</td>
<td>1.25</td>
</tr>
</tbody>
</table>

**FY 2017 Wage Index Changes and Issues**

1. **New Wage Index Labor Market Areas and Transitional Wage Indexes**
   a. Effective October 1, 2014, CMS revised the labor market areas used for the wage index based on the most recent labor market area delineations issued by the Office of Management and Budget (OMB) using 2010 Census data.

   In order to mitigate potential negative payment impacts due to the adoption of the new OMB delineations, for the few hospitals that were located in an urban county prior to October 1, 2014, that became rural effective October 1, 2014, under the new OMB delineations, CMS assigned a hold-harmless urban wage index value of the labor market area in which they are physically located for FY 2014 for 3 years beginning in FY 2015. That is, for FYs 2015, 2016, and 2017, assuming no other form of wage index reclassification or redesignation is granted, these hospitals are assigned the area wage index value of the urban CBSA in which they were geographically located in FY 2014.

   Note that for hospitals that are receiving the 3-year hold-harmless wage index, the transition is only for the purpose of the wage index and does not affect the hospital’s urban or rural status for any other payment purposes.

   b. As discussed in the FY 2017 IPPS/LTCH PPS final rule ([81 FR 56913](https://www.federalregister.gov/documents/2016/08/02/2016-18489/patient-payment-systems-longs-term-care-hospital-payment-system-final-rule)), among other changes, OMB Bulletin No. 15-01 made the following changes that are relevant to the IPPS wage index:

      Garfield County, OK, with principal city Enid, OK, which was a Micropolitan (geographically rural) area, now qualifies as an urban new CBSA 21420 called Enid, OK.

2. **Treatment of Certain Providers Redesignated Under the Social Security Act (Section 1886(d)(8)(B))**

   **[42 CFR 412.64(b)(3)(ii)](https://www.cqrcade.com/laws.cfm?doc=cfr&part=412&section=412.64) implements section (1886(d)(8)(B)) of the Social Security Act which redesignates certain rural counties adjacent to one or more urban areas as urban for the purposes of payment under the IPPS. (These counties are commonly referred to as ”Lugar counties.”) Accordingly, hospitals located in Lugar counties are deemed to be located in an urban area and their IPPS payments are determined based upon the urban area to which they are redesignated. A hospital that waives its Lugar status in order to receive the out-migration adjustment has effectively waived its deemed urban status, and is considered rural for all IPPS purposes.

3. **Section 505 Hospitals (Out-Commuting Adjustment)**

   Section 505 of the Medicare Modernization Act of 2003 (MMA), also known as the “out-migration adjustment, is an adjustment that is based primarily on commuting patterns and is available to hospitals that are not reclassified by the Medicare Geographic Classification Review Board (MGCRB), reclassified as a rural hospital under § 412.103, or redesignated under the Social Security Act (Section 1886(d)(8)(B)).

**Treatment of Certain Urban Hospitals Reclassified as Rural Hospitals Under § 412.103 and Hospitals reclassified under the Medicare Geographic Classification Review Board (MGCRB)**

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

Prior to April 21, 2016, the regulations at § 412.230(a)(5)(ii) and § 412.230(a)(5)(iii) prohibited hospitals from simultaneously receiving an urban to rural reclassification under § 412.103 and a reclassification under the MGCRB. Also, the regulations did not allow a LUGAR hospital (that is, a hospital located in a Lugar county) to keep its LUGAR status if it was approved for an urban to rural reclassification under § 412.103. In light of court decisions that ruled as unlawful the regulation precluding a hospital from maintaining simultaneous MGCRB and § 412.103 reclassifications, on April 18, 2016, CMS issued an interim final rule with comment period (CMS-1664-IFC) amending the regulations to conform to the court decisions. The IFC is effective April 21, 2016, and was finalized in the Federal Register published on August 2, 2016. The
IFC allows hospitals nationwide that have an MGCRB reclassification or LUGAR status during FY 2016 and subsequent years the opportunity to simultaneously seek urban to rural reclassification under § 412.103 for IPPS payment and other purposes, and keep their existing MGCRB reclassification or LUGAR status.

Multicampus Hospitals with Inpatient Campuses in Different CBSAs
Beginning with the FY 2008 wage index, CMS instituted a policy that allocates the wages and hours to the CBSA in which a hospital campus is located when a multi-campus hospital has campuses located in different CBSAs. Medicare payment to a hospital is based on the geographic location of the hospital facility at which the discharge occurred. Note that, under certain circumstances, it is permissible for individual campuses to have reclassifications to another CBSA. In general, subordinate campuses are subject to the same rules regarding withdrawals and cancellations of reclassifications as main providers.

Medicare-Dependent, Small Rural Hospital (MDH) Program Expiration
The MDH program provides enhanced payment to support small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges. The MDH program is currently effective through September 30, 2017, as provided by Section 205 of the Medicare Access and CHIP Reauthorization Act of 2015. Provider Types 14 and 15 continue to be valid through September 30, 2017.

In the Calendar Year (CY) 2016 OPPS Final Rule, CMS provided for a transition period for these hospitals to mitigate the financial impact of losing MDH status to hospitals that (1) lost their MDH status because they are no longer in a rural area due to the adoption of the new OMB delineations in FY 2015 and (2) have not reclassified from urban to rural under the regulations at §412.103 before January 1, 2016. During the transition period (January 1, 2016, through September 30, 2017), such hospitals (“qualifying former MDHs”) will receive a transitional add-on payment. For discharges occurring on or after October 1, 2016, through September 30, 2017, qualifying former MDHs will receive an add-on payment equal to one-third of “the MDH add-on” (that is, one-third of 75 percent of the amount by which the Federal rate payment is exceeded by the hospital’s hospital-specific rate). Information on the requirements implementing this transitional add-on payment for former MDHs are in CR9408, which is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3390CP.pdf.

Based on the best available information, CMS has identified the hospitals it believes qualify for this transitional add-on payment. The Pricer logic has been modified to calculate this transitional add-on payment in the HSP-payment field in the Pricer for the qualifying hospitals identified by CMS.

Hospital Specific (HSP) Rate Factors for Sole Community Hospitals (SCHs) and Medicare-Dependent, Small Rural Hospitals (MDHs)
For FY 2017, the HSP amount in the PSF for SCHs and MDHs will continue to be entered in FY 2012 dollars. PRICER will apply the cumulative documentation and coding adjustment factor for FYs 2011 through 2014 of 0.9480, the FY 2017 2-midnight rule one-time prospective increase of 1.006 (as well as the removal of 0.998 2-midnight rule adjustment applied in FY 2014), and apply all of the updates and DRG budget neutrality factors to the HSP amount for FY 2013 and beyond.

Low-Volume Hospitals – Criteria and Payment Adjustments for FY 2017
The temporary changes to the low-volume hospital payment adjustment originally provided by the Affordable Care Act, and extended by subsequent legislation, expanded the definition of a low-volume hospital and modified the methodology for determining the payment adjustment for hospitals meeting that definition. Section 204 of the Medicare Access and CHIP Reauthorization Act of 2015 extended the temporary changes to the low-volume hospital payment adjustment through September 30, 2017.

In order to qualify as a low-volume hospital in FY 2017, a hospital must be located more than 15 road miles from another “subsection (d) hospital” and have less than 1600 Medicare discharges (which includes Medicare Part C discharges and is based on the latest available MedPAR data). The applicable low-volume percentage increase is determined using a continuous linear sliding scale equation that results in a low-volume hospital payment adjustment ranging from an additional 25 percent for hospitals with 200 or fewer Medicare discharges to a zero percent additional payment adjustment for hospitals with 1,600 or more Medicare discharges. For FY 2017, qualifying low-volume hospitals and their payment adjustment are determined using Medicare discharge data from the March 2016 update of the FY 2015 MedPAR file. Table 14 of the FY 2017 IPPS/LTCH PPS final rule (available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2017-IPPS-Final-Rule-Home-Page.html) lists the “subsection
HOSPITAL

(d)” hospitals with fewer than 1,600 Medicare discharges based on the March 2016 update of the FY 2015 MedPAR file and their low-volume hospital payment adjustment for FY 2017 (if eligible). CMS notes that the list of hospitals with fewer than 1,600 Medicare discharges in Table 14 does not reflect whether or not the hospital meets the mileage criterion (that is, the hospital is located more than 15 road miles from any other subsection (d) hospital, which, in general, is an IPPS hospital).

A hospital must notify and provide documentation to its MAC that it meets the mileage criterion as outlined in prior program guidance and the FY 2017 IPPS/LTCH PPS final rule.

To receive a low-volume hospital payment adjustment under § 412.101 for FY 2017, a hospital must make a written request for low-volume hospital status that was received by its MAC no later than September 1, 2016, in order for the applicable low-volume hospital payment adjustment to be applied to payments for discharges occurring on or after October 1, 2016. Under this procedure, a hospital that qualified for the low-volume hospital payment adjustment in FY 2016 may continue to receive a low-volume hospital payment adjustment for FY 2017 without reapplying if it continues to meet the Medicare discharge criterion established for FY 2017 (as shown in Table 14 of the FY 2017 IPPS/LTCH PPS Final Rule) and the mileage criterion. However, the hospital must have send written verification that was received by its MAC no later than September 1, 2016, stating that it continues to be more than 15 miles from any other “subsection (d)” hospital. This written verification could be a brief letter to the MAC stating that the hospital continues to meet the low-volume hospital distance criterion as documented in a prior low-volume hospital status request. If a hospital’s written request for low-volume hospital status for FY 2017 was received after September 1, 2016, and if the MAC determines that the hospital meets the criteria to qualify as a low-volume hospital, the MAC shall apply the applicable low-volume hospital payment adjustment to determine the payment for the hospital’s FY 2017 discharges, effective prospectively within 30 days of the date of its low-volume hospital status determination.

Hospital Quality Initiative

The hospitals that will receive the quality initiative bonus are listed at www.qualitynet.org.

Hospital Acquired Condition Reduction Program (HAC)

Section 3008 of the Affordable Care Act establishes a program, beginning in FY 2015, for IPPS hospitals to improve patient safety, by imposing financial penalties on hospitals that perform poorly with regard to certain HACs. Under the HAC Reduction Program, a one (1) percent payment reduction applies to a hospital whose ranking is in the top quartile (25 percent) of all applicable hospitals, relative to the national average, of HACs acquired during the applicable period, and applies to all of the hospital’s discharges for the specified fiscal year.

A list of providers subject to the HAC Reduction Program for FY 2017 was not publicly available in the final rule because the review and correction process was not yet completed. Updated hospital level data for the HAC Reduction Program will be made publicly available following the review and corrections process.

Hospital Value Based Purchasing

Section 3001 of the Affordable Care Act added Section 1886(o) to the Social Security Act, establishing the Hospital Value-Based Purchasing (VBP) Program. This program began adjusting base operating DRG payment amounts for discharges from subsection (d) hospitals, beginning in FY 2013. Under its current agreement with CMS, Maryland hospitals are not subject to the Hospital VBP Program for the FY 2017 program year. The regulations that implement this provision are in subpart I of 42 CFR part 412 (§ 412.160 through § 412.162).

For FY 2017 CMS will implement the base operating DRG payment amount reduction and the value-based incentive payment adjustments as a single value-based incentive payment adjustment factor applied to claims for discharges occurring in FY 2017. CMS expects to post the value-based incentive payment adjustment factors for FY 2017 in the near future in Table 16B of the FY 2017 IPPS/LTCH PPS final rule.

Hospital Readmissions Reduction Program

The readmissions payment adjustment factors for FY 2017 are in Table 15 of the FY 2017 IPPS/LTCH PPS final rule. Hospitals that are not subject to a reduction under the Hospital Readmissions Reduction Program in FY 2017 (such as Maryland hospitals), have a readmission adjustment factor of 1.0000. For FY 2017, hospitals should only have a readmission adjustment factor between 1.0000 and 0.9700.
NOTE: Hospitals located in Maryland (for FY 2017) and in Puerto Rico are not subject to the Hospital Readmissions Reduction Program, and therefore, are not listed in Table 15.

Medicare Disproportionate Share Hospitals (DSH) Program
Section 3133 of the Affordable Care Act modified the Medicare DSH program beginning in FY 2014, by providing that hospitals received 25 percent of the amount they previously would have received under the current statutory formula for Medicare DSH. The remainder, equal to 75 percent of what otherwise would have been paid as Medicare DSH, will become an uncompensated care payment after the amount is reduced for changes in the percentage of individuals that are uninsured. Each Medicare DSH hospital will receive a portion of this uncompensated care pool based on its share of total uncompensated care reported by Medicare DSH hospitals. A Medicare DSH hospital’s share of uncompensated care is based on its share of insured low income days, defined as the sum of Medicare Supplemental Security Income (SSI) days and Medicaid days, relative to all Medicare DSH hospitals’ insured low income days.

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

The total uncompensated care payment amount to be paid to Medicare DSH hospitals was finalized in the FY 2017 IPPS Final Rule. The uncompensated care payment will be paid on the claim as an estimated per discharge amount to the hospitals that have been projected to receive Medicare DSH for FY 2017. The estimated per claim amount is determined by dividing the total uncompensated care payment by the average number of claims from the most recent three years of claims data (FY2013-2015). The estimated per discharge uncompensated care payment amount will be included in the outlier payment determinations. In addition, the estimated per discharge uncompensated care payment amount will be included as a Federal payment for Sole Community Hospitals to determine if a claim is paid under the hospital-specific rate or Federal rate and for Medicare Dependent Hospitals to determine if the claim is paid 75 percent of the difference between payment under the hospital-specific rate and payment under the Federal rate. The total uncompensated care payment amount displayed in the Medicare DSH Supplemental Data File on the CMS website will be reconciled at cost report settlement with the interim estimated uncompensated care payments that are paid on a per discharge basis.

Recalled Devices
A hospital’s IPPS payment is reduced, for specified MS-DRGs when the implantation of a device is replaced without cost or with a credit equal to 50 percent or more of the cost of the replacement device.

New MS-DRGs are added to the list subject to the policy for payment under the IPPS for replaced devices offered without cost or with a credit when they are formed from procedures previously assigned to MS-DRGs that were already on the list.

There are no new MS-DRGs for FY 2017 subject to the policy for replaced devices offered without cost or with a credit.

LTCH PPS FY 2017 Update
FY 2017 LTCH PPS Rates and Factors
FY 2017 LTCH PPS Rates and Factors are as follows:

<table>
<thead>
<tr>
<th>FY 2017 LTCH PPS Rates and Factors</th>
<th>Rates based on successful reporting of quality data.</th>
</tr>
</thead>
<tbody>
<tr>
<td>LTCH PPS Standard Federal Rates</td>
<td>• Full update (quality indicator on PSF = 1): $42,476.41</td>
</tr>
<tr>
<td></td>
<td>• Reduced update (quality indicator on PSF = 0 or blank): $41,641.49</td>
</tr>
<tr>
<td>Labor Share</td>
<td>66.5%</td>
</tr>
<tr>
<td>Non-Labor Share</td>
<td>33.5%</td>
</tr>
<tr>
<td>High-Cost Outlier Fixed-Loss Amount for Standard Federal Rate Discharges</td>
<td>$21,943</td>
</tr>
<tr>
<td>High-Cost Outlier Fixed-Loss Amount for Site-Neutral Rate Discharges</td>
<td>$23,573</td>
</tr>
</tbody>
</table>

The LTCH PPS Pricer has been updated with the Version 34.0 MS-LTC-DRG table, weights and factors, effective for discharges occurring on or after October 1, 2016, and on or before September 30, 2017.

**1. Application of the Site Neutral Payment Rate**

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

The application of the site neutral payment rate is codified in the regulations at § 412.522. Additional information on the final policies implementing the application of the site neutral payment rate can be found in the FY 2016 Final Rule (80 FR 49601-49623). Section 231 of the Consolidated Appropriations Act created a temporary exception to the site neutral payment rate for certain discharges from certain LTCHs. Additional information on the provisions of Section 231 can be found in the Interim Final Rule with Comment Period (IFC) published in the Federal Register on April 21, 2016 (81 FR 25430) and finalized in the FY 2017 IPPS/LTCH Final Rule (81 FR 57068). Information on the requirements implementing the application of the site neutral payment rate is available in CRs 9015 and 9599.

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

**Discharge Payment Percentage**

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

**LTCH Quality Reporting (LTCHQR) Program**

The Affordable Care Act (Section 3004(a)) requires the establishment of the Long-Term Care Hospital Quality Reporting (LTCHQR) Program. For FY 2017, the annual update to a standard Federal rate will continue to be reduced by 2.0 percentage points if a LTCH does not submit quality reporting data in accordance with the LTCHQR Program for that year.

**Cost of Living Adjustment (COLA) under the LTCH PPS**

The LTCH PPS incorporates a COLA for hospitals located in Alaska and Hawaii. There are no changes to the COLAs for FY 2017, and are the same COLAs established in the FY 2014 IPPS/LTCH PPS final rule. The applicable COLAs are the same as those in Tables 2 listed earlier in this article.

**Additional Information**

I/OCE Specifications Version 18.0 - January 2017

MLN Matters® Number: MM9892
Related Change Request (CR) #: CR 9892
Related CR Release Date: December 9, 2016
Effective Date: January 1, 2017
Related CR Transmittal #: R3674CP
Implementation Date: January 3, 2017

Provider Types Affected
This MLN Matters® Article is intended for providers who submit institutional claims to Medicare Administrative Contractors (MACs), including Home Health and Hospice (HH+H) MACs, for services provided to Medicare beneficiaries.

What You Need to Know
Change Request (CR) 9892 provides instructions and specifications for the Integrated Outpatient Code Editor (I/OCE) used for Outpatient Prospective Payment System (OPPS) and non-OPPS claims. This is 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 (PPS) or to a hospice patient for the treatment of a non-terminal illness. Make sure that your billing staffs are aware of these changes. The I/OCE specifications will be posted at [http://www.cms.gov/OutpatientCodeEdit/](http://www.cms.gov/OutpatientCodeEdit/). These specifications contain the appendices mentioned in the table below.

Key I/OCE Changes for January 2017
The following table summarizes the modifications of the IOCE for the January 2017 v18.0 release. Note that some I/OCE modifications in the update may be retroactively added to prior releases. If so, the retroactive date appears in the ‘Effective Date’ column.

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Edits Affected</th>
<th>Modification</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/1/2017</td>
<td></td>
<td>Implement new program logic for the Community Mental Health Center (CMHC) outlier limitation (see OPPS processing logic and Appendix E). Apply new Payment Method Flag 6 to all OPPS payable lines if condition code 66 is present for claims with bill type 76x.</td>
</tr>
<tr>
<td>1/1/2017</td>
<td></td>
<td>Implement new program logic to include Negative Pressure Wound Therapy (NPWT) procedure codes 97607 and 97608 to the list of codes reportable for Home Health claims with bill type 34x that are payable under OPPS (see OPPS special processing logic and Appendix F-(a)).</td>
</tr>
<tr>
<td>8/1/2016</td>
<td>67</td>
<td>Implement mid-quarter Food and Drug Administration (FDA) approval edit for 90674.</td>
</tr>
<tr>
<td>1/1/2017</td>
<td>100</td>
<td>Implement new edit: Claim for Hematopoietic Stem Cell Transplantation (HSCT) allogeneic transplantation lacks required revenue code line for donor acquisition services (claim is Returned to Provider (RTP)). Edit criteria: A claim reporting HSCT allogeneic transplantation (procedure code 38240) is reported and there is no additional line on the claim reporting revenue code 815 for donor acquisition services (see Table 4).</td>
</tr>
<tr>
<td>1/1/2017</td>
<td>41</td>
<td>Add new revenue code 815 (Allogeneic stem cell acquisition services) to the valid revenue code list.</td>
</tr>
<tr>
<td>1/1/2017</td>
<td></td>
<td>Implement updated program logic to process conditional Ambulatory Payment Classification (APC)/packaging, critical care ancillary packaging and advance care planning across the claim rather than by day (see OPPS processing logic).</td>
</tr>
<tr>
<td>Effective Date</td>
<td>Edits Affected</td>
<td>Modification</td>
</tr>
<tr>
<td>---------------</td>
<td>---------------</td>
<td>--------------</td>
</tr>
<tr>
<td>1/1/2017</td>
<td></td>
<td>Implement updated program logic for processing terminated device-intensive procedure offset determinations by HCPCS code, not by APC. Note: This also includes table changes for the quarterly data file reports.</td>
</tr>
<tr>
<td>1/1/2017</td>
<td></td>
<td>Implement new program logic for payment adjustment of film x-ray HCPCS codes. Film x-ray HCPCS codes with modifier FX reported are assigned new payment adjustment flag 21 (see OPPS processing logic, Table 7 and Appendix G).</td>
</tr>
<tr>
<td>1/1/2017</td>
<td>22</td>
<td>Add new modifiers FX (X-ray taken using film), PN (Non-excepted off-campus svc), 95 (Synchronous Telemedicine Service) and V1, V2, V3 (Demonstration modifiers 1, 2, 3) to the valid modifier list.</td>
</tr>
<tr>
<td>1/1/2017</td>
<td></td>
<td>Implement new Status Indicator (SI) value E1, to replace former SI E for non-covered services (see Table 7). Note: Edits 9, 28 and 50 applied formerly for HCPCS with SI = E are now applied to HCPCS with SI = E1.</td>
</tr>
<tr>
<td>1/1/2017</td>
<td></td>
<td>Implement new SI value E2 (Items and services for which pricing information and claims data are not available) (see Table 7).</td>
</tr>
<tr>
<td>1/1/2017</td>
<td>13</td>
<td>Reactivate edit 13: Separate payment for services is not provided by Medicare (LIR). Edit criteria: there is a line item HCPCS present with SI = E2 (see OPPS processing logic, Table 7).</td>
</tr>
<tr>
<td>1/1/2014</td>
<td></td>
<td>Correction of program logic for Extended Assessment and Management (EAM) composite APC 8009 to not consider conditional APC processing of sometimes therapy codes with SI = Q1 resulting in final SI = A as criteria for preventing assignment of the EAM composite APC. Also, units of service are not reduced to one under conditional APC processing for sometimes therapy codes resulting in final SI = A (see OPPS processing logic and Appendix K).</td>
</tr>
<tr>
<td>9/28/2016</td>
<td>68</td>
<td>Implement mid-quarter NCD coverage for G0499.</td>
</tr>
<tr>
<td>1/1/2016</td>
<td>99</td>
<td>Update the edit logic to include exceptions for certain blood clotting factor HCPCS codes that may be self-administered and do not require that an OPPS payable procedure is present. Also, program logic only is updated to apply edit 99 only to those OPPS bill types where APC information is returned (see Appendix F(a) for reference).</td>
</tr>
<tr>
<td>1/1/2016</td>
<td></td>
<td>Update the inpatient procedure processing when the patient expires to also include claims with discharge status codes indicating transfer to another hospital facility (see OPPS processing logic and Appendix L).</td>
</tr>
<tr>
<td>1/1/2016</td>
<td>70</td>
<td>Update the edit logic and description to include transfer discharge status: Edit description: CA modifier requires patient discharge status indicating expired or transferred.</td>
</tr>
<tr>
<td>1/1/2017</td>
<td></td>
<td>Implement new program logic for identifying non-excepted items or services under Section 603 requirements that are provided in off-campus provider-based hospital outpatient departments that are reported with modifier PN may be subject to alternative payment method or reduction (see OPPS processing logic and new Appendix Q).</td>
</tr>
<tr>
<td>1/1/2017</td>
<td>101</td>
<td>Implement new edit 101: Item or service with modifier PN not allowed under PFS (RTP). Edit criteria: Modifier PN is reported for an item or service that is considered to be non-excepted for an off-campus provider-based hospital outpatient department under Section 603.</td>
</tr>
<tr>
<td>Effective Date</td>
<td>Edits Affected</td>
<td>Modification</td>
</tr>
<tr>
<td>---------------</td>
<td>----------------</td>
<td>--------------</td>
</tr>
<tr>
<td>1/1/2016</td>
<td></td>
<td>Update the advance care planning logic to include add-on code 99498; change the SI to A if reported with 99497 and the annual wellness visit, otherwise package with SI = N.</td>
</tr>
<tr>
<td>1/1/2017</td>
<td></td>
<td>Update the program logic and flowcharts for partial hospitalization and daily mental health to refer to a single level per diem APC (level I/II APCs no longer applicable) (see OPPS processing logic and Appendix C (‘a’ and ‘b’). Appendices are attached to CR9892.</td>
</tr>
<tr>
<td>1/1/2017</td>
<td>87</td>
<td>Update the skin substitute product lists (Appendix O, List E: Lists A and B)</td>
</tr>
<tr>
<td>1/1/2017</td>
<td>22</td>
<td>Modifier L1, associated with the reporting of conditionally packaged laboratory procedures is deactivated (see OPPS processing logic).</td>
</tr>
<tr>
<td>1/1/2017</td>
<td></td>
<td>Update program logic for LDR brachytherapy composite APC primary code 55875 is assigned under comprehensive APCs if conditions are not met for composite APC 8001 assignment (see Appendix K).</td>
</tr>
</tbody>
</table>
| 1/1/2017      |                | Add the following new payment method flags (see Table 7 and Appendix E):  
|                |                | • 6 (CMHC Outlier limitation reached)  
|                |                | • 7 (Section 603 service with no reduction in OPPS Pricer)  
<p>|                |                | • 8 (Section 603 service with PFS reduction applied in OPPS Pricer) |
| 1/1/2017      |                | Update the description for Payment Indicator value of 2: “Services not paid by OPPS Pricer; paid under fee schedule or other payment system (SIs A, G, K)” (see Table 7). |
| 1/1/2017      |                | Add new payment adjustment flag 21 (CAA Section 502b reduction on film x-ray) (see Table 7 and Appendix G). |
| 1/1/2017      |                | Add new SI values E1 and E2 (Items and services for which pricing information and claims data are not available) (see Table 7). |
| 1/1/2017      |                | Update Appendix F (a) to include new edits 100 and 101. |
| 1/1/2017      |                | Add new Appendix Q: processing steps and criteria for non-excepted items and services under Section 603. |
| 1/1/2017      |                | Update Appendix L to include new SI values E1 and E2 in the list of SI’s that are edited as usual under comprehensive APC processing. |
| 1/1/2017      |                | Update table 4 to add new columns noting versions and dates for edits. |</p>
<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Edits Affected</th>
<th>Modification</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/1/2017</td>
<td></td>
<td>Update the following lists for the release (see quarterly data files):&lt;br&gt;• Bilateral flag lists&lt;br&gt;• Procedure and gender conflict lists (edit 8)&lt;br&gt;• Comprehensive APC list&lt;br&gt;• Complexity-adjusted Comprehensive APC code pairs&lt;br&gt;• Device and Device-Procedure lists (edit 92)&lt;br&gt;• Terminated Device offset (offset by HCPCS)&lt;br&gt;• Pass-through device offset amounts&lt;br&gt;• Film x-ray HCPCS (new logic)&lt;br&gt;• Negative pressure wound therapy (new logic)&lt;br&gt;• Section 603 override HCPCS (new logic)&lt;br&gt;• Blood clotting factor HCPCS (edit 99 exclusion)&lt;br&gt;• Skin substitutes (edit 87)&lt;br&gt;• Pass-through Radiopharmaceuticals&lt;br&gt;• Pass-through Radiopharmaceutical APC offset amounts&lt;br&gt;• Pass-through Contrast APC offset amounts&lt;br&gt;• Pass-through Skin substitutes&lt;br&gt;• Pass-through Skin substitute APC offset amounts&lt;br&gt;• Deductible-Coinsurance N/A list (Appendix O, List C)&lt;br&gt;• Service not paid Medicare list (new SI = E2)&lt;br&gt;• Not recognized Medicare list (edit 28)&lt;br&gt;• Non-covered service list (edit 9)&lt;br&gt;• Statutory exclusion list (edit 50)&lt;br&gt;• Not recognized OPPS list (edit 62)&lt;br&gt;• FQHC vaccines&lt;br&gt;• FQHC code pairs</td>
</tr>
<tr>
<td>1/1/2017</td>
<td>20, 40</td>
<td>Make all HCPCS/APC/SI changes as specified by CMS (quarterly data files).</td>
</tr>
<tr>
<td>1/1/2017</td>
<td></td>
<td>Implement version 23.0 of the NCCI (as modified for applicable outpatient institutional providers).</td>
</tr>
</tbody>
</table>

**Additional Information**


**LTCH PPS Implementation Based on Specific Clinical Criteria**

MLN Matters® Number: SE1627  
Related Change Request (CR) #: CR 9015  
Effective Date: Discharges in Cost Reporting Periods on or after October 1, 2015  
SE Article Release Date: October 18, 2016  
Related CR Transmittal #: R15440TN  
Implementation Date: October 5, 2015
Provider Types Affected
This MLN Matters® Special Edition (SE) Article is intended for Long-Term Care Hospitals (LTCHs) that submit claims to Medicare Administrative Contractors (MACs) for Long-Term Care Hospital services provided to Medicare beneficiaries.

What You Need to Know
Change Request (CR) 9015, Transmittal 1544, Implementation of Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) Based on Specific Clinical Criteria, issued September 22, 2015, describes the immediately preceding hospital as an Inpatient PPS hospital, which is inconsistent with the policy set forth in the Code of Federal Regulations. The regulations at CFR 412.522 specifies the immediately preceding discharge is from a “subsection (d) hospital”, which in general, means a hospital located in one of the 50 States or the District of Columbia other than certain specified IPPS-excluded hospitals (that is, psychiatric hospitals, rehabilitation hospitals, children’s hospitals, LTCHs, and cancer hospitals) (see §412.503).

Medicare’s claims processing system was programmed correctly to identify subsection (d) hospitals, however, the patient may have had an immediately preceding inpatient stay at a subsection (d) hospital that is not present in the Medicare claims processing system. For example, the patient may have used their Veteran Affairs benefits or received inpatient care at a military treatment facility that qualifies as an “immediately preceding” stay (prior to admission to the LTCH) if verified by the MAC. In such an occurrence, upon receipt of a site neutral payment, the LTCH shall contact their MAC who will work with the LTCH to obtain the documentation it finds sufficient to demonstrate that the applicable criteria for exclusion from the site neutral payment rate have been met and adjust the applicable LTCH claim to make any appropriate adjustments to payment.

Additional Information

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

The Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents – Payment Reform
MLN Matters® Number: SE1636
Article Release Date: December 21, 2016

Provider Types Affected
This article is intended for nursing facilities and practitioners participating in this initiative. Those are selected nursing facilities and practitioners in Alabama, Colorado, Indiana, Missouri, Nevada, New York, and Pennsylvania. The article is informational for other nursing facilities and practitioners.

Background
“The Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents – Payment Reform” tests a new payment model for nursing facilities and practitioners to incent early identification of changes in condition, treatment of specific conditions in a nursing facility without a hospital transfer, and improved care planning.

The objectives of this model are to reduce avoidable hospital transfers, improve health outcomes, and to reduce combined Medicare-Medicaid costs for long-stay nursing facility residents enrolled in Medicare and Medicaid. The model includes the introduction of six new Medicare Part B payment codes billable by nursing facilities for treatment of specific conditions and two new Medicare Part B payment codes billable by practitioners for onsite treatment and for care coordination.

The eligible beneficiaries for this initiative are long-stay nursing facility residents who have resided in the
facility for 101 cumulative days or more, who are enrolled in Medicare (Parts A and B Fee-for-Service), reside in a Medicare or Medicaid certified bed, and who have not opted out of participating in the initiative.

Note: Participation in this Initiative is limited to selected nursing facility and practitioners in Alabama, Colorado, Indiana, Missouri, Nevada, New York, and Pennsylvania. At this time, all participating nursing facilities have been chosen and screened for their eligibility to participate. The Centers for Medicare & Medicaid Services (CMS) and its partners are not recruiting new facilities at this time.

What You Need to Know
The payment model has three components:

- Nursing facility payments for the treatment of qualifying conditions (for beneficiaries not on a Medicare Part A skilled nursing facility stay)
- Practitioner payment for the treatment of conditions onsite at the nursing facility
- Practitioner payment for care coordination and caregiver engagement

Nursing Facility Payments for Treatment of Qualifying Conditions (Onsite Acute Care)
The following six new HCPCS codes can only be billed by participating nursing facilities when qualifying criteria has been met. Nursing facilities participating in this initiative should have received specific qualifying clinical criteria information from their Enhanced Care and Coordination Provider (ECCP). Please reach out to your ECCP if you do not have this information. The six codes are:

- G9679: Pneumonia - This code is for onsite acute care treatment of a nursing facility resident with pneumonia.
- G9680: Congestive Heart Failure (CHF) - This code is for onsite acute care treatment of a nursing facility resident with CHF.
- G9681: Chronic Obstructive Pulmonary Disease (COPD)/Asthma - This code is for onsite acute care treatment of a resident with COPD or asthma.
- G9682: Skin infection - This code is for the onsite acute care treatment of a nursing facility resident with a skin infection.
- G9683: Fluid or Electrolyte Disorder or Dehydration - This code is for the onsite acute care treatment of a nursing facility resident with fluid or electrolyte disorder or dehydration.
- G9684: Urinary Tract Infection (UTI) - This code is for the onsite acute care treatment of a nursing facility resident with a UTI.

Each of the six codes follows standard Medicare Part B billing requirements and should be billed on a 22x or a 23x type of bill. Nursing facilities, at a minimum, need to follow the billing rules from the National Uniform Billing Committee (NUBC). They maintain the allowable revenue codes for certain facilities. Within the rules set out by the NUBC, CMS did not limit which revenue codes could be used with the new codes and advises nursing facilities to select the revenue code most appropriate for their situation. More information on SNF Part B billing (including those revenue codes that cannot be billed on a 22x) is available at https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c07.pdf.

Participating nursing facilities will be paid a per diem rate of $218 for HCPCS codes G9679 through G9684. As a reminder, Medicare payments to providers for individual services under Medicare Parts A and B have been under sequestration for services beginning April 2013. This means that final payment to providers will be two percent less than the calculated payment amount.

Payment for these codes is limited to nursing facilities participating in the initiative. Beneficiary co-insurance and deductible will be waivered for these codes. None of these codes may be billed more than once a day for a single beneficiary and only one of these codes may be billed in a day for a single beneficiary.

Practitioner Payment for the Treatment of Acute Changes in Condition Onsite at the Nursing Facility
New practitioner code G9685 (Practitioner Payment for the Treatment of Conditions Onsite at Nursing Facility) is billable for the initial visit for the evaluation and management of a beneficiary’s acute change in
condition in a nursing facility. Payment for this code is limited to practitioners participating in the initiative when billing for services rendered at a participating nursing facility. This code may only be billed once per day per beneficiary. Beneficiary co-insurance and deductible will be waived for these codes. Practitioners are permitted to bill for these services while a beneficiary is receiving Medicare Part A skilled nursing facility benefits. The payment rate for HCPCS code G9685 is aligned with CPT code 99223 (Initial Hospital Care), to help equalize the practitioner payment across sites.

**Key Components Required**

Key components required to bill code G9685 are:

- A comprehensive review of the beneficiary’s history
- A comprehensive examination
- Medical decision making of moderate to high complexity, and
- Counseling and/or coordinating care with nursing facility staff and other providers or suppliers consistent with the nature of the problem(s) and the beneficiary’s and family’s needs.

Practitioners should reach out to their ECCP for questions and education on how and when to bill this code.

**Practitioner Payment for Care Coordination and Caregiver Engagement**

New practitioner code G9686 (Care Coordination and Caregiver Engagement Conference) is for the onsite nursing facility conference that is separate and distinct from an Evaluation and Management visit, including qualified practitioner and at least one member of the nursing facility interdisciplinary care team and resident or their designated caregiver. Payment for this code is limited to practitioners participating in the initiative when billing for services rendered at a participating nursing facility. Beneficiary co-insurance and deductible will be waived for this code. The payment rate for HCPCS code G9686 is aligned with CPT code 99214 (Office or other outpatient visit for established patient).

The code may only be billed once per year for a single beneficiary in the absence of a significant change in condition. The code can be billed with the –KX modifier within 14 days of a significant change in condition that increases the likelihood of a hospital admission. The change in condition must be documented in the beneficiary’s medical chart and include an MDS assessment.

**Key Components Required**

In order to qualify for payment for code G9686, the practitioner must conduct the discussion:

- With the beneficiary and/or individual(s) authorized to make health care decisions for the beneficiary (as appropriate)
- In a conference for a minimum of 25 minutes
- Without performing a clinical examination of the beneficiary during the discussion (this should be conducted as needed through regular operations and this session is focused on a care planning discussion), and
- With at least one member of the nursing facility interdisciplinary team.

The practitioner must also document the conversation in the beneficiary’s medical chart. The change in condition must be documented in the beneficiary’s chart and include a Minimum Data Set (MDS) assessment.

**Additional Information**

Nursing facilities and practitioners should reach out to their ECCP for questions and education on this initiative.
**MEDICAL POLICIES**

**Positron Emission Tomography Scans Coverage – R7**

The following Noridian coverage requirements for the Positron Emission Tomography Scans Coverage 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:** Positron Emission Tomography Scans Coverage (220.6)

**Summary of Changes:** Article is revised to add Contractor determined coverage for FDA approved tracers: Choline C11, effective 3/7/13, Gallium 68 Dotatate Injection, effective 9/15/16 and Fluciclovine F18, effective 10/1/16.

Q9982 and Q9983 are added as payable effective for dates of service on/after 07/01/2016 per CR 9751. Diagnosis C88.0 is added as payable effective for dates of service on/after 7/25/2016.

Diagnosis ranges are removed. The following diagnoses are deleted effective 9/30/2016: R93.4 – List I, D49.5 - List IV, R97.2 - List VI.

**Effective Date:** October 1, 2016

Read the complete National Coverage Determination requirements article.

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

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

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

**Bariatric Surgery Coverage – R6 and R7**

The following Noridian coverage requirements for the Bariatric Surgery for Treatment of Morbid Obesity 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:** Bariatric Surgery for Treatment of Morbid Obesity (100.1)

**Summary of Changes:** The article has been updated with 2016 ICD-10 code additions and deletions as follows:

**Revision 6**

**Added diagnoses:**

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Deleted diagnoses:

In-Patient procedure codes duplicated in Indications and Limitations of Coverage under Nationally Covered Inpatient Facility ICD-10-CM Procedure Codes were deleted.

Revision 7

Article is revised to remove diagnoses including unspecified eye in the description which were added in error due to the annual ICD-10 code update. Coding to the highest level of specificity is required and codes for right and left eye are included for each indication where appropriate.

Deleted diagnoses:

Effective Date: 10/01/16

Read the complete National Coverage Determination requirements article.

Bariatric Surgery Coverage – R8

The following Noridian coverage requirements for the Bariatric Surgery for Treatment of Morbid Obesity 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: Bariatric Surgery for Treatment of Morbid Obesity (100.1)

Summary of Changes: The article is revised to add ICD-10-PCS codes for Other gastroenterostomy (open Roux-en-Y) and to clarify that only one procedure code (either 43775 or 0DV64CZ) is required for billing laparoscopic sleeve gastrectomy.

Effective Date: October 1, 2016

Read the complete National Coverage Determination requirements article.
Benign Skin Lesion Removal (Excludes Actinic Keratosis and Mohs) 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: L33979:

LCD Title: Benign Skin Lesion Removal (Excludes Actinic Keratosis and Mohs)

Effective Date: 10/1/2016

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

- New/Revised ICD-10 codes
  - D49.511, D49.512, D49.519, D49.59
- Deleted ICD-10 codes
  - D49.5

View the locally hosted Noridian Active LCD PDF.

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

B-type Natriuretic Peptide (BNP) Testing – JFA LCD Number Change – Effective November 2, 2016

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

Medicare Coverage Database (MCD) Number: L34057

LCD Title: B-Type Natriuretic Peptide (BNP) Testing

Effective Date: November 2, 2016

Summary of Changes: LCD number L34057 for Jurisdiction F Part A (JFA) was retired on August 17, 2016 and combined into Jurisdiction F Part B (JFB) LCD number L34037. JFA and JFB contract numbers will have the same final MCD LCD number and remain an Active LCD. Coverage will remain the same.

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

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

- On the “Active LCDs” page, locate the above listed LCD title.
  - This link will direct you to the locally hosted copy of the LCD. You may also view the LCD on the CMS MCD by selecting the appropriate state link on the left side of the page and locating the LCD title.
Botulinum Toxin Types A and B Final LCD – Effective February 13, 2017

The following Local Coverage Determination (LCD) has completed the Open Public and Contractor Advisory Committee (CAC) comment period and is now finalized under contractor numbers 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601 (WY).

Medicare Coverage Database (MCD) Number/Contractor Determination Number: L35172

LCD Title: Botulinum Toxin Types A and B

Effective Date: February 13, 2017


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

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

• On the “Future LCDs” page, select the coordinating state and locate the above listed CMS MCD number or LCD title.
  – This link will redirect you to the state specific Future Effective LCD on the CMS website.

B-type Natriuretic Peptide (BNP) Testing LCD - R3

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

Medicare Coverage Database (MCD) Number: L34054

LCD Title: B-type Natriuretic Peptide (BNP) Testing

Effective Date: 10/01/2016

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

• New/Revised ICD-10 codes
  – I16.0: Hypertensive urgency
  – I16.1: Hypertensive emergency

• Deleted ICD-10 codes
  – None Deleted

View the locally hosted Noridian Active LCD PDF.

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

• Locate and select above listed LCD title

Chest X-Ray 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: L34097
LCD Title: Chest X-Ray
Effective Date: 10/01/2016
Summary of Changes: This LCD has been updated to include and/or remove ICD-10 codes.

- New/Revised ICD-10 codes: None Added
- Deleted ICD-10 codes
  - E08.329: Diabetes mellitus due to underlying condition with other diabetic kidney complication
  - E08.331: Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy with macular edema
  - E08.339: Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy without macular edema
  - E08.341: Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy with macular edema
  - E08.349: Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy without macular edema
  - E08.351: Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with macular edema
  - E08.359: Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy without macular edema
  - E09.321: Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy with macular edema
  - E09.329: Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy without macular edema
  - E09.331: Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy with macular edema
  - E09.339: Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy without macular edema
  - E09.341: Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy with macular edema
  - E09.349: Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy without macular edema
  - E09.351: Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with macular edema
  - E09.359: Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy without macular edema
  - E10.321: Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema
  - E10.329: Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema
  - E10.331: Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema
  - E10.339: Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema
  - E10.341: Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema
  - E10.349: Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema
- **E10.351**: Type 1 diabetes mellitus with diabetic peripheral angiopathy without gangrene
- **E10.359**: Type 1 diabetes mellitus with other circulatory complications
- **E11.321**: Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema
- **E11.329**: Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema
- **E11.331**: Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema
- **E11.339**: Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema
- **E11.341**: Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema
- **E11.349**: Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema
- **E11.351**: Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema
- **E11.359**: Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema
- **E13.321**: Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema
- **E13.329**: Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema
- **E13.331**: Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema
- **E13.339**: Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema
- **E13.341**: Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema
- **E13.349**: Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema
- **E13.351**: Other specified diabetes mellitus with proliferative diabetic retinopathy with macular edema
- **E13.359**: Other specified diabetes mellitus with proliferative diabetic retinopathy without macular edema
- **E78.0**: Pure hypercholesterolemia
- **I60.21**: Nontraumatic subarachnoid hemorrhage from right anterior communicating artery
- **I60.22**: Nontraumatic subarachnoid hemorrhage from left anterior communicating artery
- **I69.01**: Cognitive deficits following nontraumatic subarachnoid hemorrhage
- **I69.11**: Cognitive deficits following nontraumatic intracerebral hemorrhage
- **I69.21**: Dysphasia following nontraumatic subarachnoid hemorrhage
- **I69.31**: Cognitive deficits following cerebral infarction
- **I69.81**: Cognitive deficits following other cerebrovascular disease
- **J98.5**: Diseases of mediastinum, not elsewhere classified
- **K52.2**: Allergic and dietetic gastroenteritis and colitis
- **K55.0**: Acute vascular disorders of intestine
- **K85.0**: Idiopathic acute pancreatitis
- **K85.1**: Biliary acute pancreatitis
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- K85.2: Alcohol induced acute pancreatitis
- K85.3: Drug induced acute pancreatitis
- K85.8: Other acute pancreatitis
- K86.8: Other specified diseases of pancreas
- Q25.2: Atresia of aorta
- Q25.4: Other congenital malformations of aorta
- R97.2: Elevated prostate specific antigen (PSA)
- T85.81XA: Embolism due to internal prosthetic devices, implants and grafts, not elsewhere classified, initial encounter
- T85.82XA: Fibrosis due to internal prosthetic devices, implants and grafts, not elsewhere classified, initial encounter
- T85.89XA: Other specified complication of internal prosthetic devices, implants and grafts, not elsewhere classified, initial encounter
- Z98.89: Other specified postprocedural states

View the locally hosted Noridian Active LCD PDF.

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

Facet Joint Injections, Medial Branch Blocks, and Facet Joint Radiofrequency Neurotomy – JFA LCD Number Change – Effective November 2, 2016

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

Medicare Coverage Database (MCD) Number: L35178

LCD Title: Facet Joint Injections, Medial Branch Blocks, and Facet Joint Radiofrequency Neurotomy

Effective Date: November 2, 2016

Summary of Changes: LCD number L35178 for Jurisdiction F Part A (JFA) was retired on November 2, 2016 and combined into Jurisdiction F Part B (JFB) LCD number L34995. JFA and JFB contract numbers will have the same final MCD LCD number and remain an Active LCD. Coverage will remain the same.

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

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

Flow Cytometry 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).
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Medicare Coverage Database (MCD) Number: L36094

LCD Title: Flow Cytometry

Effective Date: October 1, 2016

Summary of Changes: This LCD has been updated to correct typographical errors and to add ICD-10 codes.

- New/Revised ICD-10 codes:
  - C49.A1 - Gastrointestinal stromal tumor of esophagus
  - C49.A2 - Gastrointestinal stromal tumor of stomach
  - C49.A3 - Gastrointestinal stromal tumor of small intestine
  - C49.A4 - Gastrointestinal stromal tumor of large intestine
  - C49.A5 - Gastrointestinal stromal tumor of rectum
  - C49.A9 - Gastrointestinal stromal tumor of other sites
  - D47.Z2 - Castleman disease
  - D89.40 - Mast cell activation, unspecified
  - D89.41 - Monoclonal mast cell activation syndrome
  - D89.42 - Idiopathic mast cell activation syndrome
  - D89.43 - Other mast cell activation disorder
  - D89.49 - Other mast cell activation disorder
  - N42.30 - Unspecified dysplasia of prostate
  - N42.31 - Prostatic intraepithelial neoplasia
  - N42.32 - Atypical small acinar proliferation of prostate and
  - N42.39 - Other dysplasia of prostate

View the locally hosted Noridian Active LCD PDF.

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

- Locate and select above listed LCD title.

Flow Cytometry LCD – 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: L36094

LCD Title: Flow Cytometry

Effective Date: October 1, 2015

Summary of Changes: LCD revised to add ICD-10 codes:

- C85.11 - Unspecified B-cell lymphoma, lymph nodes of head, face, and neck
- C85.12 - Unspecified B-cell lymphoma, intrathoracic lymph nodes
- C85.13 - Unspecified B-cell lymphoma, intra-abdominal lymph nodes
- C85.14 - Unspecified B-cell lymphoma, lymph nodes of axilla and upper limb
- C85.15 - Unspecified B-cell lymphoma, lymph nodes of inguinal region and lower limb
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- C85.16 - Unspecified B-cell lymphoma, intrapelvic lymph nodes
- C85.17 - Unspecified B-cell lymphoma, spleen
- C85.18 - Unspecified B-cell lymphoma, lymph nodes of multiple sites and
- C85.19 - Unspecified B-cell lymphoma, extranodal and solid organ sites

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

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

Injections - Tendon, Ligament, Ganglion Cyst, Tunnel Syndromes and Morton’s Neuroma 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: L34076
LCD Title: Injections - Tendon, Ligament, Ganglion Cyst, Tunnel Syndromes and Morton’s Neuroma
Effective Date: 10/1/2016
Summary of Changes: This LCD has been updated to include and/or remove ICD-10 codes.

- New/Revised ICD-10 codes
  - G56.03, G57.53, G57.63, S03.41XA, S03.41XD, S03.41XS, S03.42XA, S03.42XD, S03.42XS, S03.43XA, S03.43XD and S03.43XS
- Deleted ICD-10 codes
  - S03.4XXA, S03.4XXD and S03.4XXS

View the locally hosted Noridian Active LCD PDF.

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

Immune Globulin Intravenous (IVIg) JFA LCD Number Change – Effective November 10, 2016

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

Medicare Coverage Database (MCD) Number: L34092
LCD Title: Immune Globulin Intravenous (IVIg)
Effective Date: November 10, 2016
Summary of Changes: LCD number L34092 for Jurisdiction F Part A (JFA) was retired on November 9, 2016 and combined into Jurisdiction F Part B (JFB) LCD number L34074. JFA and JFB contract numbers will have the same final MCD LCD number and remain an Active LCD. Coverage will remain the same.
MEDICAL POLICIES

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

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

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

Immune Globulin Intravenous (IVlg) - 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: L34074

LCD Title: Immune Globulin Intravenous (IVlg)

Effective Date: October 1, 2016

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

• New/Revised ICD-10 codes
  – G61.82 – Other Inflammatory polyneuropathies, Multifocal Motor Neuropathy

View the locally hosted Noridian Active LCD PDF.

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

• Locate and select above listed LCD title

Lumbar Epidural Injections LCD – R7

The following JF Local Coverage Determination (LCD) has been revised under contractor numbers 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT), 03601 (WY) and 02102 (AK), 02202 (ID), 02302 (OR), 02402 (WA), 03102 (AZ), 03202 (MT), 03302 (ND), 03402 (SD), 03502 (UT), 03602 (WY).

Medicare Coverage Database (MCD) Number: L34980

LCD Title: Lumbar Epidural Injections

Effective Date: January 1, 2017

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

• New/Revised CPT codes
  – 62322: Injection(s), of diagnostic or therapeutic substance(s) (e.g. Anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance.
  – 62323: Injection(s), of diagnostic or therapeutic substance(s) (e.g. anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (i.e. fluoroscopy or CT).
- **62326**: Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance.

- **62327**: Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (i.e. Fluoroscopy or CT).

- **Deleted CPT codes**
  - **62311**: Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; lumbar or sacral (caudal)
  - **62319**: Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, includes contrast for localization when performed, epidural or subarachnoid; lumbar or sacral (caudal)

View the locally hosted Noridian Future LCD PDF.

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

- Locate and select above listed LCD title

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**Lumbar Epidural Injection – JFA LCD Number Change – Effective November 10, 2016**

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

**Medicare Coverage Database (MCD) Number**: L34983

**LCD Title**: Lumbar Epidural Injection

**Effective Date**: November 10, 2016

**Summary of Changes**: LCD number L34983 for Jurisdiction F Part A (JFA) was retired on November 9, 2016 and combined into Jurisdiction F Part B (JFB) LCD number L34980. JFA and JFB contract numbers will have the same final MCD LCD number and remain an Active LCD. Coverage will remain the same.

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

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

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

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**MolDX: Biomarkers in Cardiovascular Risk Assessment JFA and JFB LCD Number Changes - Effective October 1, 2016**

The following JF Local Coverage Determination (LCD) has been retired under contractor 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT), 03601 (WY).
Medicare Coverage Database (MCD) Number: DL36360

LCD Title: MolDX: Biomarkers in Cardiovascular Risk Assessment

Effective Date: October 1, 2016

Summary of Changes: LCD number DL36360 for Jurisdiction F Part A (JFA) was retired on October 1, 2016 and combined into Jurisdiction F Part B (JFB) LCD number L36362. JFA and JFB contract numbers will have the same final MCD LCD number and remain an Active LCD. Coverage will remain the same.

This LCD has also been updated to include and/or remove ICD-10 codes.

- New/Revised ICD-10 codes
  - E78.00 – Pure hypercholesterolemia, unspecified
  - E78.01 – Familial hypercholesterolemia

- Deleted ICD-10 codes
  - E78.0 – Pure hypercholesterolemia

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

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

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


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

Medicare Coverage Database (MCD) Number: L36321

LCD Title: MolDX: Breast Cancer Index℠ Genetic Assay

Effective Date: November 16, 2016

Summary of Changes: LCD number L36321 for Jurisdiction F Part A (JFA) was retired on November 16, 2016 and combined into Jurisdiction F Part B (JFB) LCD number L36316. JFA and JFB contract numbers will have the same final MCD LCD number and remain an Active LCD. Coverage will remain the same.

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

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

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

MolDX-CDD: ConfirmMDx Epigenetic Molecular Assay JFA and JFB LCD Number Changes - Effective October 1, 2016

The following JF Local Coverage Determination (LCD) has been retired under contractor 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT), 03601 (WY).
Medicare Coverage Database (MCD) Number: L36328

LCD Title: MolDX-CDD: ConfirmMDx Epigenetic Molecular Assay

Effective Date: October 1, 2016

Summary of Changes: LCD number L36328 for Jurisdiction F Part A (JFA) was retired on October 1, 2016 and combined into Jurisdiction F Part B (JFB) LCD number L36329. JFA and JFB contract numbers will have the same final MCD LCD number and remain an Active LCD. Coverage will remain the same.

This LCD has also been updated to include and/or remove ICD-10 codes.

- New/Revised ICD-10 codes
  - R97.20 – Elevated prostate specific antigen (PSA)

- Deleted ICD-10 codes
  - R97.2 - Elevated prostate specific antigen (PSA)

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

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

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

MolDX-CDD: ConfirmMDx Epigenetic Molecular Assay 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: L36329

LCD Title: MolDX-CDD: ConfirmMDx Epigenetic Molecular Assay

Effective Date: 10/01/16

Summary of Changes: The Part A LCD (L36328) is retired and Part A contract numbers are added to the Part B LCD (L36329).

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

- New/Revised ICD-10 codes
  - R92.20 - Elevated prostate specific antigen (PSA)
  - N40.0 - Benign prostatic hyperplasia without lower urinary tract symptoms
  - N40.1 - Benign prostatic hyperplasia with lower urinary tract symptoms

- Deleted ICD-10 codes
  - R97.2 - Elevated prostate specific antigen (PSA)

View the locally hosted Noridian Active LCD PDF.

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

- Locate and select above listed LCD title

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

Medicare Coverage Database (MCD) Number: L36344

LCD Title: MolDX-CDD: Decipher® Prostate Cancer Classifier

Effective Date: November 16, 2016

Summary of Changes: LCD number L36344 for Jurisdiction F Part A (JFA) was retired on November 16, 2016 and combined into Jurisdiction F Part B (JFB) LCD number L36345. JFA and JFB contract numbers will have the same final MCD LCD number and remain an Active LCD. Coverage will remain the same.

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

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

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


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

Medicare Coverage Database (MCD) Number: L36324

LCD Title: MolDX: GeneSight® Assay for Refractory Depression

Effective Date: November 16, 2016

Summary of Changes: LCD number L36324 for Jurisdiction F Part A (JFA) was retired on November 16, 2016 and combined into Jurisdiction F Part B (JFB) LCD number L36325. JFA and JFB contract numbers will have the same final MCD LCD number and remain an Active LCD. Coverage will remain the same.

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

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

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


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

Medicare Coverage Database (MCD) Number: L36349
MEDICAL POLICIES

LCD Title: MolDX: Prolaris™ Prostate Cancer Genomic Assay
Effective Date: November 16, 2016

Summary of Changes: LCD number L36349 for Jurisdiction F Part A (JFA) was retired on November 16, 2016 and combined into Jurisdiction F Part B (JFB) LCD number L36350. JFA and JFB contract numbers will have the same final MCD LCD number and remain an Active LCD. Coverage will remain the same.

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

MRI and CT Scan of the Head, Brain and Neck 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: L35175
LCD Title: MRI and CT Scan of the Head, Brain and Neck
Effective Date: October 1, 2016

Summary of Changes:
• LCD has been revised, effective 10/01/2015 to add the 7th character ‘D’ to ICD-10 codes. View the complete LCD for list of codes.
• The following ICD-10-CM codes added with this revision that were effective 10/01/2015, will be deleted effective 10/01/2016 and will not be displayed in this LCD. Noridian will ensure these codes will be payable until 09/30/2016.

<table>
<thead>
<tr>
<th>ICD-10 Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S06.0X2D</td>
<td>Concussion with loss of consciousness of 31 minutes to 59 minutes, subsequent encounter</td>
</tr>
<tr>
<td>S06.0X3D</td>
<td>Concussion with loss of consciousness of 1 hour to 5 hours 59 minutes, subsequent encounter</td>
</tr>
<tr>
<td>S06.0X4D</td>
<td>Concussion with loss of consciousness of 6 hours to 24 hours, subsequent encounter</td>
</tr>
<tr>
<td>S06.0X5D</td>
<td>Concussion with loss of consciousness greater than 24 hours with return to pre-existing conscious level, subsequent encounter</td>
</tr>
<tr>
<td>S06.0X6D</td>
<td>Concussion with loss of consciousness greater than 24 hours without return to pre-existing conscious level, subsequent encounter</td>
</tr>
<tr>
<td>S06.0X7D</td>
<td>Concussion with loss of consciousness greater than 24 hours without return to pre-existing conscious level, subsequent encounter</td>
</tr>
<tr>
<td>S06.0X8D</td>
<td>Concussion with loss of consciousness of any duration with death due to other cause prior to regaining consciousness, subsequent encounter</td>
</tr>
</tbody>
</table>

• Added Effective 8/11/16
and S03.2XXA* may be considered routine dental services. Providers must have documentation available for review to support these services are reasonable and necessary and not routine dental services to the Group 1: Medical Necessity ICD-10 Codes Asterisk Explanation section.

- Effective 10/01/2016, this LCD has been updated to add and remove ICD-10 codes.
  - New ICD-10 codes added to Group 1. View the complete LCD for list of codes.
  - New ICD-10 codes added to Group 2:
    - F32.81 - Premenstrual dysphoric disorder
    - F32.89 - Other specified depressive episodes.
  - Deleted ICD-10 codes from Group 1.

<table>
<thead>
<tr>
<th>ICD-10 Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D49.5</td>
<td>Neoplasm of unspecified behavior of other genitourinary organs</td>
</tr>
<tr>
<td>E08.321</td>
<td>Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy with macular edema</td>
</tr>
<tr>
<td>E08.329</td>
<td>Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy without macular edema</td>
</tr>
<tr>
<td>E08.331</td>
<td>Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy with macular edema</td>
</tr>
<tr>
<td>E08.339</td>
<td>Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy without macular edema</td>
</tr>
<tr>
<td>E08.341</td>
<td>Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy without macular edema</td>
</tr>
<tr>
<td>E08.349</td>
<td>Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy without macular edema</td>
</tr>
<tr>
<td>E08.351</td>
<td>Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with macular edema</td>
</tr>
<tr>
<td>E08.359</td>
<td>Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy without macular edema</td>
</tr>
<tr>
<td>E09.321</td>
<td>Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema</td>
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<tr>
<td>E09.329</td>
<td>Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema</td>
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<tr>
<td>E09.331</td>
<td>Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema</td>
</tr>
<tr>
<td>E09.339</td>
<td>Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema</td>
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<td>E09.341</td>
<td>Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema</td>
</tr>
<tr>
<td>E09.349</td>
<td>Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema</td>
</tr>
<tr>
<td>E09.351</td>
<td>Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with macular edema</td>
</tr>
<tr>
<td>E10.359</td>
<td>Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema</td>
</tr>
<tr>
<td>E11.351</td>
<td>Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema</td>
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<tr>
<td>E11.359</td>
<td>Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema</td>
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<tr>
<td>E13.321</td>
<td>Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema</td>
</tr>
<tr>
<td>ICD-10 Code</td>
<td>Description</td>
</tr>
<tr>
<td>------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>E13.329</td>
<td>Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema</td>
</tr>
<tr>
<td>E13.331</td>
<td>Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema</td>
</tr>
<tr>
<td>E13.339</td>
<td>Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema</td>
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<tr>
<td>E13.341</td>
<td>Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema</td>
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<tr>
<td>E13.349</td>
<td>Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema</td>
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<tr>
<td>E13.351</td>
<td>Other specified diabetes mellitus with proliferative diabetic retinopathy with macular edema</td>
</tr>
<tr>
<td>E13.359</td>
<td>Other specified diabetes mellitus with proliferative diabetic retinopathy without macular edema</td>
</tr>
<tr>
<td>H34.811</td>
<td>Central retinal vein occlusion, right eye</td>
</tr>
<tr>
<td>H34.812</td>
<td>Central retinal vein occlusion, left eye</td>
</tr>
<tr>
<td>H34.813</td>
<td>Central retinal vein occlusion, bilateral</td>
</tr>
<tr>
<td>H34.819</td>
<td>Central retinal vein occlusion, unspecified eye</td>
</tr>
<tr>
<td>H34.831</td>
<td>Tributary (branch) retinal vein occlusion, right eye</td>
</tr>
<tr>
<td>H34.832</td>
<td>Tributary (branch) retinal vein occlusion, left eye</td>
</tr>
<tr>
<td>H34.833</td>
<td>Tributary (branch) retinal vein occlusion, bilateral</td>
</tr>
<tr>
<td>H34.839</td>
<td>Tributary (branch) retinal vein occlusion, unspecified eye</td>
</tr>
<tr>
<td>I60.20</td>
<td>Nontraumatic subarachnoid hemorrhage from unspecified anterior communicating artery</td>
</tr>
<tr>
<td>I60.21</td>
<td>Nontraumatic subarachnoid hemorrhage from right anterior communicating artery</td>
</tr>
<tr>
<td>I60.22</td>
<td>Nontraumatic subarachnoid hemorrhage from left anterior communicating artery</td>
</tr>
<tr>
<td>I69.01</td>
<td>Cognitive deficits following nontraumatic subarachnoid hemorrhage</td>
</tr>
<tr>
<td>I69.11</td>
<td>Cognitive deficits following nontraumatic intracerebral hemorrhage</td>
</tr>
<tr>
<td>I69.21</td>
<td>Cognitive deficits following other nontraumatic intracranial hemorrhage</td>
</tr>
<tr>
<td>I69.31</td>
<td>Cognitive deficits following cerebral infarction</td>
</tr>
<tr>
<td>I69.81</td>
<td>Cognitive deficits following other cerebrovascular disease</td>
</tr>
<tr>
<td>I69.91</td>
<td>Cognitive deficits following unspecified cerebrovascular disease</td>
</tr>
<tr>
<td>I97.62</td>
<td>Postprocedural hemorrhage and hematoma of a circulatory system organ or structure following other procedure</td>
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<tr>
<td>M26.60</td>
<td>Temporomandibular joint disorder, unspecified</td>
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<tr>
<td>M26.61</td>
<td>Adhesions and ankylosis of temporomandibular joint</td>
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<tr>
<td>M26.62</td>
<td>Arthralgia of temporomandibular joint</td>
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<tr>
<td>M26.63</td>
<td>Articular disc disorder of temporomandibular joint</td>
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<tr>
<td>M50.02</td>
<td>Cervical disc disorder with myelopathy, mid-cervical region</td>
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<tr>
<td>M50.12</td>
<td>Cervical disc disorder with radiculopathy, mid-cervical region</td>
</tr>
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<td>Other cervical disc displacement, mid-cervical region</td>
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<td>M50.32</td>
<td>Other cervical disc degeneration, mid-cervical region</td>
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<tr>
<td>M50.82</td>
<td>Other cervical disc disorders, mid-cervical region</td>
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<tr>
<td>M50.92</td>
<td>Cervical disc disorder, unspecified, mid-cervical region</td>
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<td>S02.10XA</td>
<td>Unspecified fracture of base of skull, initial encounter for closed fracture</td>
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<tr>
<td>ICD-10 Code</td>
<td>Description</td>
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<td>-------------</td>
<td>-------------</td>
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<tr>
<td>S02.10XA</td>
<td>Unspecified fracture of base of skull, initial encounter for closed fracture</td>
</tr>
<tr>
<td>S02.10XB</td>
<td>Unspecified fracture of base of skull, initial encounter for open fracture</td>
</tr>
<tr>
<td>S02.10XD</td>
<td>Unspecified fracture of base of skull, subsequent encounter for fracture with routine healing</td>
</tr>
<tr>
<td>S02.10XK</td>
<td>Unspecified fracture of base of skull, subsequent encounter for fracture with nonunion</td>
</tr>
<tr>
<td>S02.10XS</td>
<td>Unspecified fracture of base of skull, sequela</td>
</tr>
<tr>
<td>S02.3XXA</td>
<td>Fracture of orbital floor, initial encounter for closed fracture</td>
</tr>
<tr>
<td>S02.3XXB</td>
<td>Fracture of orbital floor, initial encounter for open fracture</td>
</tr>
<tr>
<td>S02.3XXD</td>
<td>Fracture of orbital floor, subsequent encounter for fracture with routine healing</td>
</tr>
<tr>
<td>S02.3XXK</td>
<td>Fracture of orbital floor, subsequent encounter for fracture with nonunion</td>
</tr>
<tr>
<td>S02.3XXS</td>
<td>Fracture of orbital floor, sequela</td>
</tr>
<tr>
<td>S02.61XA</td>
<td>Fracture of condylar process of mandible, initial encounter for closed fracture</td>
</tr>
<tr>
<td>S02.61XB</td>
<td>Fracture of condylar process of mandible, initial encounter for open fracture</td>
</tr>
<tr>
<td>S02.61XD</td>
<td>Fracture of condylar process of mandible, subsequent encounter for fracture with routine healing</td>
</tr>
<tr>
<td>S02.61XK</td>
<td>Fracture of condylar process of mandible, subsequent encounter for fracture with nonunion</td>
</tr>
<tr>
<td>S02.61XS</td>
<td>Fracture of condylar process of mandible, sequela</td>
</tr>
<tr>
<td>S02.62XA</td>
<td>Fracture of subcondylar process of mandible, initial encounter for closed fracture</td>
</tr>
<tr>
<td>S02.62XB</td>
<td>Fracture of subcondylar process of mandible, initial encounter for open fracture</td>
</tr>
<tr>
<td>S02.62XD</td>
<td>Fracture of subcondylar process of mandible, subsequent encounter for fracture with routine healing</td>
</tr>
<tr>
<td>S02.62XK</td>
<td>Fracture of subcondylar process of mandible, subsequent encounter for fracture with nonunion</td>
</tr>
<tr>
<td>S02.62XS</td>
<td>Fracture of subcondylar process of mandible, sequela</td>
</tr>
<tr>
<td>S02.63XA</td>
<td>Fracture of coronoid process of mandible, initial encounter for closed fracture</td>
</tr>
<tr>
<td>S02.63XB</td>
<td>Fracture of coronoid process of mandible, initial encounter for open fracture</td>
</tr>
<tr>
<td>S02.63XD</td>
<td>Fracture of coronoid process of mandible, subsequent encounter for fracture with routine healing</td>
</tr>
<tr>
<td>S02.63XK</td>
<td>Fracture of coronoid process of mandible, subsequent encounter for fracture with nonunion</td>
</tr>
<tr>
<td>S02.63XS</td>
<td>Fracture of coronoid process of mandible, sequela</td>
</tr>
<tr>
<td>S02.64XA</td>
<td>Fracture of ramus of mandible, initial encounter for closed fracture</td>
</tr>
<tr>
<td>S02.64XB</td>
<td>Fracture of ramus of mandible, initial encounter for open fracture</td>
</tr>
<tr>
<td>S02.64XD</td>
<td>Fracture of ramus of mandible, subsequent encounter for fracture with routine healing</td>
</tr>
<tr>
<td>S02.64XK</td>
<td>Fracture of ramus of mandible, subsequent encounter for fracture with nonunion</td>
</tr>
<tr>
<td>S02.64XS</td>
<td>Fracture of ramus of mandible, sequela</td>
</tr>
<tr>
<td>S02.65XA</td>
<td>Fracture of angle of mandible, initial encounter for closed fracture</td>
</tr>
<tr>
<td>S02.65XB</td>
<td>Fracture of angle of mandible, initial encounter for open fracture</td>
</tr>
<tr>
<td>S02.65XD</td>
<td>Fracture of angle of mandible, subsequent encounter for fracture with routine healing</td>
</tr>
<tr>
<td>S02.65XK</td>
<td>Fracture of angle of mandible, subsequent encounter for fracture with nonunion</td>
</tr>
<tr>
<td>S02.65XS</td>
<td>Fracture of angle of mandible, sequela</td>
</tr>
<tr>
<td>S02.67XA</td>
<td>Fracture of alveolus of mandible, initial encounter for closed fracture</td>
</tr>
<tr>
<td>S02.67XB</td>
<td>Fracture of alveolus of mandible, initial encounter for open fracture</td>
</tr>
<tr>
<td>S02.67XD</td>
<td>Fracture of alveolus of mandible, subsequent encounter for fracture with routine healing</td>
</tr>
<tr>
<td>S02.67XK</td>
<td>Fracture of alveolus of mandible, subsequent encounter for fracture with nonunion</td>
</tr>
<tr>
<td>ICD-10 Code</td>
<td>Description</td>
</tr>
<tr>
<td>-------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>S02.67X</td>
<td>Fracture of alveolus of mandible, sequela</td>
</tr>
<tr>
<td>S02.8XXA</td>
<td>Fractures of other specified skull and facial bones, initial encounter for closed fracture</td>
</tr>
<tr>
<td>S02.8XXB</td>
<td>Fractures of other specified skull and facial bones, initial encounter for open fracture</td>
</tr>
<tr>
<td>S02.8XXD</td>
<td>Fractures of other specified skull and facial bones, subsequent encounter for fracture with routine healing</td>
</tr>
<tr>
<td>S02.8XXXK</td>
<td>Fractures of other specified skull and facial bones, subsequent encounter for fracture with nonunion</td>
</tr>
<tr>
<td>S02.8XXS</td>
<td>Fractures of other specified skull and facial bones, sequela</td>
</tr>
<tr>
<td>S03.0XXA</td>
<td>Dislocation of jaw, initial encounter</td>
</tr>
<tr>
<td>S03.4XXA</td>
<td>Sprain of jaw, initial encounter</td>
</tr>
<tr>
<td>S06.0X2A</td>
<td>Concussion with loss of consciousness of 31 minutes to 59 minutes, initial encounter</td>
</tr>
<tr>
<td>S06.0X2S</td>
<td>Concussion with loss of consciousness of 31 minutes to 59 minutes, sequela</td>
</tr>
<tr>
<td>S06.0X3A</td>
<td>Concussion with loss of consciousness of 1 hour to 5 hours 59 minutes, initial encounter</td>
</tr>
<tr>
<td>S06.0X3S</td>
<td>Concussion with loss of consciousness of 1 hour to 5 hours 59 minutes, sequela</td>
</tr>
<tr>
<td>S06.0X4A</td>
<td>Concussion with loss of consciousness of 6 hours to 24 hours, initial encounter</td>
</tr>
<tr>
<td>S06.0X4S</td>
<td>Concussion with loss of consciousness of 6 hours to 24 hours, sequela</td>
</tr>
<tr>
<td>S06.0X5A</td>
<td>Concussion with loss of consciousness greater than 24 hours with return to pre-existing conscious level, initial encounter</td>
</tr>
<tr>
<td>S06.0X5S</td>
<td>Concussion with loss of consciousness greater than 24 hours with return to pre-existing conscious level, sequela</td>
</tr>
<tr>
<td>S06.0X6A</td>
<td>Concussion with loss of consciousness greater than 24 hours without return to pre-existing conscious level, initial encounter</td>
</tr>
<tr>
<td>S06.0X6S</td>
<td>Concussion with loss of consciousness greater than 24 hours without return to pre-existing conscious level, sequela</td>
</tr>
<tr>
<td>S06.0X7A</td>
<td>Concussion with loss of consciousness greater than 24 hours without return to pre-existing conscious level</td>
</tr>
<tr>
<td>S06.0X7S</td>
<td>Concussion with loss of consciousness greater than 24 hours without return to pre-existing conscious level, sequela</td>
</tr>
<tr>
<td>S06.0X8A</td>
<td>Concussion with loss of consciousness of any duration with death due to other cause prior to regaining consciousness, initial encounter</td>
</tr>
<tr>
<td>S06.0X8S</td>
<td>Concussion with loss of consciousness of any duration with death due to other cause prior to regaining consciousness, sequela</td>
</tr>
<tr>
<td>T85.81XA</td>
<td>Embolism due to internal prosthetic devices, implants and grafts, not elsewhere classified, initial encounter</td>
</tr>
<tr>
<td>T85.82XA</td>
<td>Fibrosis due to internal prosthetic devices, implants and grafts, not elsewhere classified, initial encounter</td>
</tr>
<tr>
<td>T85.83XA</td>
<td>Hemorrhage due to internal prosthetic devices, implants and grafts, not elsewhere classified, initial encounter</td>
</tr>
<tr>
<td>T85.84XA</td>
<td>Pain due to internal prosthetic devices, implants and grafts, not elsewhere classified, initial encounter</td>
</tr>
<tr>
<td>T85.85XA</td>
<td>Stenosis due to internal prosthetic devices, implants and grafts, not elsewhere classified, initial encounter</td>
</tr>
<tr>
<td>T85.86XA</td>
<td>Thrombosis due to internal prosthetic devices, implants and grafts, not elsewhere classified, initial encounter</td>
</tr>
<tr>
<td>T85.89XA</td>
<td>Other specified complication of internal prosthetic devices, implants and grafts, not elsewhere classified, initial encounter</td>
</tr>
</tbody>
</table>
• LCD number L35177 for JFA was retired on October 1, 2016 and combined into JFB LCD number L35175. JFA and JFB contract numbers will have the same final MCD LCD number and remain an Active LCD.

View the locally hosted Noridian Active LCD PDF.
• Go to https://med.noridianmedicare.com/web/jfa/policies/lcd/active
  – The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
• Locate and select above listed LCD title

**Nerve Blockade for Treatment of Chronic Pain – JFA LCD Number Change – Effective November 10, 2016**

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

**Medicare Coverage Database (MCD) Number:** L35458

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

**Effective Date:** November 10, 2016

**Summary of Changes:** LCD number L35458 for Jurisdiction F Part A (JFA) was retired on November 9, 2016 and combined into Jurisdiction F Part B (JFB) LCD number L35457. JFA and JFB contract numbers will have the same final MCD LCD number and remain an Active LCD. Coverage will remain the same.

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

**Nerve Blockade for Treatment of Chronic Pain and Neuropathy LCD – R7**

The following JF Local Coverage Determination (LCD) has been revised under contractor numbers 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03300 (ND), 03401 (SD), 03501 (UT), 03601 (WY).

**Medicare Coverage Database (MCD) Number:** L35458

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

**Effective Date:** October 01, 2016

**Summary of Changes:** This LCD has been updated to include and/or remove ICD-10 codes.
• New/Revised ICD-10 codes
  – G56.03 - Other lesions of median nerve, bilateral upper limbs;
  – G56.13 - Other lesions of median nerve, bilateral upper limbs;
  – G56.23 - Lesion of ulnar nerve, bilateral upper limbs;
  – G56.33 - Lesion of radial nerve, bilateral upper limbs;
  – G56.43 - Causalgia of bilateral upper limbs;
  – G56.92 - Unspecified mononeuropathy of left upper limb;
MEDICAL POLICIES

- **G57.03** - Lesion of sciatic nerve, bilateral lower limbs;
- **G57.13** - Meralgia paresthetica, bilateral lower limbs;
- **G57.23** - Lesion of femoral nerve, bilateral lower limbs;
- **G57.33** - Lesion of lateral popliteal nerve, bilateral lower limbs;
- **G57.43** - Lesion of medial popliteal nerve, bilateral lower limbs;
- **G57.53** - Tarsal tunnel syndrome, bilateral lower limbs;
- **G57.63** - Lesion of plantar nerve, bilateral lower limbs and added the group 1 Asterisk section with G57.61 and G57.62;
- **G57.73** - Causalgia of bilateral lower limbs;
- **M50.121** - Cervical disc disorder at C4-C5 level with radiculopathy;
- **M50.122** - Cervical disc disorder at C5-C6 level with radiculopathy;
- **M50.123** - Cervical disc disorder at C6-C7 level with radiculopathy;
- **M50.221** - Other cervical disc displacement at C4-C5 level;
- **M50.222** - Other cervical disc displacement at C5-C6 level;
- **M50.223** - Other cervical disc displacement at C6-C7 level;
- **M50.321** - Other cervical disc degeneration at C4-C5 level;
- **M50.322** - Other cervical disc degeneration at C5-C6 level; and
- **M50.323** - Other cervical disc degeneration at C6-C7 level;

- Deleted ICD-10 codes
  - **M50.12** - Cervical disc disorder with radiculopathy, mid-cervical region;
  - **M50.22** - Other cervical disc displacement, mid-cervical region; and
  - **M50.32** - Other cervical disc degeneration, mid-cervical region.

View the locally hosted Noridian Active LCD PDF.

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

- Locate and select above listed LCD title.

**Nerve Blockade for Treatment of Chronic Pain and Neuropathy LCD – R9**

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

**Medicare Coverage Database (MCD) Number:** L35457

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

**Effective Date:** January 1, 2017

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

- New/Revised CPT/HCPCS codes:
  - **62320** - injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance.
  - **62321** - Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid,
steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or ct).

- 62324 - Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance.

- 62325 - Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or ct).

- Deleted CPT/HCPCS codes:
  - 62310 - injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic.
  - 62318 - Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic.

View the locally hosted Noridian Future Active LCD PDF.

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

- Locate and select above listed LCD title

**Nerve Conduction Studies and Electromyography 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:** L36526

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

**Effective Date:** 10/1/2016

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

- New/Revised ICD-10 codes
  - G56.03, G56.13, G56.23, G56.33, G56.43, G56.83, G56.93, G57.03, G57.13, G57.23, G57.33, G57.43, G57.53, G57.63, G57.73, G57.83, G57.93, G61.82, M50.021, M50.022, M50.023, M50.121, M50.122, M50.123, M50.221, M50.222, M50.223, M50.321, M50.322, M50.323, M50.821, M50.822, M50.823, S54.8X1A and S54.8X2A.

- Deleted ICD-10 codes
  - M50.02, M50.12, M50.22, M50.32, M50.82.

View the locally hosted Noridian Active LCD PDF.

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

- Locate and select above listed LCD title.
Non Covered Services LCD – R18

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, LCD

Effective Date: January 1, 2017

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

- New/Revised CPT/HCPCS codes added to Group I
  - 43284, 43285, 0446T, 0447T, 0449T, 0450T, 0451T, 0452T, 0453T, 0454T, 0455T, 0456T, 0457T, 0458T, 0459T, 0460T, 0461T, 0462T, 0463T, 0464T, 0465T, 0466T, 0467T, 0478T
- Deleted CPT/HCPCS codes from Group I
  - 0019T, 0169T, 0286T, 0287T, 0288T, 0289T, 0291T, 0292T

View the locally hosted Noridian Future Active LCD PDF.
- Go to https://med.noridianmedicare.com/web/jfa/policies/lcd/future
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
- Locate and select above listed LCD title

Outpatient Cardiac Rehabilitation – R1

The following Noridian coverage requirements for the Outpatient Cardiac Rehabilitation 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: Outpatient Cardiac Rehabilitation NCD 20.0.1

Effective Date: December 22, 2016

Article Summary of Changes: This article has been revised to combine this Local Coverage Article JFA A54069 into the JFB article A54070 so that both JFA and JFB contract numbers will have the same final MCD article number as JFB A54070 effective 12/22/2016. The following ICD-10 codes have been added effective for DOS on or after 09/13/2016.

- I21.01- ST elevation (STEMI) myocardial infarction involving left main coronary artery
- I21.02 - ST elevation (STEMI) myocardial infarction involving left anterior descending coronary artery
- I22.0 - Subsequent ST elevation (STEMI) myocardial infarction of anterior wall
- I22.1 - Subsequent ST elevation (STEMI) myocardial infarction of inferior wall
- I22.8 - Subsequent ST elevation (STEMI) myocardial infarction of other sites.

Read the complete National Coverage Determination requirements article
- The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).

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

To view a complete list of all CMS NCDs available, go to National Coverage Determinations (NCDs) Alphabetical Index
**Radiofrequency Ablation of Uterine Fibroids Article Retirement – Effective December 22, 2016**

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

**Medicare Coverage Database Number:** A53262  
**Article Title:** Radiofrequency Ablation of Uterine Fibroids  
**Effective Date:** December 22, 2016

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

- On the “Medicare Coverage Articles” page, select the state of interest in the table under “Retired Articles.”
  - This link will redirect you to the CMS website.

- Locate the above-listed CMS Medicare Coverage Database (MCD) number and article title and select the title of interest.

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**Sacral Nerve Stimulation for Urinary and Fecal Incontinence – R2**

The following Noridian coverage requirements for the Sacral Nerve Stimulation for Urinary and Fecal Incontinence 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:** Sacral Nerve Stimulation for Urinary Incontinence (230.18)  
**Summary of Changes:** The Part A coverage article (A53358) is retired effective 9/30/16 and Part A contract numbers are added to the Part B coverage article.

The following diagnoses are added effective 10/1/2016: N39.492, R39.191 and R39.192

The following diagnosis is added effective 10/1/2015: R93.11

**Effective Date:** 10/01/16

[Read the complete National Coverage Determination requirements article.](https://med.noridianmedicare.com/web/jfa/policies/coverage-articles)

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

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.](https://med.noridianmedicare.com/web/jfa/policies/coverage-articles)

To view a complete list of all CMS NCDs available, go to [National Coverage Determinations (NCDs) Alphabetical Index](https://med.noridianmedicare.com/web/jfa/policies/coverage-articles).
Serum Magnesium 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: L34509

LCD Title: Serum Magnesium

Effective Date: October 1, 2016

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

- New/Revised ICD-10 codes
  - E08.3211 - Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy with macular edema, right eye
  - E08.3212 - Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy with macular edema, left eye
  - E08.3213 - Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy with macular edema, bilateral
  - E08.3291 - Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy without macular edema, right eye
  - E08.3292 - Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy without macular edema, left eye
  - E08.3293 - Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy without macular edema, bilateral
  - E08.3311 - Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy with macular edema, right eye
  - E08.3312 - Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy with macular edema, left eye
  - E08.3313 - Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy with macular edema, bilateral
  - E08.3391 - Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy without macular edema, right eye
  - E08.3392 - Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy without macular edema, left eye
  - E08.3393 - Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy without macular edema, bilateral
  - E08.3411 - Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy with macular edema, right eye
  - E08.3412 - Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy with macular edema, left eye
  - E08.3413 - Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy with macular edema, bilateral
  - E08.3491 - Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with macular edema, right eye
  - E08.3492 - Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with macular edema, left eye
  - E08.3493 - Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with macular edema, bilateral
- E08.3511 - Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with macular edema, right eye
- E08.3512 - Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with macular edema, left eye
- E08.3513 - Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with macular edema, bilateral
- E08.3591 - Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy without macular edema, right eye
- E08.3592 - Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy without macular edema, left eye
- E08.3593 - Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy without macular edema, bilateral
- E09.3211 - Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, right eye
- E09.3212 - Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, left eye
- E09.3213 - Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, bilateral
- E09.3291 - Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, right eye
- E09.3411 - Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, right eye
- E09.3412 - Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, left eye
- E09.3413 - Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, bilateral
- E09.3491 - Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, right eye
- E09.3492 - Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, left eye
- E09.3493 - Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, bilateral
- E09.3511 - Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with macular edema, right eye
- E09.3512 - Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with macular edema, left eye
- E09.3513 - Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with macular edema, bilateral
- E09.3591 - Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy without macular edema, right eye
- E09.3592 - Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy without macular edema, left eye
- E09.3593 - Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy without macular edema, bilateral
- E10.3211 - Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, right eye
- E10.3212 - Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, left eye
- E10.3213 - Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, bilateral
- E10.3291 - Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, right eye
- E10.3292 - Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, left eye
- E10.3293 - Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, bilateral
- E10.3311 - Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, right eye
- E10.3312 - Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, left eye
- E10.3313 - Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, bilateral
- E10.3391 - Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, right eye
- E10.3392 - Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, left eye
- E10.3393 - Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, bilateral
- E10.3411 - Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, right eye
- E10.3412 - Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, left eye
- E10.3413 - Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, bilateral
- E10.3491 - Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, right eye
- E10.3492 - Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, left eye
- E10.3493 - Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, bilateral
- E10.3511 - Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema, right eye
- E10.3512 - Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema, left eye
- E10.3513 - Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema, bilateral
- E10.3551 - Type 1 diabetes mellitus with stable proliferative diabetic retinopathy, right eye
- E10.3552 - Type 1 diabetes mellitus with stable proliferative diabetic retinopathy, left eye
- E10.3553 - Type 1 diabetes mellitus with stable proliferative diabetic retinopathy, bilateral
- E10.3591 - Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema, right eye
- E10.3592 - Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema, left eye
- E10.3593 - Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema, bilateral
- E11.3211 - Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema, right eye
- E11.3212 - Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema, left eye
- E11.3213 - Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema, bilateral
- E11.3291 - Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, right eye
- E11.3292 - Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, left eye
- E11.3293 - Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, bilateral
- E11.3311 - Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, right eye
- E11.3312 - Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, left eye
- E11.3313 - Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, bilateral
- E11.3391 - Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, right eye
- E11.3392 - Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, left eye
- E11.3393 - Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, bilateral
- E11.3411 - Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, right eye
- E11.3412 - Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, left eye
- E11.3413 - Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, bilateral
- E11.3491 - Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, right eye
- E11.3492 - Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, left eye
- E11.3493 - Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, bilateral
- E11.3511 - Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema, right eye
- E11.3512 - Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema, left eye
- E11.3513 - Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema, bilateral
- E11.3591 - Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema, right eye
- E11.3592 - Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema, left eye
- E11.3593 - Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema, bilateral
- E13.3211 - Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, right eye
- E13.3212 - Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, left eye
- E13.3213 - Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, bilateral
- E13.3291 - Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, right eye
- E13.3292 - Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, left eye
- E13.3293 - Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, bilateral
- E13.3311 - Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, right eye
- E13.3312 - Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, left eye
- E13.3313 - Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, bilateral
- E13.3391 - Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, right eye
- E13.3392 - Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, left eye
- E13.3393 - Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, bilateral
- E13.3411 - Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, right eye
- E13.3412 - Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, left eye
- E13.3413 - Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, bilateral
- E13.3491 - Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, right eye
- E13.3492 - Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, left eye
- E13.3493 - Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, bilateral
- E13.3511 - Other specified diabetes mellitus with proliferative diabetic retinopathy with macular edema, right eye
- E13.3512 - Other specified diabetes mellitus with proliferative diabetic retinopathy with macular edema, left eye
- E13.3513 - Other specified diabetes mellitus with proliferative diabetic retinopathy with macular edema, bilateral
- E13.3591 - Other specified diabetes mellitus with proliferative diabetic retinopathy without macular edema, right eye
- E13.3592 - Other specified diabetes mellitus with proliferative diabetic retinopathy without macular edema, left eye
- E13.3593 - Other specified diabetes mellitus with proliferative diabetic retinopathy with macular edema, bilateral
- F42.2 - Mixed obsessional thoughts and acts
- F42.3 - Hoarding disorder
- F42.4 - Excoriation (skin-picking) disorder
- F42.8 - Other obsessive-compulsive disorder
- F42.9 - Obsessive-compulsive disorder, unspecified
- F50.81 - Binge eating disorder
- F50.89 - Other specified eating disorder
- K52.21 - Food protein-induced enterocolitis syndrome
- K52.22 - Food protein-induced enteropathy
- K52.29 - Other allergic and dietetic gastroenteritis and colitis
- K52.831 - Collagenous colitis
- K52.832 - Lymphocytic colitis
- K52.838 - Other microscopic colitis
- K90.41 - Non-celiac gluten sensitivity
- K90.49 - Malabsorption due to intolerance, not elsewhere classified

* Deleted ICD-10 codes

- E08.321 - Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy with macular edema
- E08.329 - Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy without macular edema
- E08.331 - Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy with macular edema
- E08.339 - Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy without macular edema
- E08.341 - Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy with macular edema
- E08.349 - Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy without macular edema
- E08.351 - Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with macular edema
- E08.359 - Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy without macular edema
- E09.321 - Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema
- E09.329 - Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema
- E09.331 - Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema
- E09.339 - Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema
- E09.341 - Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with macular edema
- E09.349 - Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy without macular edema
- E09.351 - Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with macular edema
- E09.359 - Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy without macular edema
- E10.321 - Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema
- E10.329 - Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema
- E10.331 - Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema
- E10.339 - Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema
- E10.341 - Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema
- E10.349 - Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema
- E10.351 - Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema
- E10.359 - Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema
- E11.321 - Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema
- E11.329 - Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema
- E11.331 - Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema
- E11.339 - Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema
- E11.341 - Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema
- E11.349 - Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema
- E11.351 - Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema
- E11.359 - Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema
- E13.321 - Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema
- E13.329 - Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema
- E13.331 - Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema
- E13.339 - Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema
- E13.341 - Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema
- E13.349 - Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema
- E13.351 - Other specified diabetes mellitus with proliferative diabetic retinopathy with macular edema
- E13.359 - Other specified diabetes mellitus with proliferative diabetic retinopathy without macular edema
- F50.8 - Other eating disorders
- K52.2 - Allergic and dietetic gastroenteritis and colitis
- K90.4 - Malabsorption due to intolerance, not elsewhere classified

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

**Serum Magnesium 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**: L34509

**LCD Title**: Serum Magnesium

**Effective Date**: October 1, 2016

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

- New/Revised ICD-10 codes missed in Revision 3:
  - E09.3292 - Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, left eye
  - E09.3293 - Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, bilateral
  - E09.3411 - Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, right eye.

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

**Special Histochemical Stains and Immunohistochemical Stains – JFA LCD Number Change – Effective November 16, 2016**

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

**Medicare Coverage Database (MCD) Number**: L36353

**LCD Title**: Special Histochemical Stains and Immunohistochemical Stains

**Effective Date**: November 16, 2016
Summary of Changes: LCD number L36353 for Jurisdiction F Part A (JFA) was retired on November 16, 2016 and combined into Jurisdiction F Part B (JFB) LCD number L36352. JFA and JFB contract numbers will have the same final MCD LCD number and remain an Active LCD. Coverage will remain the same.

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

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

Spinal Cord Stimulators for Chronic Pain 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: L36204

LCD Title: Spinal Cord Stimulators for Chronic Pain

Effective Date: October 1, 2016

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

- New/Revised ICD-10 codes:
  - G57.73 - Causalgia of bilateral lower limbs
  - T85.113A - Breakdown (mechanical) of implanted electronic neurostimulator, generator, initial encounter
  - T85.113D - Breakdown (mechanical) of implanted electronic neurostimulator, generator, subsequent encounter
  - T85.113S - Breakdown (mechanical) of implanted electronic neurostimulator, generator, sequel
  - T85.123A - Displacement of implanted electronic neurostimulator, generator, initial encounter
  - T85.123D - Displacement of implanted electronic neurostimulator, generator, subsequent encounter
  - T85.123S - Displacement of implanted electronic neurostimulator, generator, sequela
  - T85.193A - Other mechanical complication of implanted electronic neurostimulator, generator, initial encounter
  - T85.193D - Other mechanical complication of implanted electronic neurostimulator, generator, subsequent encounter
  - T85.193S - Other mechanical complication of implanted electronic neurostimulator, generator, sequela

View the locally hosted Noridian Active LCD PDF.

- Go to [https://med.noridianmedicare.com/web/jfa/policies/lcd/active](https://med.noridianmedicare.com/web/jfa/policies/lcd/active)
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
- Locate and select above listed LCD title.
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Spinal Cord Stimulators for Chronic Pain 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: L36204

LCD Title: Spinal Cord Stimulators for Chronic Pain

Effective Date: October 1, 2016

Summary of Changes: This LCD has been updated to clarify that a repeat trial is not needed when replacing the stimulator due to the need for battery change, malfunction or end of stimulator life. Also deleted HCPCS code from Group 2:
L8680 - Implantable neurostimulator electrode.

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

Stereotactic Radiation Therapy: Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiation Therapy (SBRT) 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: L34151

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

Effective Date: July 1, 2016

Summary of Changes: LCD is revised to add G25.0 to Group 1 ICD-10 codes. Coverage Indications, Limitations and/or Medical Necessity were revised to include, “8. Unilateral thalamotomy using stereotactic radiosurgery may be used to treat limb tremor in Essential Tremor that is refractory to medical management using at least two drugs but is not currently recommended by the Guidelines of the American Academy of Neurology” and Sources of Information and Basis for Decision was updated to include, “ 8. Zesiewicz TA, Elble R, Louis ED, et al., Practice Parameter: Therapies for essential tremor, Report of the Quality Standards Subcommittee of the American Academy of Neurology, Neurology 2005; 64; 2008-2020, 2005.”

This LCD, effective 7/1/2016, combines JFA L34136 into the JFB LCD so that both JFA and JFB contract numbers will have the same MCD LCD number.

To access the Noridian Active LCDs from our website, follow the instructions below.
• Go to https://med.noridianmedicare.com/web/jfa/policies/lcd/active
  – The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
• On the “Active LCDs” page, locate the above listed LCD title.
  – This link will direct you to the locally hosted copy of the Active LCD. You may also view the LCD on the CMS MCD by selecting the appropriate state link at the top of the page and locating the LCD title.
Total Hip Arthroplasty 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: L36573

LCD Title: Total Hip Arthroplasty

Effective Date: October 01, 2016

Summary of Changes: Effective 09/07/2016 this LCD is revised to remove the following 7th character information from Paragraph 1 and added each appropriate 7th character to each of the appropriate diagnosis codes.

- The appropriate 7th character is to be added to each code from category M80 as well as to each code from subcategories M84.3, M84.4, M84.5 and M84.6 from the following list:
  - A: initial encounter for fracture
  - D: subsequent encounter for fracture with routine healing
  - G: subsequent encounter for fracture with delayed healing
  - K: subsequent encounter for fracture with nonunion
  - P: subsequent encounter for fracture with malunion
  - S: sequela

- The appropriate 7th character is to be added to each code from category S32 from the following list:
  - A: initial encounter for closed fracture
  - B: initial encounter for open fracture
  - D: subsequent encounter for fracture with routine healing
  - G: subsequent encounter for fracture with delayed healing
  - K: subsequent encounter for fracture with nonunion
  - S: sequela

- The appropriate 7th character is to be added to all of the codes from category S72 from the following list:
  - A: initial encounter for closed fracture
  - B: initial encounter for open fracture type I or II initial encounter for open fracture NOS
  - C: initial encounter for open fracture type IIIA, IIIB, or IIIC
  - D: subsequent encounter for closed fracture with routine healing
  - E: subsequent encounter for open fracture type I or II with routine healing
  - F: subsequent encounter for open fracture type IIIA, IIIB, or IIIC with routine healing
  - G: subsequent encounter for closed fracture with delayed healing
  - H: subsequent encounter for open fracture type I or II with delayed healing
  - J: subsequent encounter for open fracture type IIIA, IIIB, or IIIC with delayed healing
  - K: subsequent encounter for closed fracture with nonunion
  - M: subsequent encounter for open fracture type I or II with nonunion
  - N: subsequent encounter for open fracture type IIIA, IIIB, or IIIC with nonunion
  - P: subsequent encounter for closed fracture with malunion
  - Q: subsequent encounter for open fracture type I or II with malunion
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- R: subsequent encounter for open fracture type IIIA, IIIB, or IIIC with malunion
- S: sequela

• The appropriate 7th character is to be added to each code from subcategory S79.0 from the following list:
  - A: initial encounter for closed fracture
  - D: subsequent encounter for fracture with routine healing
  - G: subsequent encounter for fracture with delayed healing
  - K: subsequent encounter for fracture with nonunion
  - P: subsequent encounter for fracture with malunion
  - S: sequela

• The appropriate 7th character is to be added to each code from category T84 from the following list:
  - A: initial encounter
  - D: subsequent encounter
  - S: sequela

Effective 10/01/2016 this LCD has also been updated to include and/or remove ICD-10 codes.

• New ICD-10 codes
  - M97.01XA - Periprosthetic fracture around internal prosthetic right hip joint, initial encounter
  - M97.01XD - Periprosthetic fracture around internal prosthetic right hip joint, subsequent encounter
  - M97.01XS - Periprosthetic fracture around internal prosthetic right hip joint, sequela
  - M97.02XA - Periprosthetic fracture around internal prosthetic left hip joint, initial encounter
  - M97.02XD - Periprosthetic fracture around internal prosthetic left hip joint, subsequent encounter
  - M97.02XS - Periprosthetic fracture around internal prosthetic left hip joint, sequela

• Deleted ICD-10 codes
  - T84.040A - Periprosthetic fracture around internal prosthetic right hip joint, initial encounter
  - T84.040D - Periprosthetic fracture around internal prosthetic right hip joint, subsequent encounter
  - T84.040S - Periprosthetic fracture around internal prosthetic right hip joint, sequela
  - T84.041A - Periprosthetic fracture around internal prosthetic left hip joint, initial encounter
  - T84.041D - Periprosthetic fracture around internal prosthetic left hip joint, subsequent encounter
  - T84.041S - Periprosthetic fracture around internal prosthetic left hip joint, sequela

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• Locate and select above listed LCD title.

**Total Knee Arthroplasty 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:** L36577
**LCD Title:** Total Knee Arthroplasty

**Effective Date:** October 01, 2016

**Summary of Changes:** Effective 09/07/2016 LCD revised to remove the following 7th character information from Paragraph 1 and added each appropriate 7th character to each of the appropriate diagnosis codes.

- The appropriate 7th character is to be added to each code from category **M80 as well as to each code from subcategories M84.3, M84.4, M84.5 and M84.6** from the following list:
  - A: initial encounter for fracture
  - D: subsequent encounter for fracture with routine healing
  - G: subsequent encounter for fracture with delayed healing
  - K: subsequent encounter for fracture with nonunion
  - P: subsequent encounter for fracture with malunion
  - S: sequela

- The appropriate 7th character is to be added to all of the codes from category **S72** from the following list:
  - A: initial encounter for closed fracture
  - B: initial encounter for open fracture type I or II initial encounter for open fracture NOS
  - C: initial encounter for open fracture type IIIA, IIIB, or IIIC
  - D: subsequent encounter for closed fracture with routine healing
  - E: subsequent encounter for open fracture type I or II with routine healing
  - F: subsequent encounter for open fracture type IIIA, IIIB, or IIIC with routine healing
  - G: subsequent encounter for closed fracture with delayed healing
  - H: subsequent encounter for open fracture type I or II with delayed healing
  - J: subsequent encounter for open fracture type IIIA, IIIB, or IIIC with delayed healing
  - K: subsequent encounter for closed fracture with nonunion
  - M: subsequent encounter for open fracture type I or II with nonunion
  - N: subsequent encounter for open fracture type IIIA, IIIB, or IIIC with nonunion
  - P: subsequent encounter for closed fracture with malunion
  - Q: subsequent encounter for open fracture type I or II with malunion
  - R: subsequent encounter for open fracture type IIIA, IIIB, or IIIC with malunion
  - S: sequela

  - EXCEPT to subcategory **S72.47** to which the appropriate 7th character is to be added to all codes from the following list:
    - A: initial encounter for closed fracture
    - D: subsequent encounter for closed fracture with routine healing
    - G: subsequent encounter for closed fracture with delayed healing
    - K: subsequent encounter for closed fracture with nonunion
    - P: subsequent encounter for closed fracture with malunion
    - S: sequela

- The appropriate 7th character is to be added to each code from subcategory **S79.1** from the following list:
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- A: initial encounter for closed fracture
- D: subsequent encounter for fracture with routine healing
- G: subsequent encounter for fracture with delayed healing
- K: subsequent encounter for fracture with nonunion
- P: subsequent encounter for fracture with malunion
- S: sequela

• The appropriate 7th character is to be added to all of the codes from category **S82** from the following list:
  - A: initial encounter for closed fracture
  - B: initial encounter for open fracture type I or II initial encounter for open fracture NOS
  - C: initial encounter for open fracture type IIIA, IIIB, or IIIC
  - D: subsequent encounter for closed fracture with routine healing
  - E: subsequent encounter for open fracture type I or II with routine healing
  - F: subsequent encounter for open fracture type IIIA, IIIB, or IIIC with routine healing
  - G: subsequent encounter for closed fracture with delayed healing
  - H: subsequent encounter for open fracture type I or II with delayed healing
  - J: subsequent encounter for open fracture type IIIA, IIIB, or IIIC with delayed healing
  - K: subsequent encounter for closed fracture with nonunion
  - M: subsequent encounter for open fracture type I or II with nonunion
  - N: subsequent encounter for open fracture type IIIA, IIIB, or IIIC with nonunion
  - P: subsequent encounter for closed fracture with malunion
  - Q: subsequent encounter for open fracture type I or II with malunion
  - R: subsequent encounter for open fracture type IIIA, IIIB, or IIIC with malunion
  - S: sequela

• **EXCEPT** to subcategory **S82.16** to which the appropriate 7th character is to be added to all codes from the following list:
  - A: initial encounter for closed fracture
  - D: subsequent encounter for closed fracture with routine healing
  - G: subsequent encounter for closed fracture with delayed healing
  - K: subsequent encounter for closed fracture with nonunion
  - P: subsequent encounter for closed fracture with malunion
  - S: sequela

• The appropriate 7th character is to be added to each code from subcategory **S89.0** from the following list:
  - A: initial encounter for closed fracture
  - D: subsequent encounter for closed fracture with routine healing
  - G: subsequent encounter for closed fracture with delayed healing
  - K: subsequent encounter for closed fracture with nonunion
  - P: subsequent encounter for closed fracture with malunion
  - S: sequela
MEDICAL POLICIES

• The appropriate 7th character is to be added to each code from category T84 from the following list:
  – A: initial encounter
  – D: subsequent encounter
  – S: sequela
• Effective 10/01/2016 LCD revised to add ICD-10-CM codes:
  – M97.11XA - Periprosthetic fracture around internal prosthetic right knee joint, initial encounter
  – M97.11XD - Periprosthetic fracture around internal prosthetic right knee joint, subsequent encounter
  – M97.11XS - Periprosthetic fracture around internal prosthetic right knee joint, sequela
  – M97.12XA - Periprosthetic fracture around internal prosthetic left knee joint, initial encounter
  – M97.12XD - Periprosthetic fracture around internal prosthetic left knee joint, subsequent encounter
  – M97.12XS - Periprosthetic fracture around internal prosthetic left knee joint, sequela
• Effective 10/01/2016 deleted ICD-10 CM codes:
  – T84.042A - Periprosthetic fracture around internal prosthetic right knee joint, initial encounter
  – T84.042D - Periprosthetic fracture around internal prosthetic right knee joint, subsequent encounter
  – T84.042S - Periprosthetic fracture around internal prosthetic right knee joint, sequela
  – T87.043A - Periprosthetic fracture around internal prosthetic left knee joint, initial encounter
  – T84.043D - Periprosthetic fracture around internal prosthetic left knee joint, subsequent encounter
  – T84.043S - Periprosthetic fracture around internal prosthetic left knee joint, sequela
View the locally hosted Noridian Active LCD PDF.
• Go to https://med.noridianmedicare.com/web/jfa/policies/lcd/active
  – The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
• Locate and select above listed LCD title

Treatment of Males with Low Testosterone 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) 02102 (AK), 02202 (ID), 02302 (OR), 02402 (WA), 03102 (AZ), 03202 (MT), 03302 (ND), 03402 (SD), 03502 (UT), 03602 (WY).

Medicare Coverage Database (MCD) Number: L36569

LCD Title: Treatment of Males with Low Testosterone

Effective Date: January 1, 2017

Summary of Changes: This LCD has been updated to include and/or remove CPT/HCPCS codes.
• New/Revised CPT/HCPCS codes
  – 84410: Testosterone; Bioavailable, direct measurement. (e.g. Differential precipitation).

View the locally hosted Noridian Future Active LCD PDF.
• Go to https://med.noridianmedicare.com/web/jfa/policies/lcd/future
  – The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
• Locate and select above listed LCD title
Treatment of Varicose Veins of the Lower Extremities 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) 02102 (AK), 02202 (ID), 02302 (OR), 02402 (WA), 03102 (AZ), 03202 (MT), 03302 (ND), 03402 (SD), 03502 (UT), 03602 (WY).

**Medicare Coverage Database (MCD) Number:** L34010

**LCD Title:** Treatment of Varicose Veins of the Lower Extremities

**Effective Date:** January 1, 2017

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

- **New/Revised CPT/HCPCS codes**
  - 36473: All imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated.
  - 36474: Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; subsequent veins(s) treated in a single extremity, each through separate access sites. (list separately in addition to code for primary procedure)

- **Deleted CPT/HCPCS codes**
  - 36299: (effective 12/31/2016): Unlisted procedure, vascular injection

View the locally hosted Noridian Future Active LCD PDF.

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

- Locate and select above listed LCD title

Treatment of Males with Low Testosterone 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:** L36569

**LCD Title:** Treatment of Males with Low Testosterone

**Effective Date:** 10/01/2016

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

- **New/Revised ICD-10 codes**
  - N50.89: Other specified disorders of the male genital organs

View the locally hosted Noridian Active LCD PDF.

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

- Locate and select above listed LCD title

Vitamin D Assay Testing Final LCD – Effective February 3, 2017

The following Local Coverage Determination (LCD) has completed the Open Public and Contractor Advisory Committee (CAC) comment period and is now finalized under contractor numbers 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) 03601 (WY) 02102 (AK), 02202 (ID), 02302 (OR), 02402 (WA), 03102 (AZ), 03202 (MT), 03302 (ND), 03402 (SD), 03502 (UT) and 03602 (WY).
Vitamin D Assay Testing LCD - R3

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

**Medicare Coverage Database (MCD) Number:** L34051

**LCD Title:** Vitamin D Assay Testing

**Effective Date:** 10/01/2016

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

- **New/Revised ICD-10 codes**
  - **E89820:** Postprocedural hematoma of an endocrine system organ or structure following an endocrine system procedure
MEDICAL POLICIES

- **E89821**: Postprocedural hematoma of an endocrine system organ or structure following other procedure
- **E89822**: Postprocedural seroma of an endocrine system organ or structure following an endocrine system procedure
- **E89823**: Postprocedural seroma of an endocrine system organ or structure following other procedure
- **K9041**: Non-celiac gluten sensitivity
- **K9049**: Malabsorption due to intolerance, not elsewhere classified

**Deleted ICD-10 codes**
- **K90.4**: Malabsorption due to intolerance, not elsewhere classified.

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

**Vitamin D Assay Testing LCD Retirement – Effective February 2, 2017**

The following JF Local Coverage Determination (LCD) will be 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**: L34094

**LCD Title**: Vitamin D Assay Testing

**Effective Date**: February 2, 2017

**Summary of Changes**: Jurisdiction F Part A (JFA) LCD L34094 will be retired on February 2, 2017 and combined with the Jurisdiction F Part B (JFB) LCD L34051. JFA and JFB contract numbers will have the same final MCD LCD number and remain an Active LCD.

To access the Noridian Retired LCDs from our website, follow the instructions below.
- Go to [https://med.noridianmedicare.com/web/jfa/policies/lcd/retired](https://med.noridianmedicare.com/web/jfa/policies/lcd/retired)
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
  - On the “Retired LCDs” page, select the state of interest.
  - This link will redirect you to the CMS website.
  - Select “Noridian Healthcare Solutions, LLC.” Locate the above listed CMS Medicare Coverage Database (MCD) number and LCD title and select the title of interest.
**Physicians! Are You Ordering Nebulizers and Inhalation Medication for Your Patient?**

Medicare will consider coverage of a nebulizer, compressor and related accessories when the patient’s medical record verifies the patient has a condition that requires certain inhalation medication (as outlined below).

For the nebulizer compressor only (E0570, E0575, E0580, E0585, K0730), the following is required prior to delivery:

<table>
<thead>
<tr>
<th>Nebulizer - Documentation prior to delivery</th>
<th>Nebulizer - Prescription prior to delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>A face-to-face-visit within six months prior to prescribing:</td>
<td>A five element order (5EO) with the following:</td>
</tr>
<tr>
<td>Documenting the patient was evaluated and/or treated for the condition supporting need for the item(s) ordered</td>
<td>• Patient name</td>
</tr>
<tr>
<td></td>
<td>• Item ordered</td>
</tr>
<tr>
<td></td>
<td>• National Provider Identifier (NPI) of prescribing practitioner</td>
</tr>
<tr>
<td></td>
<td>• Date of the order</td>
</tr>
<tr>
<td></td>
<td>• Prescribing practitioner signature</td>
</tr>
</tbody>
</table>

For any item provided based on physician contact with a DME supplier to provide the service (i.e., dispensing order), the supplier must obtain a detailed written order (DWO) before submitting a claim. The detailed written order must contain:

<table>
<thead>
<tr>
<th>Detailed Written Order (DWO) elements prior to billing</th>
<th>Items provided on a periodic basis, inhalation drugs and related accessories/supplies must include</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beneficiary’s name</td>
<td>Item(s) to be dispensed</td>
</tr>
<tr>
<td>Prescribing practitioner’s name</td>
<td>Frequency of use</td>
</tr>
<tr>
<td>Date of the order</td>
<td>Quantity to be dispensed</td>
</tr>
<tr>
<td>Detailed description of the item(s)</td>
<td>Number of refills</td>
</tr>
<tr>
<td>Prescribing practitioner’s signature and signature date</td>
<td></td>
</tr>
</tbody>
</table>

The DME MAC Nebulizers Local Coverage Determination (LCD) L33370 outlines the coverage criteria for the nebulizer, related compressor, and FDA–approved nebulizer drugs and other related accessories/supplies.

The charts below provide the various types of nebulizers and inhalation drugs covered by Medicare for specific disease categories.

**Small Volume Nebulizers A7003-A7005 Compressor E0570**

<table>
<thead>
<tr>
<th>Obstructive Pulmonary Disease</th>
<th>Cystic Fibrosis</th>
<th>Cystic Fibrosis or Bronchiectasis</th>
<th>HIV, Pneumocystosis, or Organ Transplants</th>
<th>Persistent Pulmonary Secretions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group 8 Codes)</td>
<td>(Group 9 Codes)</td>
<td>(Group 10 Codes)</td>
<td>(Group 4 Codes)</td>
<td>(Group 7 Codes)</td>
</tr>
<tr>
<td>Albutorol (J7611, J7613)</td>
<td>Dornase Alpha J7639</td>
<td>Tobramycin J7682</td>
<td>Pentamidine J2545</td>
<td>Acetylcysteine J7608</td>
</tr>
</tbody>
</table>
### NEBULIZERS

<table>
<thead>
<tr>
<th>Drug</th>
<th>Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arformoterol</td>
<td>J7605</td>
</tr>
<tr>
<td>Budesonide</td>
<td>J7626</td>
</tr>
<tr>
<td>Cromolyn</td>
<td>J7631</td>
</tr>
<tr>
<td>Formoterol</td>
<td>J7606</td>
</tr>
<tr>
<td>Ipratropium</td>
<td>J7644</td>
</tr>
<tr>
<td>Levalbuterol</td>
<td>J7612, J7614</td>
</tr>
<tr>
<td>Metaproterenol</td>
<td>J7669</td>
</tr>
</tbody>
</table>

**Large Volume Nebulizer A7007, A7017 • Compressor E0565, E0572**

Water/Saline A4217 or A7018 or Combination Code E0585

<table>
<thead>
<tr>
<th>Condition</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Persistent thick and tenacious Pulmonary Secretions</td>
<td>(Group 5 Codes)</td>
</tr>
<tr>
<td>Cystic Fibrosis</td>
<td></td>
</tr>
<tr>
<td>Bronchiectasis</td>
<td></td>
</tr>
<tr>
<td>Tracheostomy</td>
<td></td>
</tr>
<tr>
<td>Tracheobronchial Stent</td>
<td></td>
</tr>
<tr>
<td>Acetylcysteine J7608</td>
<td></td>
</tr>
</tbody>
</table>

Diagnosis codes that support medical necessity Group 5 codes section for applicable diagnoses.

**Compressor E0565 or E0572 • Filtered Nebulizer A7006**

Persistent thick and tenacious Pulmonary Secretions

<table>
<thead>
<tr>
<th>Condition</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV</td>
<td></td>
</tr>
<tr>
<td>Pneumocystosis</td>
<td></td>
</tr>
<tr>
<td>Complications of Organ Transplants</td>
<td></td>
</tr>
<tr>
<td>(Group 1 Codes)</td>
<td></td>
</tr>
<tr>
<td>Pentamidine J2545</td>
<td></td>
</tr>
</tbody>
</table>

**Small Volume Ultrasonic Nebulizer E0574**

Accessories A7013, A7014, A7016

Pulmonary Hypertension with Additional Criteria

<table>
<thead>
<tr>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Group 1 Codes)</td>
</tr>
<tr>
<td>Tresprostinil J7686</td>
</tr>
</tbody>
</table>

The Nebulizers Local Coverage Determination (LCD) L33370 provides the usual maximum frequency of replacement of related accessories/supplies, as well as, the maximum milligrams per month of inhalation drugs that are reasonable and necessary.

**Please note:** If none of the drugs (as outlined above) used with a nebulizer are covered; the compressor, the nebulizer, and other related accessories/supplies will be denied as not reasonable and necessary.

Local Coverage Determinations for Nebulizers

**Jurisdiction A:** [https://med.noridianmedicare.com/documents/2230703/7218263/Nebulizers/db04b968-5cd0-4445-9707-0fe51d34ec80](https://med.noridianmedicare.com/documents/2230703/7218263/Nebulizers/db04b968-5cd0-4445-9707-0fe51d34ec80)
Medicare A News | Noridian Medicare A Jurisdiction F | January 2017 | Issue No. 2130

**NEBULIZERS**

Jurisdiction B: [http://www.cgsmedicare.com/jb/coverage/lcdinfo.html](http://www.cgsmedicare.com/jb/coverage/lcdinfo.html)

Jurisdiction C: [http://www.cgsmedicare.com/jc/coverage/lcdinfo.html](http://www.cgsmedicare.com/jc/coverage/lcdinfo.html)

Jurisdiction D: [https://med.noridianmedicare.com/documents/2230703/7218263/Nebulizers/db04b968-5cd0-4445-9707-0fe51d34ec80](https://med.noridianmedicare.com/documents/2230703/7218263/Nebulizers/db04b968-5cd0-4445-9707-0fe51d34ec80)

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**REIMBURSEMENT**

**Implement Operating Rules - Phase III ERA EFT: CORE 360 Uniform Use of CARC, RARC and Claim Adjustment Group Code Rule - Update from CAQH CORE**

MLN Matters® Number: MM9767

Related Change Request (CR) #: CR 9767

Related CR Release Date: November 23, 2016

Effective Date: April 1, 2017

Related CR Transmittal #: R3665CP

Implementation Date: April 3, 2017

**Provider Types Affected**

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

**Provider Action Needed**

Change Request (CR) 9767 informs MACs of the regular update in the Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) defined code combinations per Operating Rule 360 - Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule. Make sure that your billing staffs are aware of these changes.

**Background**

The Department of Health and Human Services (HHS) adopted the Phase III CAQH CORE Electronic Funds Transfer (EFT) & Electronic Remittance Advice (ERA) Operating Rule Set that was implemented on January 1, 2014, under the Patient Protection and Affordable Care Act. The Health Insurance Portability and Accountability Act (HIPAA) amended the Act by adding Part C—Administrative Simplification—to Title XI of the Social Security Act, requiring the Secretary of HHS (the Secretary) to adopt standards for certain transactions to enable health information to be exchanged more efficiently and to achieve greater uniformity in the transmission of health information.

Through the Affordable Care Act, Congress sought to promote implementation of electronic transactions and achieve cost reduction and efficiency improvements by creating more uniformity in the implementation of standard transactions. This was done by mandating the adoption of a set of operating rules for each of the HIPAA transactions. The Affordable Care Act defines operating rules and specifies the role of operating rules in relation to the standards.

CR9767 deals with the regular update in CAQH CORE defined code combinations per Operating Rule 360 - Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule.

CAQH CORE will publish the next version of the Code Combination List on or about February 1, 2017. This update is based on the Claim Adjustment Reason Code (CARC), Remittance Advice Remark Code (RARC) updates as posted at the WPC website on or about November 1, 2016. This will also include updates based on Market Based Review (MBR) 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/reference](http://www.wpc-edi.com/reference) for CARC and RARC updates and

Note: Per 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/Group Code for a minimum set of 4 Business Scenarios. Medicare can use any code combination if the business scenario is not one of the 4 CORE defined business scenarios. With the 4 CORE defined business scenarios, Medicare must use the code combinations from the lists published by CAQH CORE.

Additional Information

FISS Implementation of the Restructured Clinical Lab Fee Schedule

MLN Matters® Number: MM9837
Related Change Request (CR) #: CR 9837
Related CR Release Date: November 10, 2016
Effective Date: January 1, 2018
Related CR Transmittal #: R3653CP
Implementation Date: July 3, 2017

Provider Types Affected
This MLN Matters® Article is intended for clinical laboratory providers submitting claims to Medicare Administrative Contractors (MACs) for services paid under the Clinical Lab Fee Schedule (CLFS) and provided to Medicare beneficiaries.

Provider Action Needed
Change Request (CR) 9837 informs MACs about the changes to the Fiscal Intermediary Shared System (FISS) to incorporate the revised CLFS containing the National fee schedule rates. Make sure that your billing staffs are aware of these changes.

Background
Section 216 of Public Law 113-93, the “Protecting Access to Medicare Act of 2014,” added Section 1834A to the Social Security Act (the Act). This provision requires extensive revisions to the payment and coverage methodologies for clinical laboratory tests paid under the CLFS. The Centers for Medicare & Medicaid Services (CMS) published the CLFS final rule “Medicare Clinical Diagnostic Laboratory Tests Payment System Final Rule” (CMS-1621-F) was displayed in the Federal Register on June 17, 2016, and was published on June 23, 2016, which implemented the provisions of the new legislation.

The final rule set forth new policies for how CMS sets rates for tests on the CLFS and is effective for dates of service on and after January 1, 2018. Beginning on January 1, 2017, applicable laboratories will be required to submit private payor rate data to CMS. (See MLN Matters Article SE16190 for further details of the laboratory data reporting requirements.) In general, with certain designated exceptions, the payment amount for a test on the CLFS furnished on or after January 1, 2018, will be equal to the weighted median of private payer rates determined for the test, based on data collected from laboratories during a specified data collection period. In addition, a subset of tests on the CLFS, Advanced Diagnostic Laboratory Tests (ADLTs), will have different data, reporting, and payment policies associated with them. In particular, the final rule discusses CMS’ proposals regarding:

- Definition of “applicable laboratory” (who must report data under Section 1834A of the Act)
- Definition of “applicable information” (what data will be reported)
- Data collection period
- Schedule for reporting data to CMS
- Definition of ADLT
**REIMBURSEMENT**

- Data Integrity
- Confidentiality and public release of limited data
- Coding for new tests on the CLFS
- Phased in payment reduction

**Additional Information**


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**2017 MPFS Final Rule, Telehealth Originating Site Facility Fee Payment Amount and Telehealth Services List, and CT Modifier Reduction List**

MLN Matters® Number: MM9844
Related Change Request (CR) #: CR 9844
Related CR Release Date: December 16, 2016
Effective Date: January 1, 2017
Related CR Transmittal #: R3676CP
Implementation Date: January 3, 2017

**Provider Types Affected**

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

**Provider Action Needed**

Change Request (CR) 9844 provides a summary of policies in the Calendar Year (CY) 2017 MPFS Final Rule and announces the Telehealth Originating Site Facility Fee payment amount. Make sure that your billing staffs are aware of these updates.

**Background**

Section 1848(b)(1) of the Social Security Act (the Act) requires the Secretary of Health and Human Services to establish by regulation a fee schedule of payment amounts for physicians’ services for the subsequent year. The Centers for Medicare & Medicaid Services (CMS) issued a final rule on November 2, 2016, that updates payment policies and Medicare payment rates for services furnished by physicians and Non-Physician Practitioners (NPPs) that are paid under the MPFS in CY 2017.


The key changes are as follows:

**CT Modifier Reduction Changes from 5 percent to 15 percent**

As required by Medicare law, effective January 1, 2016, a payment reduction of 5 percent applies to Computed Tomography (CT) services furnished using equipment that is inconsistent with the CT equipment standard and for which payment is made under the MPFS. The payment reduction increases to 15 percent in 2017 and subsequent years. See MLN Matters Article MM9250 at [https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9250.pdf](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9250.pdf) for more details.
Multiple Procedure Payment Reduction (MPPR) on the Professional Component (PC) of Certain Diagnostic Imaging Procedures

As required by Medicare law, CMS revised the MPPR of the PC of the second and subsequent procedures from 25 percent to 5 percent of the physician fee schedule amount. The MPPR on the Technical Component (TC) of imaging remains at 50 percent.

Currently, CMS makes full payment for the PC of the highest-priced procedure and payment at 75 percent for the PC of each additional procedure, when furnished by the same physician (or physician in the same group practice) to the same patient, in the same session on the same day. See MLN Matters Article MM9647 at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9647.pdf for more details.

Telehealth Origination Site Facility Fee Payment Amount Update

Section 1834(m)(2)(B) of the Act establishes the payment amount for the Medicare telehealth originating site facility fee for telehealth services provided from October 1, 2001, through December 31, 2002, at $20. For telehealth services provided on or after January 1 of each subsequent CY, the telehealth originating site facility fee is increased by the percentage increase in the Medicare Economic Index (MEI) as defined in Section 1842(i)(3) of the Act. The MEI increase for 2017 is 1.2 percent. Therefore, for CY 2017, the payment amount for HCPCS code Q3014 (Telehealth originating site facility fee) is 80 percent of the lesser of the actual charge, or $25.40. (The beneficiary is responsible for any unmet deductible amount and Medicare coinsurance.)

Access to Telehealth Services

CMS is adding the following services to the list of those that can be furnished to Medicare beneficiaries under the telehealth benefit:

- ESRD-related services CPT codes 90967 through 90970
- Advance care planning CPT codes 99497 through 99498
- Telehealth consultation HCPCS codes G0508 through G0509

Note: For the ESRD-related services, the required clinical examination of the catheter access site must be furnished face-to-face “hands on” (without the use of an interactive telecommunications system) by a physician, Clinical Nurse Specialist (CNS), Nurse Practitioner (NP), or Physician Assistant (PA). For the complete list of telehealth services, visit http://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/index.html.

New Place of Service (POS) Code for Telehealth

The new POPS is 02 with a description of the location where health services and health related services are provided or received, through telecommunication technology.

X-ray Reduction for Film

As required by Medicare law, Medicare reduces payment amounts under the MPFS by 20 percent for the TC (and the TC of the global fee) of imaging services that are X-rays taken using film, effective January 1, 2017, and after.

To implement this provision, CMS has created Modifier FX (X-ray taken using film). Beginning in 2017, claims for X-rays using film must include Modifier FX, which will result in the applicable payment reduction. See MLN Matters Article MM9727 at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9727.pdf for more details.

Primary Care, Care Management, and Cognitive Services

CMS is finalizing the following coding and payment changes for CY 2017 to improve payment for various primary care, care management, and cognitive services. Each of these codes is included in the 2017 HCPCS update and payment information is included in the routine annual update files:

- Separate payment for existing codes describing prolonged Evaluation and Management (E/M) services without direct patient contact by the physician (or other billing practitioner) (CPT codes 99358, 99359), and increased payment for prolonged E/M services with direct patient contact by the physician (or other billing practitioner) (CPT code 99354) adopting the RUC-recommended values. CPT codes 99358 and
99359 are listed in the “Medicare Claims Processing Manual” as non-payable (Chapter 12, Section 30.6.15.2). As of January 1, 2017, these codes are separately payable under the MPFS and changes to the manual are forthcoming.

- The MPFS includes new coding and payment for Behavioral Health Integration (BHI) services including substance use disorder treatment, specifically three new codes to describe services furnished using the psychiatric Collaborative Care Model (CoCM) (HCPCS codes G0502, G0503, G0504) and one new code to describe services furnished using other BHI care models (HCPCS code G0507).
- Separate payment for complex Chronic Care Management (CCM) services (CPT codes 99487, 99489), reduced administrative burden for CCM (CPT codes 99487, 99489, 99490), and a new add-on code to the CCM initiating visit to account for the work of the billing practitioner in assessing the beneficiary and establishing the CCM care plan (HCPCS code G0506).

**Implementation of Alternative Medicare Physician Fee Schedule (PFS) Locality Configuration for California**

On April 1, 2014, the Protecting Access to Medicare Act of 2014 (PAMA 2014) was signed into law and Section 220(h) of the legislation adds Section 1848(e) (6) of the Act, which now requires, for services furnished on or after January 1, 2017, that the locality definitions for California be based on the Metropolitan Statistical Area (MSA) delineations as defined by the Office of Management and Budget (OMB). The resulting modifications to California’s locality structure increases its number of localities from 9 under the current locality structure to 27 under the MSA based locality structure. However, both the current localities and the MSA based localities are comprised of various component counties, and in some localities only some of the component counties are subject to the blended phase-in and hold harmless provisions required by Section 1848(e)(6)(B) and (C) of the Act. Although the modifications to California’s locality structure increase the number of localities from 9 under the current locality structure, to 27 under the MSA-based locality structure, for purposes of payment, the actual number of localities under the MSA based locality structure would be 32 to account for instances where unique locality numbers are needed.

Additionally, for some of these new localities, PAMA requires that the geographic practice cost index GPCI values that would be realized under the new MSA based locality structure are gradually phased in (in one-sixth increments) over a period of 6 years.

**Update to the Methodology for Calculating GPCIs in the U.S. Territories**

CMS is revising the methodology used to calculate GPCIs in the U.S. territories, whereby Puerto Rico will be assigned the national average of 1.0 to each GPCI, as is currently done in the Virgin Islands in an effort to provide greater consistency in the calculation of the territories’ GPCIs. This change is included in the routine PFS update files.

**Data Collection Required by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) to Accurately Value Global Packages**

CMS finalized a data collection strategy to gather information needed to value global surgical services. Practitioners in Florida, Kentucky, Louisiana, Nevada, New Jersey, North Dakota, Ohio, Oregon and Rhode Island are required, beginning July 1, 2017, to report claims showing that a visit occurred during the post-operative period for select global services. Practitioners who only practice in settings of fewer than 10 practitioners are not required to report, but may do so voluntarily. Such visits will be reported using CPT code 99024. The requirement to report will only apply to specified high-volume/high-cost services. The list of services for which reporting is required will be available on the CMS website. Practitioners who are not required to report are able to report voluntarily and encouraged to do so. If reporting voluntarily, reporting should be done for all visits relating to all codes on the list of applicable codes.

In addition a survey of practitioners will be conducted to gather data on service furnished in the post-operative period.

To the extent that these data result in proposals to revalue any global packages, that revaluation will be done through notice and comment rulemaking at a future time.
CPT code 99024 is currently included on the PFS with a procedure status indicator of “B.”

Valuing Services That Include Moderate Sedation as an Inherent Part of Furnishing the Procedure

The CPT Editorial Panel created CPT codes for separately reporting moderate sedation services, which corresponded to elimination of Appendix G from the CPT Manual, effective January 1, 2017. Appendix G of the CPT Manual identified services where moderate sedation was considered an inherent part of the procedural service. The MPFS Final Rule established valuations for the new moderate sedation CPT codes and revaluation of certain procedural services previously identified in Appendix G. These coding and payment changes provide for payment for moderate sedation services only in cases where moderate sedation services are furnished.

Additional Information


The final 2017 MPFS rule is available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1654-f.html.

Therapy Cap Values - 2017

MLN Matters® Number: MM9865
Related Change Request (CR) #: CR 9865
Related CR Release Date: November 4, 2016
Effective Date: January 1, 2017
Related CR Transmittal #: R3644CP
Implementation Date: January 3, 2017

Provider Types Affected

This MLN Matters® Article is intended for physicians, therapists, and other providers submitting claims to Medicare Administrative Contractors (MACs), including Home Health & Hospice MACs, for outpatient therapy services provided to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 9865, from which this article was developed, describes the amounts and policies for outpatient therapy caps for CY 2017. For physical therapy and speech-language pathology combined, the 2017 therapy cap will be $1,980. For occupational therapy, the cap for 2017 will be $1,980. Make sure that your billing staffs are aware of these therapy cap value updates.

Background

The Balanced Budget Act of 1997 (P.L. 105-33), Section 4541(c) applies annual financial limitations on expenses considered incurred for outpatient therapy services under Medicare Part B per beneficiary, commonly referred to as “therapy caps.” Therapy caps are updated each year based on the Medicare Economic Index.

An exception for the therapy caps for reasonable and medically necessary services has been in place since CY 2006. Originally required by Section 5107 of the Deficit Reduction Act of 2005, the exceptions process for the therapy caps has been continuously extended multiple times through subsequent legislation.

The current therapy caps exceptions process, as required by Section 202 of the Medicare Access and CHIP Reauthorization Act of 2015, expires on December 31, 2017.

CR 9865 establishes that therapy caps for CY 2017 will be $1,980. MACs will update to this amount for physical therapy and speech-language pathology combined, and for occupational therapy.

Additional Information

Payment Rate Increases for RHCs for 2017

MLN Matters® Number: MM9829
Related Change Request (CR) #: CR 9829
Related CR Release Date: October 14, 2016
Effective Date: January 1, 2017
Related CR Transmittal #: R3627CP
Implementation Date: January 3, 2017

Provider Types Affected
This MLN Matters® Article is intended for Rural Health Clinics (RHCs) submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

What You Need to Know
Change Request (CR) 9829 provides MACs instructions for CY 2017 payment rate increases for RHCs. Section 1833(f) of the Social Security Act (the Act) authorizes that the payment limits for a subsequent year shall be increased in accordance with the rate of increase in the Medicare Economic Index (MEI).

Based on historical data through second quarter 2016, the CY 2017 MEI is 1.2 percent. The RHC upper payment limit per visit for CY 2017 is $82.30, effective January 1, 2017, through December 31, 2017. The CY 2017 RHC rate reflects a 1.2 percent increase above the CY 2016 payment limit of $81.32.

Your MAC will not retroactively adjust individual RHC bills paid at previous upper payment limits. However, MACs retain the discretion to make adjustments to the interim payment rate or a lump sum adjustment to total payments already made to take into account any excess or deficiency in payments to date.

Additional Information

RHC and FQHCs - Medicare Benefit Policy Manual Chapter 13 Update

MLN Matters® Number: MM9864
Related Change Request (CR) #: CR 9864
Related CR Release Date: December 9, 2016
Effective Date: March 9, 2017
Related CR Transmittal #: R230BP
Implementation Date: March 9, 2017

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

Provider Action Needed
Change Request (CR) 9864 requires Medicare Administrative Contractors to be aware of the updates to the “Medicare Benefit Policy Manual” - Chapter 13. Make sure that your billing staffs are aware of these changes.

Background
The 2017 update of the “Medicare Benefit Policy Manual,” Chapter 13 - Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services - provides information on requirements and payment
policies for RHCs and FQHCs, as authorized by Section 1861(aa) of the Social Security Act. The Centers for Medicare & Medicaid Services (CMS) has revised Chapter 13 to include that beginning in 2017, the FQHC PPS base rate will be updated by the FQHC Market Basket, and that services furnished by auxiliary personnel incident to a transitional care management (TCM) or chronic care management (CCM) visit may be furnished under general supervision instead of direct supervision, as finalized in the CY 2017 Physician Fee Schedule Final Rule. All other revisions serve to clarify existing policy. The key revised areas include the following sections:

- Section 70.3 revised to include that beginning in 2017, the FQHC PPS base rate will be updated by the FQHC Market Basket.
- Section 110.3 revised to clarify information on payment for Graduate Medical Education in RHCs and FQHCs.
- Section 110.4 revised to include that services furnished by auxiliary personnel incident to a TCM visit may be furnished under general supervision.
- Section 110.5 revised to include services furnished by auxiliary personnel incident to a CCM visit may be furnished under general supervision.
- Section 130.3 updated to remove the payment restriction for an RHC owned by a physician assistant.
- Section 160 updated to remove services furnished incident to a clinical social worker service.
- Section 180 revised to include speech-language pathology services.
- Section 220.4 revised to clarify copayment for FQHC preventive services under the FQHC Prospective Payment System (PPS).

Additional Information

UPDATES

Implementing Provider File Updates and PECOS to FISS Interface Via Extract File Updates to Accommodate Section 603 Bipartisan Budget Act of 2015

MLN Matters® Number: MM9613
Related Change Request (CR) #: CR 9613
Related CR Release Date: August 5, 2016
Effective Date: January 1, 2017
Related CR Transmittal #: R1704OTN
Implementation Date: January 3, 2017

Provider Types Affected
This MLN Matters® Article is intended for hospitals with off-campus outpatient departments submitting claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries.

Provider Action Needed
Change Request (CR) 9613 reminds you that all off-campus outpatient departments of a hospital provider are required to be correctly identified. Make sure that your billing staffs are aware of these requirements.
Background
Hospital providers are required to include all practice locations on the CMS 855A enrollment form. The Centers for Medicare & Medicaid Services (CMS) has performed a re-validation process (March 25, 2011 – March 23, 2015) where in the last 4 years all hospital providers have completed an 855A enrollment form to either 1) initially enroll in Medicare, 2) add a new practice location, or 3) revalidate its enrollment information. If a hospital claim is submitted with a service facility location that was not included on the CMS 855A enrollment form, it will be returned to the provider until the CMS 855A enrollment form and claims processing system is updated.

Section 1833(t) of the Social Security Act (the Act), as amended by Section 603 of the Bipartisan Budget Act of 2015, requires that certain off-campus departments of a hospital provider be paid under the “applicable payment system” rather than under the Hospital Outpatient Prospective Payment System. CMS established payment policies to pay nonexcepted off-campus departments of a hospital provider under the Medicare Physician Fee Schedule effective for services furnished on or after January 1, 2017. It is important for hospitals to ensure that an accurate address for each hospital department practice location is included on the CMS 855A enrollment form.

Additional Information

SNF Correct Errors and Omissions – Internet Only Manual Updates to Pub. 100-01, 100-02 and 100-04 – Revised
MLN Matters® Number: MM9748 Revised
Related Change Request (CR) #: CR 9748
Related CR Release Date: October 13, 2016
Effective Date: October 18, 2016
Related CR Transmittal #: R101GI, R228BP and R3612CP
Implementation Date: October 18, 2016

This article was revised on October 17, 2016, to reflect a new Change Request (CR). That CR revised Chapter 8 to correct minor omissions in Sections 10.2 and 70. Additionally, Section 20 was removed from the CR in order to rescind unclear wording (page 2 in bold below). The transmittal number, CR release date and link to the transmittal were also changed. All other information remains the same.

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

Provider Action Needed
CR 9748 revises the following Medicare manuals to correct various minor technical errors and omissions:

- “Medicare General Information, Eligibility, and Entitlement Manual”
- “Medicare Benefit Policy Manual” and
- “Medicare Claims Processing Manual”

The revisions of these manuals are intended to clarify the existing content, and no policy, processing, or system changes are anticipated.

Key Points of CR9748
CR9748 includes all revisions as attachments, and selected extracts from these attachments are as follows:
“Medicare General Information, Eligibility, and Entitlement Manual” Revision Summary
• Chapters 4 and 5 of this manual are revised to include references to another manual with related information and a reference to a related regulation.

“Medicare Benefit Policy Manual” Summary of Key Revisions
• In several sections, references to related material in other manuals are included.
• Language is added to refer providers to a list of exclusions from consolidated billing (CB, the SNF “bundling” requirement), which is available at http://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/index.html.
• Language that was initially added by CR9748 in Transmittal R227BP to §20 of Chapter 8, regarding the scope and purpose of Medicare’s post-hospital extended care benefit, inadvertently included unclear wording and has been rescinded by Transmittal R228BP. As a result, the original version of this section’s text, as it read prior to that revision, is now restored.

“Medicare Claims Processing Manual” Key Revision Summary
• In several sections, references to related material in other manuals are included.

Additional Information
The official instruction, CR9748, issued to your MAC regarding this change is available via three transmittals:

RARC, CARC, MREP and PC Print Update
MLN Matters® Number: MM9774
Related Change Request (CR) #: CR 9774
Related CR Release Date: November 18, 2016
Effective Date: April 1, 2017
Related CR Transmittal #: R3660CP
Implementation Date: April 3, 2017
Provider Types Affected
This MLN Matters® Article is intended for physicians, providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed
Change Request (CR) 9774 updates the Remittance Advice Remark Code (RARC) and Claim Adjustment Reason Code (CARC) lists and instructs Medicare system maintainers to update Medicare Remit Easy Print (MREP) and PC Print. Make sure that your billing staffs are aware of these changes and obtain the updated MREP and PC Print software if they use that software.

Background
The Health Insurance Portability and Accountability Act (HIPAA) of 1996 instructs health plans to be able to conduct standard electronic transactions adopted under HIPAA using valid standard codes. Medicare policy states that CARCs and RARCs, as appropriate, that provide either supplemental explanation for a monetary adjustment or policy information that generally applies to the monetary adjustment, are required in the remittance advice and coordination of benefits transactions.
The Centers for Medicare & Medicaid Services (CMS) instructs contractors to conduct updates based on the code update schedule that results in publication three times a year – around March 1, July 1, and November 1.

CMS provides this CR as a code update notification indicating when updates to CARC and RARC lists are made available on the Washington Publishing Company (WPC) website. Shared System Maintainers (SSMs) have the responsibility to implement code deactivation, making sure that any deactivated code is not used in original business messages and allowing the deactivated code in derivative messages. SSMs must make sure that Medicare does not report any deactivated code on or after the effective date for deactivation as posted on the WPC website. If any new or modified code has an effective date past the implementation date specified in this CR, contractors must implement on the date specified on the WPC website, which is at http://wpc-edi.com/Reference/.

A discrepancy between the dates may arise as the WPC website is only updated three times a year and may not match the CMS release schedule. For this recurring CR, the MACs and the SSMs must get the complete list for both CARC and RARC from the WPC website to obtain the comprehensive lists for both code sets and determine the changes that are included on the code list since the last code update CR (CR 9695).

Additional Information

Annual Update to the Therapy Code List - 2017
MLN Matters® Number: MM9782
Related Change Request (CR) #: CR 9782
Related CR Release Date: November 10, 2016
Effective Date: January 1, 2017
Related CR Transmittal #: R3654CP
Implementation: January 3, 2017

Provider Types Affected
This MLN Matters® Article is intended for physicians, therapists, and other providers, including Comprehensive Outpatient Rehabilitation Facilities (CORFs), submitting claims to Medicare Administrative Contractors (MACs), including Home Health & Hospice MACs, for outpatient therapy services provided to Medicare beneficiaries.

What You Need to Know
This article is based on Change Request (CR) 9782 which updates the therapy code list for Calendar Year (CY) 2017 by adding eight “always therapy” codes (97161 – 97168) for physical therapy (PT) and occupational therapy (OT) evaluative procedures. CR 9782 also deletes the four codes currently used to report these services (97001 – 97004). Make sure your billing staffs are aware of these updates.

Background
Section 1834(k)(5) of the Social Security Act requires that all claims for outpatient rehabilitation therapy services and CORF services be reported using the uniform coding system. The Calendar Year (CY) 2017 Healthcare Common Procedure Coding System and Current Procedural Terminology, Fourth Edition (HCPCS/CPT-4) is the coding system used for reporting these services.

For CY 2017, the Current Procedural Terminology (CPT) Editorial Panel created eight new codes (97161-97168) to replace the 4-code set (97001-97004) for Physical Therapy (PT) and Occupational Therapy (OT) evaluative procedures. The new CPT code descriptors for PT and OT evaluative procedures include specific components that are required for reporting as well as the corresponding typical face-to-face times for each service.
**UPDATEs**

**Evaluation Codes.** The CPT Editorial Panel created three new codes to replace each existing PT and OT evaluation code, 97001 and 97003, respectively. These new evaluation codes are based on patient complexity and the level of clinical decision-making – low, moderate and high complexity: for PT, codes 97161, 97162 and 97163; and for OT, codes 97165, 97166 and 97167.

**Re-evaluation Codes.** One new PT code, 97164, and one new OT code, 97168, were created to replace the existing codes – 97002 and 97004, respectively. The re-evaluation codes are reported for an established patient’s when a revised plan of care is indicated.

Just as their predecessor codes were, the new codes are “always therapy” and must be reported with the appropriate therapy modifier, GP or GO, to indicate that the services are furnished under a PT or OT plan of care, respectively.

The new PT Evaluative procedure codes are listed in the chart below with their short descriptors* and the required corresponding therapy modifier:

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Short Descriptor*</th>
<th>Modifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>97161</td>
<td>PT EVAL LOW COMPLEX 20 MIN</td>
<td>GP</td>
</tr>
<tr>
<td>97162</td>
<td>PT EVAL MOD COMPLEX 30 MIN</td>
<td>GP</td>
</tr>
<tr>
<td>97163</td>
<td>PT EVAL HIGH COMPLEX 45 MIN</td>
<td>GP</td>
</tr>
<tr>
<td>97164</td>
<td>PT RE-EVAL EST PLAN CARE</td>
<td>GP</td>
</tr>
</tbody>
</table>

The new OT Evaluative procedure codes are listed in the chart below with their short descriptors* and the required OT therapy modifier:

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Short Descriptor*</th>
<th>Modifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>97165</td>
<td>OT EVAL LOW COMPLEX 30 MIN</td>
<td>GO</td>
</tr>
<tr>
<td>97166</td>
<td>OT EVAL MOD COMPLEX 45 MIN</td>
<td>GO</td>
</tr>
<tr>
<td>97167</td>
<td>OT EVAL HIGH COMPLEX 60 MIN</td>
<td>GO</td>
</tr>
<tr>
<td>97168</td>
<td>OT RE-EVAL EST PLAN CARE</td>
<td>GO</td>
</tr>
</tbody>
</table>

*NOTE: Please note that the short descriptors cannot be used in place of the CPT long descriptions which officially define each new PT and OT service. Refer to the two tables with these new CPT codes and their long descriptions that appear at the end of this article.

**Additional Information**


The therapy code list of “always” and “sometimes” therapy services is available at [http://www.cms.gov/Medicare/Billing/TherapyServices/index.html](http://www.cms.gov/Medicare/Billing/TherapyServices/index.html).

**HH PPS Rate Update for 2017**

**MLN Matters® Number: MM9820**
**Related Change Request (CR) #: CR 9820**
**Related CR Release Date: October 14, 2016**
**Effective Date: January 1, 2017**
**Related CR Transmittal #: R3624CP**
**Implementation Date: January 3, 2017**

**Provider Types Affected**

This MLN Matters® Article is intended for Home Health Agencies (HHAs) submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.
Provider Action Needed

Change Request (CR) 9820 updates the national, standardized 60-day episode rates, the national per-visit rates, and the non-routine medical supply payment amounts under the Home Health Prospective Payment System (HH PPS) for Calendar Year (CY) 2017. Make sure your billing staff are aware of these changes.

Background

The Affordable Care Act (Section 3131(a)) mandates that starting in CY 2014, the Centers for Medicare & Medicaid Services (CMS) must apply an adjustment to the national, standardized 60-day episode payment rate and other amounts applicable under the Social Security Act (Section 1895(b)(3)(A)(i)(III)) to reflect factors such as changes in the number of visits in an episode, the mix of services in an episode, the level of intensity of services in an episode, the average cost of providing care per episode, and other relevant factors. The Affordable Care Act (Section 3131(a)) mandates that this rebasing must be phased-in over a 4-year period in equal increments, not to exceed 3.5 percent of the amount (or amounts), as of the date of enactment, applicable under the Social Security Act (Section 1895(b)(3)(A)(i)(III)), and be fully implemented by CY 2017.

In addition, the Affordable Care Act (Section 3401(e)) requires that the market basket percentage under the HH PPS be annually adjusted by changes in economy-wide productivity for CY 2015 and each subsequent calendar year.

The Medicare Modernization Act (MMA; Section 421(a)), as amended by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA; Pub. L. 114–10; Section 210), provides an increase of 3 percent of the payment amount otherwise made under the Social Security Act (Section 1895) for home health services furnished in a rural area (as defined in the Social Security Act (Section 1886(d)(2)(D)), with respect to episodes and visits ending on or after April 1, 2010 and before January 1, 2018. The statute waives budget neutrality related to this provision, as the statute specifically states that CMS will not reduce the standard prospective payment amount (or amounts) under the Social Security Act (Section 1895) applicable to home health services furnished during a period to offset the increase in payments resulting in the application of this section of the statute.

Market Basket Update

The CY 2017 HH market basket update is 2.8 percent which is then reduced by a multi-factor productivity (MFP) adjustment of 0.3 percentage points. The resulting home health (HH) payment update is equal to 2.5 percent. HHAs that do not report the required quality data will receive a 2 percentage point reduction to the HH payment update.

National, Standardized 60-Day Episode Payment

As described in the CY 2017 HH PPS final rule, in order to calculate the CY 2017 national, standardized 60-day episode payment rate, CMS applies a wage index budget neutrality factor of 0.9996 and a case-mix budget neutrality factor of 1.0214 to the previous calendar year’s national, standardized 60-day episode rate. In order to account for nominal case-mix growth from CY 2012 to CY 2014, CMS applies a payment reduction of 0.97 percent to the national, standardized 60-day episode payment rate. CMS then applies an $80.95 rebasing reduction (which is 3.5 percent of the CY 2010 national, standardized 60-day episode rate of $2,312.94) to the national, standardized 60-day episode rate. Lastly, the national, standardized 60-day episode payment rate is updated by the CY 2017 HH payment update percentage of 2.5 percent for HHAs that submit the required quality data and by 2.5 percent minus 2 percentage points, or 0.5 percent, for HHAs that do not submit quality data. These two episode payment rates are shown in Table 1 and Table 2. These payments are further adjusted by the individual episode’s case-mix weight and by the wage index.

Table 1: For HHAs that DO Submit Quality Data – National, Standardized 60-Day Episode Amount for CY 2017

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>$2,965.12</td>
<td>0.9996</td>
<td>1.0214</td>
<td>0.9903</td>
<td>-80.95</td>
<td>1.025</td>
<td>$2,989.97</td>
</tr>
</tbody>
</table>
### National Per-Visit Rates

In order to calculate the CY 2017 national per-visit payment rates, CMS starts with the CY 2016 national per-visit rates. CMS applies a wage index budget neutrality factor of 1.0000 to ensure budget neutrality for low utilization payment adjustment (LUPA) per-visit payments after applying the CY 2017 wage index, and then applies the maximum rebasing adjustments to the per-visit rates for each discipline. The per-visit rates are then updated by the CY 2017 HH payment update of 2.5 percent for HHAs that submit the required quality data and by 0.5 percent for HHAs that do not submit quality data. The per-visit rates are shown in Table 3 and Table 4.

### Table 3: For HHAs that DO Submit Quality Data – CY 2017 National Per-Visit Amounts for LUPAs and Outlier Calculations

<table>
<thead>
<tr>
<th>HH Discipline Type</th>
<th>CY 2016 Per-Visit Payment</th>
<th>Wage Index Budget Neutrality Factor</th>
<th>CY 2017 Rebasing Adjustment</th>
<th>CY 2017 HH Payment Update</th>
<th>CY 2017 Per-Visit Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Aide</td>
<td>$60.87</td>
<td>X 1.0000</td>
<td>+ $1.79</td>
<td>X 1.025</td>
<td>$64.23</td>
</tr>
<tr>
<td>Medical Social Services</td>
<td>$215.47</td>
<td>X 1.0000</td>
<td>+ $6.34</td>
<td>X 1.025</td>
<td>$227.36</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>$147.95</td>
<td>X 1.0000</td>
<td>+ $4.35</td>
<td>X 1.025</td>
<td>$156.11</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>$146.95</td>
<td>X 1.0000</td>
<td>+ $4.32</td>
<td>X 1.025</td>
<td>$155.05</td>
</tr>
<tr>
<td>Skilled Nursing</td>
<td>$134.42</td>
<td>X 1.0000</td>
<td>+ $3.96</td>
<td>X 1.025</td>
<td>$141.84</td>
</tr>
<tr>
<td>Speech-Language Pathology</td>
<td>$159.71</td>
<td>X 1.0000</td>
<td>+ 4.70</td>
<td>X 1.025</td>
<td>$168.52</td>
</tr>
</tbody>
</table>

### Table 4: For HHAs that DO NOT Submit Quality Data – CY 2017 National Per-Visit Amounts for LUPAs and Outlier Calculations

<table>
<thead>
<tr>
<th>HH Discipline Type</th>
<th>CY 2016 Per-Visit Payment</th>
<th>Wage Index Budget Neutrality Factor</th>
<th>CY 2017 Rebasing Adjustment</th>
<th>CY 2017 HH Payment Update</th>
<th>CY 2017 Per-Visit Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Aide</td>
<td>$60.87</td>
<td>X 1.0000</td>
<td>+ $1.79</td>
<td>X 1.005</td>
<td>$62.97</td>
</tr>
<tr>
<td>Medical Social Services</td>
<td>$215.47</td>
<td>X 1.0000</td>
<td>+ $6.34</td>
<td>X 1.005</td>
<td>$222.92</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>$147.95</td>
<td>X 1.0000</td>
<td>+ $4.35</td>
<td>X 1.005</td>
<td>$153.06</td>
</tr>
</tbody>
</table>
**UPDATES**

<table>
<thead>
<tr>
<th>HH Discipline Type</th>
<th>CY 2016 Per-Visit Payment</th>
<th>Wage Index Budget Neutrality Factor</th>
<th>CY 2017 Rebas ing Adjustment</th>
<th>CY 2017 HH Payment Update</th>
<th>CY 2017 Per-Visit Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Therapy</td>
<td>$146.95</td>
<td>X 1.0000</td>
<td>+ $4.32</td>
<td>X 1.005</td>
<td>$152.03</td>
</tr>
<tr>
<td>Skilled Nursing</td>
<td>$134.42</td>
<td>X 1.0000</td>
<td>+ $3.96</td>
<td>X 1.005</td>
<td>$139.07</td>
</tr>
<tr>
<td>Speech-Language Pathology</td>
<td>$159.71</td>
<td>X 1.0000</td>
<td>+ 4.70</td>
<td>X 1.005</td>
<td>$165.23</td>
</tr>
</tbody>
</table>

**Non-Routine Supply Payments**

Payments for non-routine supplies (NRS) are computed by multiplying the relative weight for a particular NRS severity level by an NRS conversion factor. To determine the CY 2017 NRS conversion factors, CMS starts with the CY 2016 NRS conversion factor and applies a 2.82 percent rebasing adjustment as described in the CY 2017 HH PPS final rule. CMS then updates the conversion factor by the CY 2017 HH payment update of 2.5 percent for HHAs that submit the required quality data and by 0.5 percent for HHAs that do not submit quality data. CMS does not apply any standardization factors as the NRS payment amount calculated from the conversion factor is neither wage nor case-mix adjusted when the final payment amount is computed. The NRS conversion factor for CY 2017 payments for HHAs that do submit the required quality data is shown in Table 5a and the payment amounts for the various NRS severity levels are shown in Table 5b. The NRS conversion factor for CY 2017 payments for HHAs that do not submit quality data is shown in Table 6a and the payment amounts for the various NRS severity levels are shown in Table 6b.

**Table 5a: CY 2017 NRS Conversion Factor for HHAs that DO Submit the Required Quality Data**

<table>
<thead>
<tr>
<th>CY 2016 NRS Conversion Factor</th>
<th>CY 2017 Rebas ing Adjustment</th>
<th>CY 2017 HH Payment Update</th>
<th>CY 2017 NRS Conversion Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>$52.71</td>
<td>X 0.9718</td>
<td>X 1.025</td>
<td>$52.50</td>
</tr>
</tbody>
</table>

**Table 5b: CY 2017 Relative Weights and Payment Amounts for the 6-Severity NRS System for HHAs that DO Submit Quality Data**

<table>
<thead>
<tr>
<th>Severity Level</th>
<th>Points (Scoring)</th>
<th>Relative Weight</th>
<th>CY 2017 NRS Payment Amounts</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>0.2698</td>
<td>$ 14.16</td>
</tr>
<tr>
<td>2</td>
<td>1 to 14</td>
<td>0.9742</td>
<td>$ 51.15</td>
</tr>
<tr>
<td>3</td>
<td>15 to 27</td>
<td>2.6712</td>
<td>$ 140.24</td>
</tr>
<tr>
<td>4</td>
<td>28 to 48</td>
<td>3.9686</td>
<td>$ 208.35</td>
</tr>
<tr>
<td>5</td>
<td>49 to 98</td>
<td>6.1198</td>
<td>$ 321.29</td>
</tr>
<tr>
<td>6</td>
<td>99+</td>
<td>10.5254</td>
<td>$ 552.58</td>
</tr>
</tbody>
</table>

**Table 6a: CY 2017 NRS Conversion Factor for HHAs that DO NOT Submit the Required Quality Data**

<table>
<thead>
<tr>
<th>CY 2016 NRS Conversion Factor</th>
<th>CY 2017 Rebas ing Adjustment</th>
<th>CY 2017 HH Payment Update Percentage Minus 2 Percentage Points</th>
<th>CY 2017 NRS Conversion Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>$52.71</td>
<td>X 0.9718</td>
<td>X 1.005</td>
<td>$51.48</td>
</tr>
</tbody>
</table>
Table 6b: CY 2017 Relative Weights and Payment Amounts for the 6-Severity NRS System for HHAs that DO NOT Submit Quality Data

<table>
<thead>
<tr>
<th>Severity Level</th>
<th>Points (Scoring)</th>
<th>Relative Weight</th>
<th>CY 2017 NRS Payment Amounts</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>0.2698</td>
<td>$13.89</td>
</tr>
<tr>
<td>2</td>
<td>1 to 14</td>
<td>0.9742</td>
<td>$50.15</td>
</tr>
<tr>
<td>3</td>
<td>15 to 27</td>
<td>2.6712</td>
<td>$137.51</td>
</tr>
<tr>
<td>4</td>
<td>28 to 48</td>
<td>3.9686</td>
<td>$204.30</td>
</tr>
<tr>
<td>5</td>
<td>49 to 98</td>
<td>6.1198</td>
<td>$315.05</td>
</tr>
<tr>
<td>6</td>
<td>99+</td>
<td>10.5254</td>
<td>$541.85</td>
</tr>
</tbody>
</table>

Rural Add-On

As stipulated in the MMA (Section 421(a)), the 3 percent rural add-on is applied to the national, standardized 60-day episode rate, national per-visit payment rates, LUPA add-on payments, and the NRS conversion factor when home health services are provided in rural (non-CBSA) areas for episodes and visits ending on or after April 1, 2010, and before January 1, 2018. Refer to Table 7, Table 8, Table 9a and Table 9b which follow below for the CY 2017 rural payment rates.

Table 7: CY 2017 National, Standardized 60-Day Payment Amounts for Services Provided in a Rural Area

For HHAs that DO Submit Quality Data | For HHAs that DO NOT Submit Quality Data
--- | ---
CY 2017 National, Standardized 60-Day Episode Payment Rate | Multiply by the 3 Percent Rural Add-On
$2,989.97 X 1.03 | $3,019.58

Table 8: CY 2017 National Per-Visit Amounts for Services Provided in a Rural Area

<table>
<thead>
<tr>
<th>HH Discipline Type</th>
<th>CY 2017 Per-visit rate</th>
<th>Multiply by the 3 Percent Rural Add-On</th>
<th>CY 2017 Rural Per-Visit Rates</th>
<th>CY 2017 Per-visit rate</th>
<th>Multiply by the 3 Percent Rural Add-On</th>
<th>CY 2017 Rural Per-Visit Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>HH Aide</td>
<td>$64.23</td>
<td>X 1.03</td>
<td>$66.16</td>
<td>$62.97</td>
<td>X 1.03</td>
<td>$64.86</td>
</tr>
<tr>
<td>MSS</td>
<td>$227.36</td>
<td>X 1.03</td>
<td>$234.18</td>
<td>$222.92</td>
<td>X 1.03</td>
<td>$229.61</td>
</tr>
<tr>
<td>OT</td>
<td>$155.11</td>
<td>X 1.03</td>
<td>$160.79</td>
<td>$153.06</td>
<td>X 1.03</td>
<td>$157.65</td>
</tr>
<tr>
<td>PT</td>
<td>$155.05</td>
<td>X 1.03</td>
<td>$159.70</td>
<td>$152.03</td>
<td>X 1.03</td>
<td>$156.59</td>
</tr>
<tr>
<td>SN</td>
<td>$141.84</td>
<td>X 1.03</td>
<td>$146.10</td>
<td>$139.07</td>
<td>X 1.03</td>
<td>$143.24</td>
</tr>
<tr>
<td>SLP</td>
<td>$168.52</td>
<td>X 1.03</td>
<td>$173.58</td>
<td>$165.23</td>
<td>X 1.03</td>
<td>$170.19</td>
</tr>
</tbody>
</table>
Table 9a: CY 2017 NRS Conversion Factor for Services Provided in Rural Areas

<table>
<thead>
<tr>
<th>CY 2017 Conversion Factor</th>
<th>Multiply by the 3 Percent Rural Add-On</th>
<th>CY 2017 Rural NRS Conversion Factor</th>
<th>Multiply by the 3 Percent Rural Add-On</th>
<th>CY 2017 Rural NRS Conversion Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>$52.50</td>
<td>X 1.03</td>
<td>$54.08</td>
<td>X 1.03</td>
<td>$53.02</td>
</tr>
</tbody>
</table>

Table 9b: CY 2017 Relative Weights and Payment Amounts for the 6-Severity NRS System for Services Provided in Rural Areas

<table>
<thead>
<tr>
<th>Severity Level</th>
<th>Points (Scoring)</th>
<th>Relative Weight</th>
<th>CY 2017 NRS Payment Amounts for Rural Areas</th>
<th>Relative Weight</th>
<th>CY 2017 NRS Payment Amounts for Rural Areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>0.2698</td>
<td>$14.59</td>
<td>0.2698</td>
<td>$14.30</td>
</tr>
<tr>
<td>2</td>
<td>1 to 14</td>
<td>0.9742</td>
<td>$52.68</td>
<td>0.9742</td>
<td>$51.65</td>
</tr>
<tr>
<td>3</td>
<td>15 to 27</td>
<td>2.6712</td>
<td>$144.46</td>
<td>2.6712</td>
<td>$141.63</td>
</tr>
<tr>
<td>4</td>
<td>28 to 48</td>
<td>3.9686</td>
<td>$214.62</td>
<td>3.9686</td>
<td>$210.42</td>
</tr>
<tr>
<td>5</td>
<td>49 to 98</td>
<td>6.1198</td>
<td>$330.96</td>
<td>6.1198</td>
<td>$324.47</td>
</tr>
<tr>
<td>6</td>
<td>99+</td>
<td>10.5254</td>
<td>$569.21</td>
<td>10.5254</td>
<td>$558.06</td>
</tr>
</tbody>
</table>

These changes are implemented through the Home Health Pricer software in Medicare’s shared systems.

Additional Information

Updates to Pub. 100-04, Chapters 8, 13 and 14 to Correct Remittance Advice Messages

MLN Matters® Number: MM9841
Related Change Request (CR) #: CR 9841
Related CR Release Date: November 10, 2016
Effective Date: February 10, 2017
Related CR Transmittal #: R3650CP
Implementation Date: February 10, 2017

Provider Types Affected
This MLN Matters® Article is intended for physicians and providers, especially clinical diagnostic laboratories, ambulatory surgical centers, and end stage renal disease facilities submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.
UPDATES

What You Need to Know
Change Request (CR) 9841 revises Chapters 8, 13, and 14 of the “Medicare Claims Processing Manual” to ensure that all remittance advice coding is consistent with nationally standard operating rules. CR9841 also provides a format for consistently showing remittance advice coding throughout the “Medicare Claims Processing Manual.”

Background
Section 1171 of the Social Security Act requires a standard set of operating rules to regulate the health insurance industry’s use of Electronic Data Interchange (EDI) transactions. Operating Rule 360: Uniform Use of Claims Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs), regulates the way in which group codes, CARCs, and RARCs may be used. The rule requires specific codes which are to be used in combination with one another if one of the named business scenarios applies. The Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) authored this rule.

Medicare and all other payers must comply with the CAQH CORE-developed code combinations. The business scenario for each payment adjustment must be defined, if applicable, and a valid code combination selected for all remittance advice messages. CR9841 updates Chapters 8, 13, and 14 of the manual to reflect the standard format and to correct any non-compliant code combinations. Certain sections of Chapter 8 that contained remittance advice codes are deleted since the instructions are now obsolete. Additional CRs will follow to provide similar revisions to the remaining chapters of the “Medicare Claims Processing Manual.”

Additional Information

DMEPOS Fee Schedule – 2017 Update
MLN Matters® Number: MM9854
Related Change Request (CR) #: CR 9854
Related CR Release Date: December 5, 2016
Effective Date: January 1, 2017
Related CR Transmittal #: R3671CP
Implementation Date: January 3, 2017

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

What You Need to Know
Change Request (CR) 9854 provides the calendar year (CY) 2017 annual update for the Medicare DMEPOS fee schedule. The instructions include information on the data files, update factors and other information related to the update of the fee schedule. Make sure your billing staffs are aware of these updates.

Background
The Centers for Medicare & Medicaid Services (CMS) updates the DMEPOS fee schedule on an annual basis in accordance with statute and regulations. The update process for the DMEPOS fee schedule is located in Chapter 23 Section 60 in the “Medicare Claims Processing Manual.”

Payment on a fee schedule basis is required for certain durable medical equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by the Social Security Act (the Act). Also, payment on a fee schedule basis is a regulatory requirement at 42 CFR Section 414.102 for parenteral and enteral nutrition (PEN), splints, casts and intraocular lenses (IOLs) inserted in a physician’s office.
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. The Act provides authority for making adjustments to the fee schedule amounts for enteral nutrients, equipment, and supplies (enteral nutrition) based on information from CBPs. The methodologies for adjusting DMEPOS fee schedule amounts using information from CBPs are established in regulations at 42 CFR Section 414.210(g). Also, program instructions on these changes are available in Transmittal 3551, CR 9642 (MLN Matters article MM9642), dated June 23, 2016, and Transmittal 3416, CR 9431 (MM9431), dated November 23, 2015.

The DMEPOS and PEN fee schedule files contain Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the adjusted fee schedule amounts as well as codes that are not subject to the fee schedule CBP adjustments. Fee schedule amounts that are adjusted using information from CBPs will not be subject to the annual DMEPOS covered item update, but will be updated pursuant to 42 CFR 414.210(g)(8) when information from the CBPs is updated. This update to the adjusted fees includes information from the CBPs that takes effect on January 1, 2017 (Round 1 2017). Pursuant to 42 CFR Section 414.210(g)(4), for items where the single payment amounts (SPAs) from CBPs no longer in effect are used to adjust fee schedule amounts, the SPAs will be increased by an inflation adjustment factor that corresponds to the year in which the adjustment would go into effect (for example, 2017 for this update) and for each subsequent year such as 2018 and 2019.

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. Regulations at Section 414.202 define rural areas to be a geographical area represented by a postal ZIP code where at least 50 percent of the total geographical area of the ZIP code is estimated to be outside any MSA. A rural area also includes any ZIP Code within an MSA that is excluded from a competitive bidding area established for that MSA.

Policy: Fee Schedule and Rural Zip Code Files

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

The DMEPOS and PEN fee schedules and the rural ZIP code public use files (PUFs) will be available for State Medicaid Agencies, managed care organizations, and other interested parties on the CMS DMEPOS fee schedule website after November 18, 2016.

New Codes Added

The new codes are not to be used for billing purposes until they are effective on January 1, 2017. For gap-filling pricing purposes, deflation factors are applied before updating to the current year. The deflation factors for 2016 by payment category are in the table below.

<table>
<thead>
<tr>
<th>Code Description</th>
<th>Deflation Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oxygen</td>
<td>0.454</td>
</tr>
<tr>
<td>Capped Rental</td>
<td>0.457</td>
</tr>
<tr>
<td>Prosthetics and Orthotics</td>
<td>0.458</td>
</tr>
<tr>
<td>Surgical Dressings</td>
<td>0.582</td>
</tr>
<tr>
<td>Parental and Enteral Nutrition</td>
<td>0.633</td>
</tr>
<tr>
<td>Splints and Casts</td>
<td>0.969</td>
</tr>
<tr>
<td>Intraocular Lenses</td>
<td>0.952</td>
</tr>
</tbody>
</table>

Codes Deleted

Codes deleted from the DMEPOS fee schedule files effective January 1, 2017, are:

- B9000 - Enteral nutrition infusion pump - without alarm
- B9000MS - Enteral nutrition infusion pump - without alarm
- E0628 - Separate seat lift mechanism for use with patient owned furniture-electric
UPDATES

- K0901 - Knee orthosis (ko), single upright, thigh and calf, with adjustable flexion and extension joint ( unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated, off-the-shelf ( Ko single upright pre ots)

- K0902 - Knee orthosis (ko), double upright, thigh and calf, with adjustable flexion and extension joint ( unicentric or polycentric), medial-lateral and control, with or without varus/valgus adjustment, prefabricated, off-the-shelf ( Ko double upright pre ots)

Effective January 1, 2017, codes B9000 and E0628 will crosswalk to codes B9002 and E0627 respectively. Payment for necessary maintenance and servicing of B9000 pumps will also crosswalk to B9002MS.

Effective January 1, 2017, the fees for wheelchair accessories and seat and back cushions denoted with the HCPCS modifier ‘KU’ are deleted from the DMEPOS fee schedule file.

The fee schedule amounts associated with the KU modifier were mandated by Section 2 of Patient Access and Medicare Protection Act (PAMPA) effective for dates of service January 1, 2016 through December 31, 2016. The list of HCPCS codes to which this statutory section applied is available in Transmittal 3535, CR 9520, Transmittal 3535, CR 9520, dated June 7, 2016.

Specific Coding and Pricing Issues

Effective January 1, 2017, existing off-the-shelf orthotic (OTS) codes K0901 and K0902 are re-designated as codes L1851 and L1852 respectively. The fee schedule amounts for codes K0901 and K0902 will be applied to the corresponding new codes L1851 and L1852 as part of this update. Attachment B in CR 9854 updates the list of orthotic codes that are designated as OTS on the CMS orthotics website to reflect the addition of the two renumbered codes (L1851 and L1852).

As part of the this update, the adjusted fee schedule amounts for the following groups of similar items are adjusted in accordance with 42 CFR Section 414.210 (g)(6) to limit the single payment amounts (SPAs) for items without certain features to the weighted average of the SPAs for the items both with and without the features prior to using the SPAs in adjusting the fee schedule amounts:


2. Mattress and overlays (HCPCS codes E0277, E0371, E0372, and E0373)

3. Power wheelchairs (HCPCS codes K0813, K0814, K0815, K0816, K0820, K0821, K0822, and K0823)

4. Seat lift mechanisms (HCPCS codes E0627 and E0629)

5. TENS devices (HCPCS codes E0720 and E0730)

6. Walkers (HCPCS codes E0130, E0135, E0141 and E0143)

CMS is also adjusting the fee schedule amounts for shoe modification codes A5503 through A5507 as part of this update in order to reflect more current allowed service data. Section 1833(o)(2)(C) of the Act required that the payment amounts for shoe modification codes A5503 through A5507 be established in a manner that prevented a net increase in expenditures when substituting these items for therapeutic shoe insert codes (A5512 or A5513).

To establish the fee schedule amounts for the shoe modification codes, the base fees for codes A5512 and A5513 were weighted based on the approximated total allowed services for each code for items furnished during the second quarter of calendar year 2004.

For 2017, CMS is updating the weighted average insert fees used to establish the fee schedule amounts for the shoe modification codes with more current allowed service data for each insert code. The base fees for A5512 and A5513 will be updated based on the approximated total allowed services for each code for items furnished during the calendar year 2015. The fee schedule amounts for shoe modification codes A5503 through A5507 are being revised to reflect this change, effective January 1, 2017.

Diabetic Testing Supplies

The fee schedule amounts for non-mail order diabetic testing supplies (DTS) (without KL modifier) for codes A4233, A4234, A4235, A4236, A4253, A4256, A4258, A4259 are not updated by the covered item update. In accordance with Section 636(a) of the American Taxpayer Relief Act of 2012, the fee schedule amounts for these codes were adjusted in CY 2013 so that they are equal to the single payment amounts
for mail order DTS established in implementing the national mail order CBP under Section 1847 of the Act.

The non-mail order payment amounts on the fee schedule file will be updated each time the single payment amounts are updated. This can happen no less often than every time the mail order CBP contracts are re-competed. The CBP for mail order diabetic supplies is effective July 1, 2016, to December 31, 2018. The program instructions reviewing these changes are Transmittal 2709, CR 8325 (MM8325), dated May 17, 2013, and Transmittal 2661, CR 8204 (MM8204), dated February 22, 2013. Note that the mail order DTS (KL) fee schedule amounts for all states and territories were removed from the DMEPOS fee schedule file as part of the July 1, 2016, update.

2017 Fee Schedule Update Factor of 0.7 Percent

For CY 2017, an update factor of 0.7 percent is applied to certain DMEPOS fee schedule amounts.

In accordance with the statutory Sections 1834(a)(14) of the Act, certain DMEPOS fee schedule amounts are updated for 2017 by the percentage increase in the consumer price index for all urban consumers (United States city average) or urban consumers (CPI-U) for the 12-month period ending with June of 2016, adjusted by the change in the economy-wide productivity equal to the 10-year moving average of changes in annual economy-wide private non-farm business multi-factor productivity (MFP). The MFP adjustment is 0.3 percent and the CPI-U percentage increase is 1 percent. Therefore, the 1 percentage increase in the CPI-U is reduced by the 0.3 percentage increase in the MFP resulting in a net increase of 0.7 percent for the update factor.

2017 Update to the Labor Payment Rates

Included below and in Attachment A in CR9854 are the CY 2017 allowed payment amounts for HCPCS labor payment codes K0739, L4205 and L7520. Since the percentage increase in the CPI-U for the twelve month period ending with June 30, 2016, is 1 percent, this change is applied to the 2016 labor payment amounts to update the rates for CY 2017. The 2017 labor payment amounts in Attachment A are effective for claims submitted using HCPCS codes K0739, L4205 and L7520 with dates of service from January 1, 2017, through December 31, 2017.

<table>
<thead>
<tr>
<th>STATE</th>
<th>K0739</th>
<th>L4205</th>
<th>L7520</th>
<th>STATE</th>
<th>K0739</th>
<th>L4205</th>
<th>L7520</th>
</tr>
</thead>
<tbody>
<tr>
<td>AK</td>
<td>$28.29</td>
<td>$32.23</td>
<td>$37.92</td>
<td>NC</td>
<td>$15.02</td>
<td>$22.38</td>
<td>$30.38</td>
</tr>
<tr>
<td>AL</td>
<td>$15.02</td>
<td>$22.38</td>
<td>$30.38</td>
<td>ND</td>
<td>$18.72</td>
<td>$32.16</td>
<td>$37.92</td>
</tr>
<tr>
<td>AR</td>
<td>$15.02</td>
<td>$22.38</td>
<td>$30.38</td>
<td>NE</td>
<td>$15.02</td>
<td>$22.35</td>
<td>$42.36</td>
</tr>
<tr>
<td>AZ</td>
<td>$18.57</td>
<td>$22.35</td>
<td>$37.92</td>
<td>NH</td>
<td>$16.13</td>
<td>$22.35</td>
<td>$30.38</td>
</tr>
<tr>
<td>CA</td>
<td>$23.04</td>
<td>$36.74</td>
<td>$42.81</td>
<td>NJ</td>
<td>$20.26</td>
<td>$22.35</td>
<td>$30.38</td>
</tr>
<tr>
<td>CO</td>
<td>$15.02</td>
<td>$22.38</td>
<td>$30.38</td>
<td>NM</td>
<td>$15.02</td>
<td>$22.38</td>
<td>$30.38</td>
</tr>
<tr>
<td>CT</td>
<td>$25.08</td>
<td>$22.88</td>
<td>$30.38</td>
<td>NV</td>
<td>$23.93</td>
<td>$22.35</td>
<td>$41.41</td>
</tr>
<tr>
<td>DC</td>
<td>$15.02</td>
<td>$22.35</td>
<td>$30.38</td>
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2017 National Monthly Fee Schedule Amounts for Stationary Oxygen Equipment

As part of this update, CMS is implementing the 2017 monthly fee schedule payment amounts for stationary oxygen equipment (HCPCS codes E0424, E0439, E1390 and E1391), effective for claims with dates of service from January 1, 2017, through December 31, 2017. As required by statute, the addition of the separate payment classes for oxygen generating portable equipment (OGPE) and stationary and portable oxygen contents must be annually budget neutral. Medicare expenditures must account for these separate oxygen payment classes. Therefore, the fee schedule amounts for stationary oxygen equipment are reduced by a certain percentage each year to balance the increase in payments made for the additional separate oxygen payment classes. For dates of service January 1, 2017, through December 31, 2017, the 2017 monthly fee schedule payment amounts for stationary oxygen equipment range from approximately $67 to $77, incorporating the budget neutrality adjustment factor.

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

2017 Maintenance and Servicing Payment Amount for Certain Oxygen Equipment

Also updated for 2017 is the payment amount for maintenance and servicing for certain oxygen equipment. Payment for claims for maintenance and servicing of oxygen equipment was instructed in Transmittal 635, CR 6972 (MM6972), dated February 5, 2010 and Transmittal 717, CR6990 (MM6990), dated June 8, 2010. To summarize, payment for maintenance and servicing of certain oxygen equipment can occur every 6 months, beginning 6 months after the end of the 36th month of continuous use or end of the supplier’s or manufacturer’s warranty, whichever is later for HCPCS codes E1390, E1391, E0433 or K0738, billed with the MS modifier. Payment cannot occur more than once per beneficiary, regardless of the combination of oxygen concentrator equipment and/or transfilling equipment used by the beneficiary for any 6-month period.

Per 42 CFR Section 414.210(5)(iii), the 2010 maintenance and servicing fee for certain oxygen equipment was based on 10 percent of the average price of an oxygen concentrator. For CY 2011 and subsequent years, the maintenance and servicing fee is adjusted by the covered item update for DME as set forth in Section 1834(a)(14) of the Act. Therefore, the 2016 maintenance and servicing fee is adjusted by the 0.7 percent MFP-adjusted covered item update factor to yield CY 2017 maintenance and servicing fee of $69.97 for oxygen concentrators and transfilling equipment.

Additional Information

Prolonged Services Without Direct Face-to-Face Patient Contact Separately Payable Under the Physician Fee Schedule (Manual Update)

MLN Matters® Number: MM9905
Related Change Request (CR) #: CR 9905
Related CR Release Date: December 16, 2016
Effective Date: January 1, 2017
Related CR Transmittal #: R3678CP
Implementation Date: January 3, 2017

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

Provider Action Needed
Change Request (CR) 9905 provides that the Centers for Medicare & Medicaid Services (CMS) revises Chapter 12, Section 30.6.15.2 of the “Medicare Claims Processing Manual” to indicate that beginning Calendar Year (CY) 2017, Current Procedural Terminology (CPT) codes 99358 and 99359 (prolonged services without face-to-face contact) are separately payable under the Medicare Physician Fee Schedule. Make sure your billing staffs are aware of these CPT code changes.

Background
Prior to CY 2017, CPT codes 99358 and 99359 (prolonged services without face-to-face contact) were not separately payable, and were included for payment under the related face-to-face Evaluation and Management (E/M) service code. Practitioners were not permitted to bill the patient for services described by these codes, since they are Medicare covered services and payment was included in the payment for other billable services.

The CPT prefatory language and reporting rules apply for the Medicare billing of these codes, for example, CPT codes 99358 and 99359:

- Cannot be reported during the same service period as complex Chronic Care Management (CCM) services or transitional care management services.
- Are not reported for time spent in non-face-to-face care described by more specific codes having no upper time limit in the CPT code set.

CMS has posted a file at [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html) that notes the times assumed to be typical, for purposes of Physician Fee Schedule (PFS) rate-setting. While these typical times are not required to bill the displayed codes, CMS would expect that only time spent in excess of these times would be reported under CPT codes 99358 and 99359. Further, CMS notes: 1) that these codes can only be used to report extended qualifying time of the billing physician or other practitioner (not clinical staff); and 2) Prolonged services cannot be reported in association with a companion E/M code that also qualifies as the initiating visit for CCM services. Practitioners should instead report the add-on code for CCM initiation, if applicable.

Additional Information