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General IVR inquiries available 24/7.

Claim-specific inquiries
Monday – Friday
8 a.m. – 4 p.m.
(in respective time zones)

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

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

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

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

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

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

The purpose of the Quarterly Provider Update is to:
• Inform providers about new developments in the Medicare program;
• Assist providers in understanding CMS programs and complying with Medicare regulations and instructions;
• Ensure that providers have time to react and prepare for new requirements;
• Announce new or changing Medicare requirements on a predictable schedule; and
• Communicate the specific days that CMS business will be published in the Federal Register.

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

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

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

Unsolicited or Voluntary Refunds Reminder

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

Background

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

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

Additional Information


Effective Date: January 1, 2005

Implementation Date: January 4, 2005


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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<td><a href="https://med.noridianmedicare.com/web/jddme/education/act">https://med.noridianmedicare.com/web/jddme/education/act</a></td>
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**Event Materials/Education On Demand Tutorials New Navigation**

Recently, Noridian revamped the Education & Outreach webpages to make it easier for providers to locate our educational items. Providers can now view our outreach materials containing a brief description of each presentation under the Event Materials. In addition, the Education on Demand Tutorials have now been neatly placed in their own location under the Events Materials. To begin your navigational experience, follow this link to our Education & Outreach.

Noridian hopes you find these updates appealing to your navigation on our website.

**FQHC and RHC Educational Resources Updated**

The Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) Visiting Nurse Services article and billing guides have been updated. These updates include instructions for the billable visit code G0490 effective and payable as a stand-alone service beginning with dates of service on or after April 1, 2016. Claims can be reprocessed following the updated instruction.

**FQHC**
- Visiting Nurse Services article
- Billing Guide

**RHC**
- Visiting Nurse Services article
- Billing Guide

**Tips for Claims Processing**
A previously processed claim requires the appropriate condition code. Choose the appropriate condition code from the Adjustment/Cancel Claim Change list. The type of bill (TOB) on the corrected or adjusted claim is identified by 717 for RHC or 777 for FQHC.
CMS Manual System – Change Request 9896

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Transmittal 279, dated December 16, 2016, is being rescinded and replaced by Transmittal 1776, dated, January 27, 2017 to correct one of the items required to be reported by the provider in its election request; i.e., FFY Based on CY Begin Date (YYYY) should be FFY Based on CR Begin Date. In addition, a clarifying phrase was added to the third paragraph under the “Realignment” section of the CR. Also, this CR has been changed from a Pub. 100-06 to a Pub. 100-20. All other information remains the same.

SUBJECT: Instructions to Hospitals on the Election of a Medicare-Supplemental Security Income (SSI) Component of the Disproportionate Share (DSH) Payment Adjustment for Cost Reports that Involve SSI Ratios for Fiscal Year (FY) 2004 and earlier, or SSI Ratios for Hospital Cost-reporting Periods for Patient Discharges Occurring before October 1, 2004

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to direct the contractors to inform hospitals of the requirements for making an election for a particular fiscal period covered by the Centers for Medicare & Medicaid Services’ (CMS) Ruling 1498-R (as modified by CMS Ruling 1498-R2).

EFFECTIVE DATE: January 19, 2017

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

IMPLEMENTATION DATE: January 19, 2017

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

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

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

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III. FUNDING:

For Medicare Administrative Contractors (MACs):

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

IV. ATTACHMENTS:

One-Time Notification
Attachment – One-Time Notification

Transmittal 279, dated December 16, 2016, is being rescinded and replaced by Transmittal 1776, dated, January 27, 2017 to correct one of the items required to be reported by the provider in its election request; i.e., FFY Based on CY Begin Date (YYYY) should be FFY Based on CR Begin Date. In addition, a clarifying phrase was added to the third paragraph under the “Realignment” section of the CR. Also, this CR has been changed from a Pub. 100-06 to a Pub. 100-20. All other information remains the same.

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EFFECTIVE DATE: January 19, 2017
*Unless otherwise specified, the effective date is the date of service.

IMPLEMENTATION DATE: January 19, 2017

I. GENERAL INFORMATION

A. Background: On April 28, 2010, the Administrator of the Centers for Medicare & Medicaid Services (CMS) issued CMS Ruling 1498-R. The Ruling addressed administrative appeals on three different issues related to Medicare Disproportionate Share Hospital (DSH) payment: (1) the Medicare-Supplemental Security Income (SSI) fraction data matching process issue, and the method for recalculating the hospital’s Medicare-SSI fraction by matching Medicare and SSI entitlement data; (2) the exclusion from the Medicare fraction and the numerator of the Medicaid fraction of non-covered inpatient hospital days for patients entitled to Medicare Part A, including days for which the patient’s Part A inpatient hospital benefits were exhausted; and (3) the exclusion from the DSH calculation of labor/delivery room (LDR) inpatient days. On April 22, 2015, the Administrator of CMS issued CMS Ruling 1498-R2, which effectively amended CMS Ruling 1498-R. This modification and amendment of CMS Ruling 1498-R affects a change only with respect to the relief that is available for revised Medicare-SSI fractions, and the interaction between Medicare-SSI fractions suitably revised to address the data matching process issue and the issue of Medicare Part A non-covered or exhausted benefit days (“dual-eligible non-covered days”) for cost reporting periods involving patient discharges before October 1, 2004.

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

Prior to the implementation of the FY 2005 IPPS final rule, inpatient days were included in the numerator of the Medicare-SSI fraction only if the inpatient hospital days were “covered” under Medicare Part A and the patient was entitled to SSI benefits. Part A coverage of inpatient days alone was required for inclusion in the denominator of the Medicare-SSI fraction. The FY 2005 IPPS final rule amended the DSH regulations by eliminating the requirement that Part A inpatient hospital days must be covered in order for such days to be included in the Medicare-SSI fraction and made clear that patient days were to be included in that fraction if the patient was entitled to Medicare Part A. See the FY 2005 IPPS final rule (69 FR 49246) (revising 42 CFR 412.106(b)(2)(i)). Under our revised policy, the inpatient days of a person who was entitled to Medicare Part A are included in the numerator of the hospital’s Medicare-SSI fraction (provided that the patient was also entitled to SSI at that time) and in the Medicare-SSI fraction denominator, regardless of whether the individual’s inpatient hospital stay was covered under Part A or whether the patient’s Part A hospital benefits were exhausted. The FY 2005 IPPS final rule revision to the DSH regulations was effective for patient discharges occurring on or after October 1, 2004 (69 FR 49099).

The CMS Ruling 1498-R2 provided notice of CMS’ determination that CMS Ruling 1498-R shall be amended regarding its remedy for recalculation of certain Medicare DSH payment adjustments. CMS Ruling 1498-R required the Provider Reimbursement Review Board (PRRB) and other Medicare administrative appeals tribunals to remand each qualifying appeal to the appropriate Medicare contractor. CMS Ruling 1498-R further explained how CMS and Medicare contractors were to recalculate the provider’s DSH adjustment resolving any of the three different DSH issues. CMS and the Medicare contractor also were to apply the provisions of CMS Ruling 1498-R, on all three DSH issues, to each qualifying hospital cost reporting period where the contractor had not yet final settled the provider’s Medicare cost report. CMS Ruling 1498-R2 is a modification and amendment of CMS Ruling 1498-R, but only insofar as CMS Ruling 1498-R2 requires an election with respect to the Medicare-SSI component of the DSH payment adjustment for cost reports that involve SSI ratios for federal fiscal year 2004 and earlier, or SSI ratios for hospital cost-reporting periods, but only for those patient discharges occurring before October 1, 2004.

The CMS and the Medicare contractors will resolve each Medicare-SSI and dual-eligible non-covered day appeal remanded by the PRRB to the contractor, or open hospital cost reporting period subject to CMS Ruling 1498-R and the amendment in CMS Ruling 1498-R2 by allowing hospitals to exercise an election. This election is available for hospital cost reporting periods where the Medicare contractor has not yet final settled the provider’s Medicare cost report, as well as appeals remanded to the contractor pursuant to CMS Ruling 1498-R (assuming any such hospital cost reporting period involves SSI ratios for federal fiscal year 2004 and earlier or SSI ratios for hospital cost-reporting periods, but only for those patient discharges occurring before October 1, 2004). The election is also available for hospital cost reporting periods previously reopened specifically on the Medicare-SSI fraction issue – neither CMS Ruling 1498-R nor the amendment in CMS Ruling 1498-R2 required reopening. For a particular hospital cost reporting period or, as applicable, the portion of a particular cost reporting period prior to October 1, 2004, subject to CMS Ruling 1498-R and the amendment in CMS Ruling 1498-R2, hospitals may elect either to:

1. include inpatient days of a person entitled to Medicare Part A in the numerator of the hospital’s Medicare-SSI fraction (provided that the patient was also entitled to SSI) and in that fraction’s denominator, even if the inpatient stay was not covered under Part A or the patient’s Part A hospital benefits were exhausted (that is, elect to have applied a suitably revised Medicare-SSI fraction calculated on the basis of “total days”); or

2. exclude such days where the patient’s Part A hospital benefits were exhausted or otherwise were not in a covered Part A stay from both the numerator and denominator of the Medicare-SSI fraction (that is, elect to have applied a suitably revised Medicare-SSI fraction calculated on the basis of “covered days”).

In summary, a provider may elect whether to receive a suitably revised Medicare-SSI fraction on the basis of “covered days” or “total days” for hospital cost reporting periods that involve SSI ratios for federal fiscal year 2004 and earlier, or SSI ratios for hospital cost reporting periods, but only for those patient discharges occurring before October 1, 2004. CMS Ruling 1498-R2 does not effect any change with respect to the Medicaid fraction of the Medicare DSH payment calculation. The amendment to CMS Ruling 1498-R only allows providers to exercise a choice with respect to the Medicare-SSI fraction, and nothing in the amended Ruling or these instructions shall be interpreted to affect a hospital’s Medicaid fraction of its DSH payment calculation.

The CMS has published on its Web site suitably revised Medicare-SSI fractions that display Medicare-SSI fractions calculated on the basis of “covered days,” as well as “total days.” Before an initial Notice of Program Reimbursement (NPR) or revised NPR pursuant to the amendment to CMS Ruling 1498-R is issued by its Medicare contractor, a hospital’s designated representative should submit to its Medicare contractor a written request that reflects the hospital’s election of whether, for a particular fiscal period, the hospital’s suitably revised Medicare-SSI fraction will be calculated on the basis of “total days” or “covered days.” The written request must be received by the Medicare contractor within 180 calendar days of the date instructions are posted on the contractor’s Web site. The request to the Medicare contractor must include the following information:

- Provider Number
- Hospital Name
- PRRB Case Number and PRRB Remand Date (if applicable)
- Case Name, Docket Number (if applicable)
Realignment

42 CFR 412.106(b)(3) allows the hospital the opportunity to request to have their Medicare-SSI fraction realigned based on its cost reporting period (as opposed to the federal fiscal year).

For cost reporting periods subject to CMS Ruling 1498-R and the amendment in CMS Ruling 1498-R2, CMS will furnish (at the hospital’s written request and at no cost to the hospital) patient-level data concerning the number of the hospital’s “covered” and “total” Medicare-SSI days, and the number of the hospital’s “covered” and “total” Medicare days. Hospitals with cost reporting periods that ended before December 8, 2004, that did not receive an initial NPR, must appeal the issue of the calculation of their Medicare-SSI days to the PRRB subsequent to receipt of an initial NPR in order to receive their data at no cost. Such data will be provided on the federal fiscal year basis for the relevant cost reporting period, or, if the hospital does not report on the federal fiscal year basis, the two federal fiscal years in which the hospital’s cost reporting period falls.

If a provider previously submitted a realignment request for an open cost report, or for a cost report with an SSI appeal or SSI remand that uses a federal fiscal year 2004 or earlier Medicare-SSI fraction, the contractor shall send a notice to the provider to inform them that the realignment request no longer applies since the provider will first receive an initial/resvied NPR with a revised Medicare-SSI fraction calculated based on the federal fiscal year. After receiving its revised Medicare-SSI fraction, the provider may request realignment, based on the revised Medicare-SSI fraction, within the normal timeframes.

The hospital must submit a written request to its contractor if it elects to receive the suitably revised Medicare-SSI fractions on the basis of its cost reporting period. The request must be on provider letterhead and signed by authorized hospital personnel. The request must specify whether the provider elects to have its realigned Medicare-SSI fraction generated on the basis of “total days” or “covered days.” Hospitals requesting that CMS recalculate their SSI ratios on the basis of their cost reporting period shall send their Medicare contractor the following information:

- Provider Number
- Hospital Name
- PRRB Case Number and PRRB Remand Date (if applicable)
- Case Name, Docket Number (if applicable)
- Hospital’s designated representative (if applicable)
- Cost Report Begin Date (YYYYMMDD)
- Cost Report End Date (YYYYMMDD)
- FFY Based on CR Begin Date (YYYY)
- Provider Election (“Total” or “Covered”)
If the hospital’s realignment request does not contain all of the required information, notably if the request does not contain an election of “total” or “covered” with regard to the SSI ratio, the Medicare contractor shall contact the hospital via letter, using a method that tracks delivery and receipt, to obtain the required information and if the provider does not respond within 30 days of the date of the letter, the Medicare contractor shall inform CMS that no election was provided. In this instance, CMS will provide a realigned Medicare SSI ratio using the higher of the two revised Medicare-SSI fractions for the hospital’s cost reporting period.

If a provider submitted a realignment request within 3 years of the NPR where there is no SSI appeal or SSI remand, the provider will receive its requested realignment using the original SSI ratio.

II. BUSINESS REQUIREMENTS TABLE

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

<table>
<thead>
<tr>
<th>Number</th>
<th>Requirement</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A/B MAC</td>
<td>DME MAC</td>
</tr>
<tr>
<td></td>
<td>A</td>
<td>B</td>
</tr>
<tr>
<td>9896.1</td>
<td>Using the policy in this CR, contractors shall inform hospitals of the election available for hospital cost reporting periods that involve SSI ratios for federal fiscal year 2004 and earlier, or SSI ratios for hospital realignment requests to use its cost reporting periods, but only for those patient discharges occurring before October 1, 2004.</td>
<td>X</td>
</tr>
</tbody>
</table>
### III. PROVIDER EDUCATION TABLE

<table>
<thead>
<tr>
<th>Number</th>
<th>Requirement</th>
<th>Responsibility</th>
<th>A/B MAC</th>
<th>DME MAC</th>
<th>Shared-System Maintainers</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>9896.2</td>
<td>CR as Provider Education: Contractors shall post this entire instruction, or a direct link to this instruction, on their Web sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the availability of the article. In addition, the entire instruction must be included in the contractor’s next regularly scheduled bulletin. Contractors are free to supplement it with localized information that would benefit their provider community in billing and administering the Medicare program correctly.</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### IV. SUPPORTING INFORMATION

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

*Should*” denotes a recommendation.

<table>
<thead>
<tr>
<th>X-Ref Requirement Number</th>
<th>Recommendations or other supporting information:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>None</td>
</tr>
</tbody>
</table>

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

### V. CONTACTS

Pre-Implementation Contact(s): Emily Lipkin, 410-786-3633 or emily.lipkin@cms.hhs.gov (Medicare DSH Policy), Dorothy Braunsar, 410-786-4037 or dorothy.braunsar@cms.hhs.gov

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

### VI. FUNDING

**Section A: For Medicare Administrative Contractors (MACs):**

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

**ATTACHMENTS: 0**
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 fourth 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. Revised in this release:

- The “Same-day Stays for Medical DRGs” and “Same-day Stays for Surgical DRGs” target areas have been discontinued.
- The “One-day Stays for Medical DRGs” and “One-day Stays for Surgical DRGs” target areas have been revised to include same-day stays (where the patient was admitted and discharged on the same day), in addition to stays where the patient was admitted on one day and discharged on the next.
- The one-day stays and two-day stays target areas now exclude claims with occurrence span code 72 (which is used to identify outpatient time associated with an inpatient admission) with “through” date on or day prior to inpatient admission.

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.

Do you have questions or comments about PEPPER or need help obtaining your report? Visit our Help Desk. Provide feedback or suggestions regarding PEPPER through our feedback form.

FISS Implementation of the Restructured Clinical Lab Fee Schedule – Revised

MLN Matters® Number: MM9837 Revised
Related Change Request (CR) #: CR 9837
Related CR Release Date: March 23, 2017
Effective Date: January 1, 2018
Related CR Transmittal #: R3740CP
Implementation Date: July 3, 2017

This article was revised on March 23, 2017, to reflect the revised CR9837 issued that day. In the article, the CR release date, transmittal number, and the Web address for accessing CR9837 are revised. All other information remains the same.

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 SE1619 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 payor 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
- Data Integrity
- Confidentiality and public release of limited data
- Coding for new tests on the CLFS
- Phased in payment reduction

Additional Information


Additional ICD-10 Codes for System Changes to Implement Section 231 of the Consolidated Appropriations Act 2016
MLN Matters® Number: MM9872
Related Change Request (CR) #: CR 9872
Related CR Release Date: February 3, 2017
Effective Date: April 21, 2016
Related CR Transmittal #: R1786OTN
Implementation Date: July 3, 2017

Provider Types Affected
This MLN Matters® Article is intended for hospitals, including certain Long Term Care Hospitals (LTCHs) submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.
Provider Action Needed

This article is based on Change Request (CR) 9872 which informs MACs about an update to include additional ICD-10 codes for the implementation of the temporary exception for certain wound care discharges from the site neutral payment rate for certain LTCH Hospitals within Hospitals (HwHs).

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

Background

Under the LTCH Prospective Payment System (PPS), for LTCH discharges in cost reporting periods beginning on or after October 1, 2015, Medicare established two separate payment categories for LTCH patients upon discharge. LTCH cases meeting specific clinical criteria are paid the LTCH PPS standard Federal rate payment and those cases not meeting specific clinical criteria are paid the site neutral rate payment (the lesser of an “Inpatient Prospective Payment System (IPPS)-comparable” payment amount or 100 percent of the estimated cost of the case).

In general, in order to be paid at the LTCH PPS standard Federal rate payment amount, an LTCH discharge must either:

1. 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 have a principal diagnosis in the LTCH of a psychiatric or rehabilitation diagnosis or
2. Have been admitted directly from an IPPS hospital and the LTCH discharge is assigned to an MS-LTC-DRG based on the receipt of ventilator services of at least 96 hours, but must not have a principal diagnosis in the LTCH of a psychiatric or rehabilitation diagnosis.

Section 231 of the Consolidated Appropriations Act of 2016 established an additional temporary exception from the site neutral payment rate for patients discharged from certain LTCHs with a severe wound, effective for discharges occurring before January 1, 2017. In a final rule published in the Federal Register on August 22, 2016 (81 FR 57068 through 57075), the Centers for Medicare & Medicaid Services (CMS) updated the list of ICD-10 codes that qualify as severe wounds under the categories:

- Stage 3 wound
- Stage 4 wound
- Unstageable wound
- Non-healing surgical wound
- Fistula
- Osteomyelitis

The complete list of ICD-10 codes for this provision is available for download at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/download.htm. CR9872 adds ICD-10 codes L97.112-L97.114, L97.122-L97.124, L97.912-L97.914, L97.921-L97.924, T81.30XA, T81.30XD, T81.31XA, T81.31XD, T81.32XA, T81.32XD, T81.4XX, T81.4XXA, T81.4XXD, T81.89XA, T81.89XD to this list.

As noted in CR9599, only grandfathered LTCH HwHs are eligible to qualify for this temporary exception. MACs shall verify such status upon request from a hospital.

MACs will reprocess claims with a through date (for interim claims) or a discharge date (for final claims) on or after April 21, 2016, through December 31, 2016, containing one of the above ICD-10 codes and which are eligible for this temporary exception. Such claims will be reprocessed within 60 days of the implementation date of CR9872.

Additional Information

Implementation of New Influenza Virus Vaccine Code

MLN Matters® Number: MM9876
Related Change Request (CR) #: CR 9876
Related CR Release Date: February 3, 2017
Effective Date: July 1, 2017
Related CR Transmittal #: R3711CP
Implementation Date: July 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 services provided to Medicare beneficiaries.

What You Need to Know
Change Request (CR) 9876 provides instructions for payment and edits for the common working file (CWF) to include influenza virus vaccine code 90682 (Influenza virus vaccine, quadrivalent (RIV4), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use) for claims with dates of service on or after July 1, 2017. Make sure that your billing staffs are aware of these instructions.

Background
Effective for dates of service on and after July 1, 2017, influenza virus code 90682 will be payable by Medicare. Annual Part B deductible and coinsurance amounts do not apply to this code. MACs will:

- Effective for dates of service on or after August 1, 2017, MACs will pay for code 90682 using the Centers for Medicare & Medicaid Services (CMS) Seasonal Influenza Vaccines Pricing at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html) to determine the payment rate for influenza virus vaccine code 90682.
- Pay for vaccine code 90682 on institutional claims as follows:
  - Hospitals – Types of Bill (TOB) 12X and 13X, Skilled Nursing Facilities (SNFs) – TOB 22X and 23X, Home Health Agencies (HHAs) – TOB 34X, hospital-based Renal Dialysis Facilities (RDFs) – TOB 72X, and Critical Access Hospitals (CAHs) – TOB 85X, based on reasonable cost
  - Indian Health Service (IHS) Hospitals – TOB 12X, and 13X, IHS CAHs – TOB 85X, and hospices (81X and 82X) based on the lower of the actual charge or 95 percent of the Average Wholesale Price (AWP)
  - Comprehensive Outpatient Rehabilitation Facility (CORF) – TOB 75X, and independent RDFs – TOB 72X, based on the lower of actual charge or 95 percent of the AWP
- MACs will pay at discretion claims for code 90682 with dates of service July 1, 2017, through July 31, 2017.
- MACs will return to the provider (RTP) institutional claims if submitted with code 90682 for dates of service January 1, 2017, through June 30, 2017.
- MACs will deny Part B claims submitted with code 90682 for dates of service January 1, 2017, through June 30, 2017, using the following messages:
  - Claim Adjustment Reason Code: 181 – “Procedure code was invalid on the date of service.”
  - Remittance Advice Remark Code: N56 – “Procedure code billed is not correct/valid for the services billed or the date of service billed.”
- Group Code: CO (Contractual Obligation)
In addition, effective for claims with dates of service on or after October 1, 2016, MACs will pay vaccines (Influenza, PPV, and HepB) to hospices based on the lower of the actual charge or 95% of AWP. Coinsurance and deductibles do not apply. Further, MACs will adjust previously processed hospice claims (TOB 81x or 82x) for these vaccines with dates of service on or after October 1, 2016.

Additional Information

Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment – 2017 Update

MLN Matters® Number: MM9909
Related Change Request (CR) #: CR 9909
Related CR Release Date: December 29, 2016
Effective Date: January 1, 2017
Related CR Transmittal #: R3687CP
Implementation Date: January 3, 2017

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

Provider Action Needed
Change Request (CR) 9909 provides instructions for the Calendar Year (CY) 2017 clinical laboratory fee schedule, mapping for new codes for clinical laboratory tests, and updates for laboratory costs subject to the reasonable charge payment. This update applies to Chapter 16, Section 20 of the “Medicare Claims Processing Manual.”

Background
In accordance with Section 1833(h)(2)(A)(i) of the Social Security Act (the Act), the annual update to the local clinical laboratory fees for CY 2017 is 0.70 percent. The annual update to payments made on a reasonable charge basis for all other laboratory services for CY 2017 is 1.00 percent (See 42 CFR 405.509(b)(1)).

Section 1833(a)(1)(D) of the Act provides that payment for a clinical laboratory test is the lesser of the actual charge billed for the test, the local fee, or the National Limitation Amount (NLA). The Part B deductible and coinsurance do not apply for services paid under the clinical laboratory fee schedule.

Key Points of CR9909

National Minimum Payment Amounts
For a cervical or vaginal smear test (pap smear), Section 1833(h)(7) of the Act requires payment to be the lesser of the local fee or the NLA, but not less than a national minimum payment amount (described below). However, for a cervical or vaginal smear test (pap smear), payment may also not exceed the actual charge.

The CY 2017 national minimum payment amount is $14.49 ($14.39 times 0.70 percent update for CY 2017). The affected codes for the national minimum payment amount are 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88154, 88164, 88165, 88166, 88174, 88175, 80123, 80143, 80144, 80145, 80147, 80148, 80476, and P3000.

National Limitation Amounts (Maximum)
For tests for which NLAs were established before January 1, 2001, the NLA is 74 percent of the median of the local fees. For tests for which the NLAs are first established on or after January 1, 2001, the NLA is 100 percent of the median of the local fees in accordance with Section 1833(h)(4)(B)(viii) of the Act.
Access to Data File

Internet access to the CY 2017 clinical laboratory fee schedule data file will be available at [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/index.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/index.html). Other interested parties, such as the Medicaid state agencies, the Indian Health Service, the United Mine Workers, and the Railroad Retirement Board, should use the Internet to retrieve the CY 2017 clinical laboratory fee schedule. It will be available in multiple formats: Excel, text, and comma delimited.

Data File Format

For each test code, if your system retains only the pricing amount, load the data from the field named “60% Pricing Amt.” For each test code, if your system has been developed to retain the local fee and the NLA, you may load the data from the fields named “60% Local Fee Amt” and “60% Natl Limit Amt” to determine payment. For test codes for cervical or vaginal smears (pap smears), you should load the data from the field named “60% Pricing Amt” which reflects the lower of the local fee or the NLA, but not less than the national minimum payment amount. MACs should use the field “62% Pricing Amt” for payment to qualified laboratories of sole community hospitals.

Public Comments and Final Payment Determinations

On July 18, 2016, the Centers for Medicare & Medicaid Services (CMS) hosted a public meeting to solicit input on payment methods for reconsidered CY 2016 codes and new CY 2017 codes. Notice of the meeting was published in the Federal Register on May 13, 2016 and on the CMS web site on approximately May 18, 2016. Recommendations were received from many attendees, including individuals representing laboratories, manufacturers, and medical societies. CMS posted a summary of the meeting and the tentative payment determinations at [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/index.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/index.html).

Additional written comments from the public were accepted until October 31, 2016. CMS has posted a summary of the public comments and the rationale for the final payment determinations at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/Downloads/CY2017-CLFS-Codes-Final-Determinations.pdf](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/Downloads/CY2017-CLFS-Codes-Final-Determinations.pdf).

Pricing Information

The CY 2017 clinical laboratory fee schedule includes separately payable fees for certain specimen collection methods (codes 36415, P9612, and P9615). The fees have been established in accordance with Section 1833(h)(4)(B) of the Act.

The fees for clinical laboratory travel codes P9603 and P9604 are updated on an annual basis. The clinical laboratory travel codes are billable only for traveling to perform a specimen collection for either a nursing home or homebound patient. If there is a revision to the standard mileage rate for CY 2017, CMS will issue a separate instruction on the clinical laboratory travel fees.

The CY 2017 clinical laboratory fee schedule also includes codes that have a “QW” modifier to both identify codes and determine payment for tests performed by a laboratory having only a certificate of waiver under the Clinical Laboratory Improvement Amendments (CLIA).

Organ or Disease Oriented Panel Codes

Similar to prior years, the CY 2017 pricing amounts for certain organ or disease panel codes and evocative/suppression test codes were derived by summing the lower of the clinical laboratory fee schedule amount or the NLA for each individual test code included in the panel code. The NLA field on the data file is zero-filled.

Mapping Information

New codes:
- G0659 is priced at the same rate as code G0479.
- 80305 is priced at the same rate as code G0477.
- 80306 is priced at the same rate as code G0478.
- 80307 is priced at the same rate as code G0479.
• 81327 is priced at the same rate as code 81287.
• 81413 is priced at the same rate as code 81435.
• 81414 is priced at the same rate as code 81436.
• 81422 is priced at the same rate as code 81436.
• 81439 is priced at the same rate as code 81435.
• 81539 is priced at the same rate as code 0010M.
• 84410 is priced at the same rate as the sum of codes 84402 and 84403.
• 87483 is priced at the same rate as code 87633.
• 87338QW is priced at the same rate as code 87338.
• 87631QW is priced at the same rate as code 87631.

Existing Codes:
• 81420 is priced at the same rate as code 81435.
• G0475 is priced at the same rate as code 87389.
• G0476 is priced at the same rate as code 87624.
• G0480 is priced at the same rate as 4.75 times code 82542.
• G0481 is priced at the same rate as 6.50 times code 82542.
• G0482 is priced at the same rate as 8.25 times code 82542.
• G0483 is priced at the same rate as 10.25 times code 82542.
• G0477, G0478, G0479, 0010M, and 82272QW are all to be deleted.

Laboratory Costs Subject to Reasonable Charge Payment in CY 2017
For outpatients, the following codes are paid under a reasonable charge basis (See Section 1842(b)(3) of the Act). In accordance with 42 CFR 405.502 through 42 CFR 405.508, the reasonable charge may not exceed the lowest of the actual charge or the customary or prevailing charge for the previous 12-month period ending June 30, updated by the inflation-indexed update. The inflation-indexed update is calculated using the change in the applicable Consumer Price Index for the 12-month period ending June 30 of each year as set forth in 42 CFR 405.509(b)(1). The inflation-indexed update for CY 2017 is 1.0 percent.

Chapter 23, Sections 80 through 80.8 of the “Medicare Claims Processing Manual” contains instructions for determining the reasonable charge payment. If there is sufficient charge data for a code, the instructions permit considering charges for other similar services and price lists.

When services described by the HCPCS in the following list are performed for independent dialysis facility patients, Chapter 8, Section 60.3 of the “Medicare Claims Processing Manual” instructs that the reasonable charge basis applies. However, when these services are performed for hospital-based renal dialysis facility patients, payment is made on a reasonable cost basis. Also, when these services are performed for hospital outpatients, payment is made under the hospital Outpatient Prospective Payment System (OPPS).

Note: Reasonable charge codes P9070, P9071, P9072 and 89337 may be included in the next calendar year’s reasonable charge update.
Blood Products

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Also, payment for the following codes should be applied to the blood deductible as instructed in Chapter 3, Sections 20.5 through 20.5.4 of the "Medicare General Information, Eligibility and Entitlement Manual.”

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Note: Biologic products not paid on a cost or prospective payment basis are paid based on Section 1842(o) of the Act. The payment limits based on Section 1842(o), including the payment limits for codes P9041, P9045, P9046, and P9047, should be obtained from the Medicare Part B drug pricing files.

Transfusion Medicine

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Additional Information
**Episode Payment Model Operations**

**MLN Matters® Number: MM9916**  
**Related Change Request (CR) #: CR 9916**  
**Related CR Release Date: February 17, 2017**  
**Effective Date: July 1, 2017**  
**Related CR Transmittal #: R169DEMO**  
**Implementation Date: July 3, 2017**

**Provider Types Affected**  
This MLN Matters® is intended for physicians and acute care hospitals that submit claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

**Provider Action Needed**  
In August 2016, the Centers for Medicare & Medicaid Services (CMS) published a proposed rule that planned to implement an additional set of models that share many design features of the Comprehensive Care for Joint Replacement (CJR) model, but focus on three different clinical conditions. The new Episode Payment Models (EPMs) will focus on Acute Myocardial Infarction (AMI), Coronary Artery Bypass Graft (CABG), and Surgical Hip and Femur Fracture Treatment (SHFFT), most frequently hip pinning. These models will begin in 2017 and run for 5 years.

Change Request (CR) 9916 is intended to prepare Medicare’s claims processing systems for implementation of Episode Payment Models (EPMs). CR9916 directs the MACs to conduct beneficiary eligibility checks, including for overall eligibility for the EPMs as well as for additional related services such as post-discharge home visits. Under EPM, CMS will allow a beneficiary in certain EPM episodes to receive Skilled Nursing Facility (SNF) services without having to meet the three-day requirement in performance years 2 through 5 of the model. This will allow payment of claims for SNF services delivered to beneficiaries at eligible sites.

**Background**  
The Social Security Act (Section 1115A) authorizes 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 (CHIP) beneficiaries. CMS has previously used its legislative authority to create payment models, such as the Bundled Payments for Care Improvement (BPCI) initiative, to test bundled payments.

In April 2016, CMS began testing a new bundled payment model called the Comprehensive Care for Joint Replacement (CJR) Model. The CJR Model requires that hospitals test bundled payments for Lower Extremity Joint Replacement (LEJR) episodes in multiple geographic areas. The CJR Model is designed to promote quality and financial accountability for episodes of care surrounding a LEJR and 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.

In December 2016, CMS published a final rule that implements an additional set of models that share many design features of the CJR Model, but focus on three different clinical conditions, namely:

- Acute Myocardial Infarction (AMI),
- Coronary Artery Bypass Graft (CABG), and
- Surgical Hip and Femur Fracture Treatment (SHFFT), most frequently hip pinning.

These models will begin in 2017 and run for 5 Performance Years (PY).

- PY1: July 1, 2017 – December 31, 2017
- PY2: January 1, 2018 – December 31, 2018
- PY3: January 1, 2019 – December 31, 2019
- PY4: January 1, 2020 – December 31, 2020
- PY5: January 1, 2021 – December 31, 2021
Under the EPMs, acute care hospitals in certain selected geographic areas will take on quality and payment accountability for retrospectively calculated bundled payments for AMI, CABG, and/or SHFFT episodes. All related care within 90 days of hospital discharge will be included in the episode of care.

The final rule also finalized the concurrent implementation of a Cardiac Rehabilitation Incentive Payment (CR) Model. The CR Model will provide incentive payments to hospitals that discharge patients following an AMI or CABG with referral to cardiac rehabilitation/intensive cardiac rehabilitation, an underutilized but effective treatment for patients recovering from an acute cardiac event. Incentive payments will be tied to the number of cardiac rehabilitation/intensive cardiac rehabilitation visits that the patient completes. The CR Model will be implemented in two separate cohorts in order to test its efficacy, one in the same regions as the AMI and CABG models, and one in purely Fee-For-Service (FFS) regions.

EPM Episodes of Care
Medicare currently pays for AMI, CABG, and SHFFT procedures under the Inpatient Prospective Payment System (IPPS) through Medicare Severity Diagnosis Related Groups (MS-DRGs). Under the EPMs, episodes would begin with admission to an acute care hospital when a claim is assigned to an MS-DRG included in one of the EPMs upon beneficiary discharge and paid under the IPPS, and would end 90 days after the date of discharge from the acute care hospital. The episode would include the inpatient 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.

EPM Participants
Participants would be acute care hospitals, who would be the episode initiators (that is, the entity where the episode begins) and bear quality and episode payment accountability under the EPMs. CMS will require all hospitals paid under the IPPS and located in selected geographic areas to participate in the EPMs, with limited exceptions for those hospitals currently participating in BPCI Model 2 or Model 4 for the same clinical episodes. The care for eligible beneficiaries who receive care at these hospitals will automatically be included in the model.

EPM Model Beneficiary Inclusion Criteria
The defined population of Medicare beneficiaries whose care will be included in the EPMs 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 (ESRD) benefit.
- The beneficiary is not prospectively assigned to an Accountable Care Organization (ACO) in the Next Generation ACO model, an ACO in a track of the Comprehensive ESRD Care Model incorporating downside risk for financial losses, or a Shared Savings Program ACO in Track 3.
- 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.

EPM Episode Reconciliation Activities
CMS will continue paying hospitals and other providers according to the conventional Medicare FFS rules during all Performance Years. After each Performance Year, the Medicare payments for services included in the episode for an EPM beneficiary will be aggregated to calculate an actual episode payment. The actual episode payment will then be compared against an established EPM target price that reflects a discount over expected episode spending based on a blend of hospital-specific and regional historical episode data. Based on this comparison and taking into consideration episode quality performance based on the composite quality score calculated for each hospital each performance year, CMS will determine whether reconciliation payment to (applicable for PYs 1-5) or recoupment from (applicable for some hospitals PYs 3-5 and other hospitals PYs 2-5) the hospital will be conducted. In addition, in order to be eligible for a reconciliation payment, the hospital must meet the applicable minimum composite quality score. Calculation of these reconciliation or recoupment amounts will be conducted by a specialty contractor annually and paid or recouped beginning in 2018.
Identifying EPM Claims
To validate the retroactive identification of EPM episodes, CMS is associating the Demonstration Code 79 with the EPM initiative. This code will be used to operationalize the waiver of the 3-day stay requirement for covered SNF services. This waiver will be effective in conjunction with the introduction of downside risk to the AMI episodes ending on or after January 1, 2019 (and beginning on or after 10/4/2018) and it will allow for the payment of SNF Claims for beneficiaries who have not met the 3-day hospital stay requirement for claims containing the Demonstration code 79.3.

SNF 3-Day Waiver
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 beneficiaries for covered SNF services in AMI EPM episodes, effective with AMI EPM episodes that start on or after payment year 3 of the model (January 1, 2019).

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 SNF benefit is available in the “Medicare Benefit Manual,” (Pub 100–02, Chapter 8, Skilled Nursing Facility Services).

As of October 4, 2018, CR9916 allows for payment of SNF claims without a 3-day hospital stay (that is, CMS will waive the 3-day hospital stay requirement when all of the following conditions are 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 hospital participating in an EPM. Participants can be confirmed by a posted file on the CMS website and will be shared with MACs on a monthly basis.

The beneficiary must have been discharged from the EPM hospital for one of the specified MS–DRGs (231-236, 246-251, 280-282) within 30 days prior to the initiation of SNF services. (Note that this list of MS-DRGs may need to be updated prior to October 4, 2018 if annual changes to the IPPS MS-DRGs add, combine or delete any of these DRGs.)

- The beneficiary meets the criteria for inclusion in an EPM 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 American health plan, is not prospectively assigned to an ACO in the Next Generation ACO model, an ACO in a track of the Comprehensive ESRD Care Model incorporating downside risk for financial losses, or a Shared Savings Program ACO in Track 3, and Medicare is the primary payer.

- The waiver will apply if the SNF is qualified to admit EPM beneficiaries under the waiver. A list of qualified SNFs will be communicated to MACs and CMS 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 79 in the Treatment Authorization field on claims that qualify for the SNF waiver under the EPM. Note: The waiver is not valid for swing bed (TOB 18X) stays.

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

Post-Discharge Home Visits
In order for Medicare to pay for home health services, a beneficiary must be determined to be “homebound” and in need of skilled care (skilled nursing, physical therapy or speech-language pathology services). Additional information regarding the home health benefit is available in the Medicare Benefit Manual (Pub 100–02, Chapter 7, Home Health Services.)
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 Physician Fee Schedule (PFS). Medicare policy also allows licensed clinical staff to furnish services “incident to” the physician or NPP visit at a beneficiary’s home when such services are provided under the direct supervision of the physician or NPP. Licensed clinical staff may be any employees, leased employees, or independent contractors who are licensed under applicable state law to perform ordered services. Additional information regarding the “incident to” requirements is available in the Medicare Benefit Manual (Pub 100–02, Chapter 15, Covered Medical and Other Health Services, Sections 60–60.4.1).

For those EPM 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 but who are not homebound or otherwise eligible for the Medicare home health benefit, 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 anytime during the episode, subject to the following conditions:

- Licensed clinical staff will furnish the service under the general supervision of a physician or NPP, who may be either an employee or a contractor of the participant hospital.
- Services will be billed under the PFS by the supervising physician or NPP or by the hospital 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 90-day post-anchor hospitalization EPM episode.
- The service will be billed with HCPCS G-code 9863, which is specific to the AMI, CABG, or SHFFT model home visits for patient assessment. These visits must be performed by clinical staff for an individual not considered homebound, and may include but not necessarily be limited to patient assessment of clinical status, safety/fall prevention, functional status/ambulation, medication reconciliation/management, compliance with orders/plan of care, performance of activities of daily living, and ensuring beneficiary connections to community and other services. The HCPCS G-code is approved for use only in the Medicare approved AMI, CABG, or SHFFT models and may not be billed for a 30-day period covered by a transitional care management code and paid under the PFS.
- The service cannot be furnished to an EPM beneficiary who has qualified, or would qualify, for home health services when the visit was furnished.

As described in the “Medicare Claims Processing Manual” (Pub 100-04, 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 the EPMs, 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.

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.

Additional information on billing and payment for the post-discharge home visit HCPCS G-Code will be available in the July 2017 release of the Medicare Physician Fee Schedule (MPFS) Recurring Update.

**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” (Pub 100-02, Chapter 15, Section 270) and the Medicare Claims Processing Manual (Pub 100-04, Chapter 12, Section 190).
Under EPM, CMS will allow a beneficiary in an EPM 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 an EPM 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 EPM model.
- The telehealth geographic area waiver and the allowance of home as an originating site under the EPM 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 proposed EPM 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 EPM model that reflect the home setting.
- For level 4 and 5 EPM telehealth home visits, 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 would be waived if the service was originated in the beneficiary’s home.

Additional information on billing and payment for the telehealth home visit HCPCS G-Codes will be available in the July 2017 release of the MPFS Recurring Update.

Cardiac Rehabilitation (CR) Incentive Payment Model Billing and Payment

CR services are covered by Medicare and have been shown by research to improve health outcomes. However, these cardiac rehabilitation services have been historically under-utilized by Medicare beneficiaries. The CR Incentive Payment model is designed to provide participant hospitals in 90 different Metropolitan Statistical Areas with incentive payments to encourage the use of cardiac rehabilitation services for beneficiaries in certain MS-DRGs. Providers and suppliers will continue to be paid under the usual Medicare payment system rules and procedures. Following the end of a model performance year, depending on beneficiaries’ utilization of CR/Intensive CR services, participant hospitals may receive an additional incentive payment from Medicare. CMS has provided a waiver of the definition of a physician to include a physician or NPP (defined for the purposes of this waiver as a physician assistant, nurse practitioner, or clinical nurse specialist) in performing specific physician functions in conjunction with the delivery of CR services to EPM-CR and FFS-CR beneficiaries during AMI care periods and CABG care periods.

Additional Information

Changes to the Laboratory NCD Edit Software for April 2017

MLN Matters® Number: MM9934
Related Change Request (CR) #: CR 9934
Related CR Release Date: January 13, 2017
Effective Date: October 1, 2016
Related CR Transmittal #: R3691CP
Implementation Date: April 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 services provided to Medicare beneficiaries.

Provider Action Needed
Change Request (CR) 9934 informs MACs about the changes that will be included in the April 2017 quarterly release of the edit module for clinical diagnostic laboratory services. Make sure that your billing staffs are aware of these changes.

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. Nationally uniform software was developed and incorporated in the Medicare shared systems so laboratory claims subject to one of the 23 NCDs ("Medicare National Coverage Determinations Manual," Sections 190.12 – 190.34, available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part3.pdf) were processed uniformly throughout the nation effective April 1, 2003.

In accordance with Chapter 16, Section 120.2 of the “Medicare Claims Processing Manual,” the laboratory edit module is updated quarterly as necessary to reflect ministerial coding updates and substantive changes to the NCDs developed through the NCD process. This manual chapter is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c16.pdf. 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. CR9934 lists numerous changes to the codes applicable to the various laboratory NCDs code lists for April 2017. Those changes are too numerous to repeat in this article, but the changes are detailed in the spreadsheet attachments to CR9934.

Additional Information
Medicare Outpatient Observation Notice (MOON) Instructions – Revised

MLN Matters® Number: MM9935 Revised
Related Change Request (CR) #: CR 9935
Related CR Release Date: January 27, 2017
Effective Date: February 21, 2017
Related CR Transmittal #: R3698CP
Implementation Date: February 21, 2017

This article was revised on February 2, 2017 to reflect a revised CR9935 issued on January 27. In the article, the CR release date, transmittal number, and the Web address for accessing the CR were revised. All other information remains the same.

Provider Types Affected
This MLN Matters® Article is intended for hospitals, including Critical Access Hospitals (CAHs) submitting claims to Medicare Administrative Contractors (MACs) for outpatient observation services provided to Medicare beneficiaries.

Provider Action Needed
Change Request (CR) 9935 updates Chapter 30 of the “Medicare Claims Processing Manual” to include the Medicare Outpatient Observation Notice (MOON), CMS-10611, and related instructions. Providers should use the MOON to inform Medicare beneficiaries when they are an outpatient receiving observation services, and are not an inpatient of the hospital or a Critical Access Hospital (CAH). The instructions included in Chapter 30 provide guidance for proper issuance of the MOON. The updated Chapter 30 is attached to CR9935.

Background
The MOON is mandated by the Federal Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act), passed on August 6, 2015. This law amended Section 1866(a)(1) of the Social Security Act by adding new subparagraph (Y) that requires hospitals and CAHs to provide written notification and an oral explanation of such notification to individuals receiving observation services as outpatients for more than 24 hours at the hospitals or CAHs.

Scope
Hospitals and CAHs must provide the MOON to beneficiaries in Original Medicare (Fee-For-Service) who receive observation services as outpatients for more than 24 hours. (Note: MA plans are to follow MOON instructions outlined in CR9935/Section 400 of Chapter 30 of the Medicare Claims Processing Manual.

All beneficiaries receiving services in hospitals and CAHs must receive a MOON no later than 36 hours after observation services as an outpatient begin. For purposes of these instructions, the term “beneficiary,” means either beneficiary or representative, when a representative is acting for a beneficiary. This also includes beneficiaries in the following circumstances:

- Beneficiaries who do not have Part B coverage
- Beneficiaries who are subsequently admitted as an inpatient prior to the required delivery of the MOON
- Beneficiaries for whom Medicare is either the primary or secondary payer

The statute expressly provides that the MOON be delivered to beneficiaries receiving observation services as an outpatient for more than 24 hours. In other words, the MOON should not be delivered to all beneficiaries receiving outpatient services. The MOON is intended to inform beneficiaries who receive observation services for more than 24 hours that they are outpatients receiving observation services and not inpatients, and the reasons for such status, and must be delivered no later than 36 hours after observation services begin.
However, hospitals and CAHs may deliver the MOON to an individual receiving observation services as an outpatient before such individual has received more than 24 hours of observation services. Allowing delivery of the MOON before an individual has received 24 hours of observation services affords hospitals and CAHs the flexibility to deliver the MOON consistent with any applicable State law that requires notice to outpatients receiving observation services within 24 hours after observation services begin. The flexibility to deliver the MOON any time up to, but no later than, 36 hours after observation services begin also allows hospitals and CAHs to spread out the delivery of the notice and other hospital paperwork in an effort to avoid overwhelming and confusing beneficiaries.

Hospitals Affected by These Instructions
These instructions apply to hospitals as well as CAHs per Section 1861(e) and Section 1861(mm) of the Social Security Act.

Medicare Outpatient Observation Notice
The MOON is subject to the Paperwork Reduction Act (PRA) process and approved by the Office of Management and Budget (OMB). OMB-approved notices may only be modified as per their accompanying form instructions, as well as per guidance in this section of the manual. Unapproved modifications cannot be made to the OMB-approved, standardized MOON. The notice and accompanying form instructions are available at [http://www.cms.gov/Medicare/Medicare-General-Information/BNI](http://www.cms.gov/Medicare/Medicare-General-Information/BNI).

Alterations to the Notice
In general, the MOON must remain two pages, except as needed for the additional information field discussed below or to include State-specific information below. Hospitals and CAHs subject to State law observation notice requirements may attach an additional page to the MOON to supplement the “Additional Information” section in order to communicate additional content required under State law, or may attach the notice required under State law to the MOON. The pages of the notice can be two sides of one page or one side of separate pages, but must not be condensed to one page.

Hospitals may include their business logo and contact information on the top of the MOON. Text may not be shifted from page 1 to page 2 to accommodate large logos, address headers, or any other information.

Completing the MOON
Hospitals must use the OMB-approved MOON (CMS-10611). Hospitals must type or write the following information in the corresponding blanks of the MOON:

- Patient name
- Patient number
- Reason patient is an outpatient

Hospital Delivery of the MOON
Hospitals and CAHs must provide both the standardized written MOON, as well as oral notification. Oral notification must consist of an explanation of the standardized written MOON. The format of such oral notification is at the discretion of the hospital or CAH, and may include, but is not limited to, a video format. However, a staff person must always be available to answer questions related to the MOON, both in its written and oral delivery formats.

The hospital or CAH must ensure that the beneficiary or representative signs and dates the MOON to demonstrate that the beneficiary or representative received the notice and understands its contents. Use of assistive devices may be used to obtain a signature.

Electronic issuance of the MOON is permitted. If a hospital or CAH elects to issue a MOON viewed on an electronic screen before signing, the beneficiary must be given the option of requesting paper issuance over electronic issuance if that is what the beneficiary prefers. Regardless of whether a paper or electronic version is issued and regardless of whether the signature is digitally captured or manually penned, the beneficiary must be given a paper copy of the MOON with the required beneficiary specific information inserted, at the time of notice delivery.
Refusal to Sign the MOON
If the beneficiary refuses to sign the MOON, and there is no representative to sign on behalf of the beneficiary, the notice must be signed by the staff member of the hospital/CAH who presented the written notification. The staff member’s signature must include the name and title of the staff member, a certification that the notification was presented, and the date and time the notification was presented. The staff member annotates the “Additional Information” section of the MOON to include the staff member’s signature and certification of delivery. The date and time of refusal is considered to be the date of notice receipt.

MOON Delivery to Representatives

The MOON may also be delivered to an authorized representative. Generally, an authorized representative is an individual who, under State or other applicable law, may make health care decisions on a beneficiary’s behalf (for example, the beneficiary’s legal guardian, or someone appointed in accordance with a properly executed durable medical power of attorney).

Notification to a beneficiary who has been deemed legally incompetent is typically made to an authorized representative of the beneficiary. However, if a beneficiary is temporarily incapacitated, a person (typically, a family member or close friend) whom the hospital or CAH has determined could reasonably represent the beneficiary, but who has not been named in any legally binding document, may be a representative for the purpose of receiving the MOON. Such a representative should act in the beneficiary’s best interests and in a manner that is protective of the beneficiary and the beneficiary’s rights. Therefore, a representative should have no relevant conflict of interest with the beneficiary.

In instances where the notice is delivered to a representative who has not been named in a legally binding document, the hospital or CAH should annotate the MOON with the name of the staff person initiating the contact, the name of the person contacted, and the date, time, and method (in person or telephone) of the contact.

Note: There is an exception to the in-person notice delivery requirement. If the MOON must be delivered to a representative who is not physically present to receive delivery of the notice, the hospital/CAH is not required to make an off-site delivery to the representative. The hospital/CAH must complete the MOON as required and telephone the representative.

• The information provided telephonically should include all contents of the MOON.
• Note the date and time the hospital or CAH communicates (or makes a good faith attempt to communicate) this information telephonically to the representative is considered the receipt date of the MOON.
• Annotate the “Additional Information” section to reflect that all of the information indicated above was communicated to the representative.
• Annotate the “Additional Information” section with the name of the staff person initiating the contact, the name of the representative contacted by phone, the date and time of the telephone contact, and the telephone number called.

A copy of the annotated MOON should be mailed to the representative the day telephone contact is made. A hard copy of the MOON must be sent to the representative by certified mail, return receipt requested, or any other delivery method that can provide signed verification of delivery (for example: FedEx or UPS). The burden is on the hospital or CAH to demonstrate that timely contact was attempted with the representative and that the notice was delivered.

If the hospital or CAH and the representative both agree, the hospital or CAH may send the notice by fax or e-mail; however, the hospital or CAH’s fax and e-mail systems must meet the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy and security requirements.
Ensuring Beneficiary Comprehension
The OMB-approved standardized MOON is available in English and Spanish. If the individual receiving the notice is unable to read its written contents and/or comprehend the required oral explanation, hospitals and CAHs must employ their usual procedures to ensure notice comprehension. Usual procedures may include, but are not limited to, the use of translators, interpreters, and assistive technologies.

Hospitals and CAHs are reminded that recipients of Federal financial assistance have an independent obligation to provide language assistance services to individuals with Limited English Proficiency (LEP) consistent with Section 1557 of the Affordable Care Act and Title VI of the Civil Rights Act of 1964.
In addition, recipients of Federal financial assistance have an independent obligation to provide auxiliary aids and services to individuals with disabilities free of charge, consistent with Section 1557 of the Affordable Care Act and Section 504 of the Rehabilitation Act of 1973.

Completing the Additional Information Field of the MOON
This section may be populated with any additional information a hospital wishes to convey to a beneficiary. Such information may include, but is not limited to:
• Contact information for specific hospital departments or staff members
• Additional content required under applicable State law related to notice of observation services
• Part A cost-sharing responsibilities if a beneficiary is admitted as an inpatient before 36 hours following initiation of observation services
• The date and time of the inpatient admission if a patient is admitted as an inpatient prior to delivery of the MOON
• Medicare Accountable Care Organization information
• Hospital waivers of the beneficiary’s responsibility for the cost of self-administered drugs
• Any other information pertaining to the unique circumstances regarding the particular beneficiary
If a hospital or CAH wishes to add information that cannot be fully included in the “Additional Information” section, an additional page may be attached to the MOON.

Notice Retention for the MOON
The hospital or CAH must retain the original signed MOON in the beneficiary’s medical record. The beneficiary should receive a paper copy of the MOON that includes all of the required information. Electronic notice retention is permitted.

Intersection with State Observation Notices
Hospitals and CAHs in States that have State-specific observation notice requirements may add State-required information to the “Additional Information” field, attach an additional page, or attach the notice required under State law to the MOON.

Additional Information
The official instruction, CR9935, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3698CP.pdf. As mentioned earlier, the notice and accompanying instructions are available at http://www.cms.gov/Medicare/Medicare-General-Information/BNI.
ASP Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files – April 2017

MLN Matters® Number: MM9945
Related Change Request (CR) #: CR 9945
Related CR Release Date: January 13, 2017
Effective Date: April 1, 2017
Related CR Transmittal #: R3692CP
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.

What You Need to Know
Change Request (CR) 9945 provides the April 2017 quarterly update and instructs MACs to download and implement the April 2017 ASP drug pricing files and, if released by the Centers for Medicare & Medicaid Services (CMS), the revised January 2017, October 2016, July 2016, and April 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 April 3, 2017, with dates of service April 1, 2017, through June 30, 2017. MACs will not search and adjust claims previously processed unless brought to their attention.

For claims with a date of service on or after January 1, 2017, and consistent with Section 5004 of the 21st Century Cures Act, which was signed into law on December 13, 2016, payment for infusion drugs furnished through a covered item of Durable Medical Equipment (DME) will be based on Section 1847A of the Social Security Act, meaning that most of the payments will be based on the ASP of these drugs. Payment for DME infusion drugs that do not appear on the ASP Drug Pricing Files will be determined by the MACs in accordance with the “Medicare Claims Processing Manual,” Chapter 17, Section 20.1.3, which is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c17.pdf. 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>April 2017 ASP and ASP NOC</td>
<td>April 1, 2017, through June 30, 2017</td>
</tr>
<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>
</tbody>
</table>

Additional Information
Clinical Laboratory Fee Schedule – Medicare Travel Allowance Fees for Collection of Specimens

MLN Matters® Number: MM9960
Related Change Request (CR) #: CR 9960
Related CR Release Date: February 10, 2017
Effective Date: January 1, 2017
Related CR Transmittal #: R3717CP
Implementation Date: May 12, 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) 9960 revises the payment of travel allowances when billed on a per mileage basis using Health Care Common Procedure Coding System (HCPCS) code P9603 and when billed on a flat-rate basis using HCPCS code P9604 for Calendar Year (CY) 2017. Make sure that your billing staffs are aware of these changes.

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

Key Changes
The travel codes allow for payment either on a per mileage basis (P9603) or on a flat-rate per trip basis (P9604). Payment of the travel allowance is made only if a specimen collection fee is also payable. The travel allowance is intended to cover the estimated travel costs of collecting a specimen including the laboratory technician's salary and travel expenses. MAC discretion allows the contractor to choose either a mileage basis or a flat rate, and how to set each type of allowance. Because audits have shown that some laboratories abused the per mile fee basis by claiming travel mileage in excess of the minimum distance necessary for a laboratory technician to travel for specimen collection, many MACs established local policy to pay based on a flat-rate basis only.

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

- Per Mile Travel Allowance (P9603) – The per mile travel allowance is to be used in situations where the average trip to the patients' homes is longer than 20 miles round trip, and is to be prorated in situations where specimens are drawn from non-Medicare patients in the same trip.
- The allowance per mile was computed using the Federal mileage rate of $0.535 per mile plus an additional $0.45 per mile to cover the technician's time and travel costs. MACs have the option of establishing a higher per mile rate in excess of the minimum $0.99 per mile ($0.985 is rounded up for system purposes) if local conditions warrant it. The minimum mileage rate will be reviewed and updated throughout the year, as well as in conjunction with the Clinical Laboratory Fee Schedule (CLFS), as needed. At no time will the laboratory be allowed to bill for more miles than are reasonable, or for miles that are not actually traveled by the laboratory technician.
- Per Flat-Rate Trip Basis Travel Allowance (P9604) – The per flat-rate trip basis travel allowance is $9.85.

The Internal Revenue Service (IRS) determines the standard mileage rate for businesses based on periodic studies of the fixed and variable costs of operating an automobile.

Additional Information
MPFSDB – April 2017 Update

MLN Matters® Number: MM9977
Related Change Request (CR) #: CR 9977
Related CR Release Date: February 15, 2017
Effective Date: January 1, 2017
Related CR Transmittal #: R3719CP
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 and subject to the Medicare Physician Fee Schedule (MPFS).

Provider Action Needed
Change Request (CR) 9977 informs MACs about changes to the MPFS payment files. While the changes will be implemented in Medicare systems on April 3, the changes are effective January 1, 2017. Note that MACs need not search their files to either retract payment for claims already paid or to retroactively pay claims already processed. However, the MACs will adjust such claims that you bring to their attention. Make sure that your billing staffs are aware of these changes.

Background
Payment files were issued to the MACs based upon the CY 2017 MPFS Final Rule, published in the Federal Register on November 15, 2016, to be effective for services furnished between January 1, 2017, and December 31, 2017.

Below is a summary of the changes for the April update to the 2017 MPFSDB. These changes are effective for dates of service on or after January 1, 2017.

<table>
<thead>
<tr>
<th>CPT/HCPCS Code</th>
<th>Mod</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0477</td>
<td></td>
<td>Procedure Status = I</td>
</tr>
<tr>
<td>G0478</td>
<td></td>
<td>Procedure Status = I</td>
</tr>
<tr>
<td>G0479</td>
<td></td>
<td>Procedure Status = I</td>
</tr>
<tr>
<td>22867</td>
<td></td>
<td>Assistant Surgery Indicator = 2</td>
</tr>
<tr>
<td>22869</td>
<td></td>
<td>Assistant Surgery Indicator = 2</td>
</tr>
<tr>
<td>76519</td>
<td>26</td>
<td>Bilateral Surgery Indicator = 3</td>
</tr>
<tr>
<td>92136</td>
<td>26</td>
<td>Bilateral Surgery Indicator = 3</td>
</tr>
<tr>
<td>97161</td>
<td></td>
<td>Non-facility &amp; Facility PE RVU = 1.00</td>
</tr>
<tr>
<td>97162</td>
<td></td>
<td>Non-facility &amp; Facility PE RVU = 1.00</td>
</tr>
<tr>
<td>97163</td>
<td></td>
<td>Non-facility &amp; Facility PE RVU = 1.00</td>
</tr>
<tr>
<td>97165</td>
<td></td>
<td>Non-facility &amp; Facility PE RVU = 1.32</td>
</tr>
<tr>
<td>97166</td>
<td></td>
<td>Non-facility &amp; Facility PE RVU = 1.32</td>
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<tr>
<td>97167</td>
<td></td>
<td>Non-facility &amp; Facility PE RVU = 1.32</td>
</tr>
<tr>
<td>97168</td>
<td></td>
<td>Non-facility &amp; Facility PE RVU = 0.93</td>
</tr>
</tbody>
</table>
In addition, the following new codes have been added to the HCPCS file effective February 1, 2017. The HCPCS file coverage code is C (carrier judgment) for these new codes. Coverage and payment will be determined by the MAC (they are not part of the MPFS).

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>0001U</td>
<td>RBC DNA HEA 35 AG 11 BLD GRP</td>
<td>Red blood cell antigen typing, DNA, human erythrocyte antigen gene analysis of 35 antigens from 11 blood groups, utilizing whole blood, common RBC alleles reported</td>
</tr>
<tr>
<td>0002U</td>
<td>ONC CLRCT 3 UR METAB ALG PLP</td>
<td>Oncology (colorectal), quantitative assessment of three urine metabolites (ascorbic acid, succinic acid and carnitine) by liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring acquisition, algorithm reported as likelihood of adenomatous polyps</td>
</tr>
<tr>
<td>0003U</td>
<td>ONC OVAR 5 PRTN SER ALG SCOR</td>
<td>Oncology (ovarian) biochemical assays of five proteins (apolipoprotein A-1, CA 125 II, follicle stimulating hormone, human epididymis protein 4, transferrin), utilizing serum, algorithm reported as a likelihood score</td>
</tr>
</tbody>
</table>

Additional Information

### Clarification of Admission Order and Medical Review Requirements

**MLN Matters® Number:** MM9979  
**Related Change Request (CR) #:** CR 9979  
**Related CR Release Date:** March 10, 2017  
**Effective Date:** January 1, 2016  
**Related CR Transmittal #:** R234BP  
**Implementation Date:** June 12, 2017

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

**Provider Action Needed**
Change Request (CR) 9979, from which this article was developed, clarifies the rulemaking language of the Centers for Medicare & Medicaid Services (CMS) as it relates to “Admission and Medical Review Criteria for Hospital Inpatient Services Under Medicare Part A: Requirements for Physician Orders.” The updated language will be added to Chapter 1, Section 10.2 (Hospital Inpatient Admission Order and Certification) of the “Medicare Benefit Policy Manual” (Pub. 100-02).

**Background**
In response to concerns about the provision of observation services for increasingly long periods of time and in response to stakeholders’ concerns about the clarity and appropriateness of Medicare’s hospital inpatient admission and medical review guidelines, CMS published several clarifications and changes in policy in the Fiscal Year (FY) 2014 Inpatient Prospective Payment System (IPPS)/Long-Term Care Hospital (LTCH), PPS final rule and subsequent rulemaking. These clarifications and changes remain in the text of the final rules. However, the “Benefit Policy Manual” has not been updated to reflect the same clarifications and changes. CR 9979 resolves that issue.

In the FY 2014 IPPS/LTCH PPS final rule and subsequent rulemaking, CMS clarified and specified that an individual becomes an inpatient of a hospital, including a Critical Access
Hospital (CAH), when formally admitted as such pursuant to an order for inpatient admission by a physician or other qualified practitioner described in the final regulations. The order is required for payment of hospital inpatient services under Medicare Part A.

CMS specified that for those hospital stays in which the physician expects the beneficiary to require care that crosses two midnights and admits the beneficiary based upon that expectation, Medicare Part A payment is generally appropriate. Conversely, CMS specified that hospital stays in which the physician expects the patient to require care less than two midnights, payment under Medicare Part A is generally inappropriate.

This revised CMS guidance to hospitals and physicians relating to when hospital inpatient admissions are determined reasonable and necessary for payment under Part A.

Additional Information

Gender Dysphoria and Gender Reassignment Surgery
MLN Matters® Number: MM9981
Related Change Request (CR) #: CR 9981
Related CR Release Date: March 3, 2017
Effective Date: August 30, 2016
Related CR Transmittal #: R194NCD
Implementation Date: April 4, 2017

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

What You Need to Know
This article is based on Change Request (CR) 9981, which informs MACs that coverage determinations for gender reassignment surgery will continue to be made by the local MACs on a case-by-case basis. Make sure that your billing staffs are aware of these changes.

Background
On August 30, 2016, the Centers for Medicare & Medicaid Services (CMS) issued a final decision memorandum (DM) on gender reassignment surgery for gender dysphoria. Importantly, the DM did not create or change existing policy – CMS did not issue a national coverage determination (NCD).

The purpose of this CR is to include an explanatory paragraph about gender reassignment surgery in the Medicare NCD Manual at Chapter 1, Part 2, Section 140.9. This is in response to public inquires to have information about gender reassignment surgery among Medicare coverage information.

Policy: Effective for claims with dates of service on or after August 30, 2016, coverage determinations for gender reassignment surgery, under section 1862(a)(11)(A) of the Social Security Act and any other relevant statutory requirements, will continue to be made by the local Medicare Administrative Contractors (MACs) on a case-by-case basis.

Additional Information
DMEPOS Fee Schedule – April 2017 Update

MLN Matters® Number: MM 9988
Related Change Request (CR) #: CR9988
Related CR Release Date: March 3, 2017
Effective Date: April 1, 2017
Related CR Transmittal #: R3729CP
Implementation Date: April 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) 9988 provides the April 2017 quarterly update for the Medicare DMEPOS fee schedule, and it includes information, when necessary, to implement fee schedule amounts for new codes and correct any fee schedule amounts for existing codes.

Background
The DMEPOS fee schedules are updated on a quarterly basis, when necessary, in order to implement fee schedule amounts for new and existing codes, as applicable, and apply changes in payment policies. The quarterly update process for the DMEPOS fee schedule is located in the “Medicare Claims Processing Manual” (Pub.100-04, Chapter 23, Section 60).

Payment on a fee schedule basis is required for durable medical equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by the Social Security Act (§1834(a), (h), and (i)). Also, payment on a fee schedule basis is a regulatory requirement at 42 Code of Federal Regulations (CFR) §414.102 for parenteral and enteral nutrition (PEN), splints and casts, and intraocular lenses (IOLs) inserted in a physician’s office.

Additionally, Section §1834(a)(1)(F)(ii) of the Act mandates adjustments to the fee schedule amounts for certain items furnished on or after January 1, 2016, in areas that are not competitive bid areas, based on information from competitive bidding programs (CBPs) for DME. The Social Security Act (§1842(s)(3)(B)) provides authority for making adjustments to the fee schedule amount for enteral nutrients, equipment, and supplies (enteral nutrition) based on information from CBPs. Also, the adjusted fees apply a rural payment rule. The DMEPOS and PEN fee schedule files contain HCPCS codes that are subject to the adjustments as well as codes that are not subject to the fee schedule adjustments. Additional information on adjustments to the fee schedule amounts based on information from CBPs is available in CR 9642 (Transmittal 3551, dated June 23, 2016).

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

The Calendar Year (CY) 2017 DMEPOS and PEN fee schedules and the April 2017 DMEPOS Rural ZIP code file public use files (PUFs) will be available for State Medicaid Agencies, managed care organizations, and other interested parties shortly after the release of the data files at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched.
KU Modifier for Complex Rehabilitative Power Wheelchair Accessories & Seat and Back Cushions

Section 16005 of the 21st Century Cures Act extends the effective date through June 30, 2017, to exclude adjustments to fees using information from CBPs for certain wheelchair accessories (including seating systems) and seat and back cushions furnished in connection with Group 3 complex rehabilitative power wheelchairs (codes K0848 through K0864). As a result, the KU modifier fees have been added back to the DMEPOS fee schedule file effective January 1, 2017, and are effective for dates of service through June 30, 2017. The fees for items denoted with the HCPCS modifier ‘KU’ represent the unadjusted fee schedule amounts (the CY 2015 fee schedule amount updated by the 2016 and 2017 DMEPOS covered item update factor of 0.7 percent). The applicable complex rehabilitative wheelchair accessory codes are listed in CR 9520 (Transmittal 3535, dated June 7, 2016).

Note for Change Request 8822 Reclassification of Certain DME to the Capped Rental Payment Category

For dates of service on or after January 1, 2017, payment for the following HCPCS codes in all geographic areas is made on a capped rental basis: E0197, E0140, E0149, E0985, E1020, E1028, E2228, E2368, E2369, E2370, E2375, K0015, K0070, and E0955.

For dates of service on or after July 1, 2016, through December 31, 2016, these HCPCS codes were reclassified from the payment category for inexpensive and routinely purchased DME to payment on a capped rental basis in all areas except the nine Round 1 Recompete (Round 1 2014) Competitive Bidding Areas (CBAs). Program instructions on these changes were issued in CR 8822 (Transmittal 1626, dated February 19, 2016) and CR 8566 (Transmittal 1332, dated January 2, 2014). Related MLN Matters® articles are at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8822.pdf and https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8566.pdf, respectively.

When submitting claims, suppliers that submit claims with more than four modifiers including when the claim is being billed with both the RT (right) and the LT (left) modifiers will include the NU (Purchase of new equipment) or RR (Rental) modifier as appropriate, the RT and LT modifiers and then the 99 modifier to signify that there are additional modifiers in use. On the narrative line, the supplier will include all applicable modifiers including the NU or RR, RT and LT modifiers.

Example

- Procedure code: E2370
- Units of Service = 2
- Modifiers: RR, LT, RT, 99 (RB, KX reported in additional narrative)

Payment for Oxygen Volume Adjustments and Portable Oxygen Equipment

CR 9848 (Transmittal 3679, dated December 16, 2016) titled Payment for Oxygen Volume Adjustments and Portable Oxygen Equipment, updated the “Medicare Claims Processing Manual” (Pub.100-04, chapter 20, section 130.6) to clarify billing when the prescribed amount of stationary oxygen exceeds 4 liters per minute (LPM) and portable oxygen is prescribed. The QF modifier is used to denote when the oxygen flow exceeds 4 LPM and portable oxygen is prescribed.

The Social Security Act (§ 1834(a)(5)(C) and (D)) requires that when there is an oxygen flow rate that exceeds 4 LPM that the Medicare payment amount be the higher of 50 percent of the stationary payment amount (codes E0424, E0439, E1390, or E1391) or the portable oxygen add-on amount (E0431, E0433, E0434, E1392, or K0738), and never both.

To facilitate this payment calculation, the QF modifier is added to the DMEPOS fee schedule file effective April 1, 2017, for both stationary and portable oxygen. The stationary oxygen QF modifier fee schedule amounts represent 100 percent of the stationary oxygen fee schedule amount. The portable oxygen QF fee schedule amounts represent the higher of 50 percent of the monthly stationary oxygen payment amount or the fee schedule amount for the portable oxygen add-on amount.

Effective April 1, 2017, the modifier “QF” should be used in conjunction with claims submitted for stationary oxygen (codes E0424, E0439, E1390, or E1391) and portable oxygen (codes E0431, E0433, E0434, E1392, or K0738) when the prescribed amount of oxygen is greater than 4 liters per minute (LPM).
Additional Information

I/OCE Specifications Version 18.1 – April 2017
MLN Matters® Number: MM10002
Related Change Request (CR) #: CR 10002
Related CR Release Date: March 10, 2017
Effective Date: April 1, 2017
Related CR Transmittal #: R3735CP
Implementation Date: April 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) 10002 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 your billing staff is aware of these changes. The I/OCE specifications will be posted at http://www.cms.gov/OutpatientCodeEdit/. These specifications contain the appendices mentioned in the table below.

Key I/OCE Changes for April 2017
The following table summarizes the modifications of the I/OCE for the April 2017 v18.1 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>101</td>
<td>Update Section 603 logic to remove observation and change Payment Method Flag assignment to 8 (see Appendix E, Appendix Q of attachment to CR10002).</td>
</tr>
<tr>
<td>1/1/2017</td>
<td></td>
<td>Update Section 603 logic to change the Payment Method Flag to 8 for New Technology Ambulatory Payment Classifications (APC) (see Appendix Q).</td>
</tr>
<tr>
<td>1/1/2015</td>
<td></td>
<td>Update comprehensive APC logic to clear Composite Adjustment Flag assignment (if present) from the output when reported on a comprehensive APC claim (see Special processing logic, Appendix K – multiple imaging composite and Appendix L).</td>
</tr>
<tr>
<td>1/1/2017</td>
<td></td>
<td>Update logic to output Status Indicator (SI) = E1 for revenue codes reported without HCPCS codes that previously had SI = E (see Appendix N).</td>
</tr>
<tr>
<td>1/1/2017</td>
<td></td>
<td>Update logic for Advance Care Planning (ACP) to revert to processing at the day level (not claim level). Additionally, update logic for add-on ACP code 99498 to retain SI = N when reported on a claim with the Annual Wellness Visit (AWV) but without primary ACP code 99497 (see Special processing logic).</td>
</tr>
<tr>
<td>Date</td>
<td>Description</td>
<td></td>
</tr>
<tr>
<td>------------</td>
<td>-------------</td>
<td></td>
</tr>
<tr>
<td>1/1/2017</td>
<td>Update Section 603 logic to change the Payment Method Flag to 8 for New Technology Ambulatory Payment Classifications (APC) (see Appendix Q).</td>
<td></td>
</tr>
<tr>
<td>2/1/2017</td>
<td>Implement mid-quarter coverage for new Proprietary Laboratory Analysis (PLA) codes 0001U, 0002U, and 0003U.</td>
<td></td>
</tr>
<tr>
<td>4/1/2017</td>
<td>Terminate the editing requirements for Partial Hospitalization Program (PHP)/Community Mental Health Centers (CMHC) add-on codes reported without a primary PHP procedure (see notes in Table 4 and Appendix F-a).</td>
<td></td>
</tr>
<tr>
<td>1/1/2017</td>
<td>Correct conditional APC program logic to assign standard SI/APC for critical care ancillary service codes 36600, 43752 and 94660 that have SI = Q1 when the codes are reported without critical care or other payable HCPCS.</td>
<td></td>
</tr>
<tr>
<td>4/1/2017</td>
<td>Revised documentation in the special processing logic section for Conditional APC processing and Critical Care Ancillary Services processing for clarity; this clarification does not represent any changes to the processing logic.</td>
<td></td>
</tr>
<tr>
<td>4/1/2017</td>
<td>Update the following lists for the release (see quarterly data files):</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Edit 99 exclusion list</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Device procedure list (edit 92)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Skin substitute product list (edit 87 and Appendix O)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Complexity-adjusted comprehensive APC pairs (new table, CapcPairs)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Terminated Device-Procedures (terminated procedures or those submitted for device credit): note several codes with corrected device credit amounts</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Code Pairs (termination of PHP pairs for edit 84; move complexity-adjusted pairs to new table CapcPair)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Offset APC (Contrast APCs subject to pass-through offset)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Radiation HCPCS (new table listing HCPCS subject to Section 603 exclusion logic)</td>
<td></td>
</tr>
<tr>
<td>4/1/2017</td>
<td>Make all HCPCS/APC/SI changes as specified by CMS (quarterly data files).</td>
<td></td>
</tr>
<tr>
<td>4/1/2017</td>
<td>Implement version 23.1 of the NCCI (as modified for applicable outpatient institutional providers).</td>
<td></td>
</tr>
</tbody>
</table>

Additional Information

Chronic Care Management Services FAQs – Rescinded
MLN Matters® Number: SE1516 Rescinded
Article Release Date: January 19, 2017

This article was rescinded on January 19, 2017, because CMS has implemented changes to the payment policy for Chronic Care Management beginning January 1, 2017. Those changes are outlined in the Calendar Year 2017 Physician Fee Schedule (PFS) Final Rule at https://www.gpo.gov/fdsys/pkg/FR-2016-11-15/pdf/2016-26668.pdf and the new guidance on the PFS Care Management web page at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Care-Management.html.
HCPCS Codes Used for Home Health Consolidated Billing Enforcement – Annual Update – Revised

MLN Matters® Number: MM9771 Revised
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

This article was revised on January 12, 2017, to correct in the table on page 2. The table incorrectly listed HCPCS code 97177. The correct HCPCS code is HCPCS 97167 (OT EVAL HIGH COMPLEX 60 MIN). All other information is unchanged.

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>
</tbody>
</table>
**HCPCS Code** | **Descriptor**
--- | ---
97166 | OT EVAL MOD COMPLEX 45 MIN
97167 | OT EVAL HIGH COMPLEX 60 MIN
97168 | OT RE-EVAL EST PLAN CARE

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**

**Instructions to Process Services Not Authorized by the VA in a Non-VA Facility Reported with VC 42 – Revised**

MLN Matters® Number: MM9818 Revised
Related Change Request (CR) #: CR 9818
Related CR Release Date: February 14, 2017
Effective Date: October 1, 2013
Related CR Transmittal #: R3718CP
Implementation Date: April 3, 2017

This article was revised on February 17, 2017, to reflect a revised CR9818 issued on February 14. In the article, the CR release date, transmittal number, and the Web address for accessing the CR were revised. All other information remains the same.

**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 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


Common Working File MSP Type for Liability Medicare Set-Aside Arrangements and No-Fault Medicare Set-Aside Arrangements

MLN Matters® Number: MM9893
Related Change Request (CR) #: CR 9893
Related CR Release Date: February 3, 2017
Effective Date: October 1, 2017
Related CR Transmittal #: R1787OTN
Implementation Date: October 2, 2017

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

What You Need to Know
This article is based on Change Request (CR) 9893. To comply with the Government Accountability Office (GAO) final report entitled Medicare Secondary Payer (MSP): Additional Steps Are Needed to Improve Program Effectiveness for Non-Group Health Plans (GAO 12-333), the Centers for Medicare & Medicaid Services (CMS) will establish two (2) new set-aside processes: a Liability Insurance Medicare Set-Aside Arrangement (LMSA), and a No-Fault Insurance Medicare Set-Aside Arrangement (NFMSA). An LMSA or an NFMSA is an allocation of funds from a liability or an auto/no-fault related settlement, judgment, award, or other payment that is used to pay for an individual’s future medical and/or future prescription drug treatment expenses that would otherwise be reimbursable by Medicare.

Please be sure your billing staffs are aware of these changes.

Background
CMS will establish two (2) new set-aside processes: a Liability Medicare Set-aside Arrangement (LMSA), and a No-Fault Medicare Set-aside Arrangement (NFMSA).

CR 9893 addresses (1) the policies, procedures, and system updates required to create and utilize an LMSA and an NFMSA MSP record, similar to a Workers’ Compensation Medicare Set-Aside Arrangement (WCMSA) MSP record, and (2) instructs the MACs and shared systems when to deny payment for items or services that should be paid from an LMSA or an NFMSA fund.
Pursuant to 42 U.S.C. Sections 1395y(b)(2) and 1862(b)(2)(A)(ii) of the Social Security Act, Medicare is precluded from making payment when payment “has been made or can reasonably be expected to be made under a workers’ compensation plan, an automobile or liability insurance policy or plan (including a self-insured plan), or under no-fault insurance.” Medicare does not make claims payment for future medical expenses associated with a settlement, judgment, award, or other payment because payment “has been made” for such items or services through use of LMSA or NFMSA funds. However, Liability and No – Fault MSP claims that do not have a Medicare Set-Aside Arrangement (MSA) will continue to be processed under current MSP claims processing instructions.

Key Points of CR9893

Medicare will not pay for those services related to the diagnosis code (or related within the family of diagnosis codes) associated with the open LMSA or NFMSA MSP record when the claim’s date of service is on or after the MSP effective date and on or before the MSP termination date. Your MAC will deny such claims using Claim Adjustment Reason Code (CARC) 201 and Group Code “PR” will be used when denying claims based on the open LMSA or NFMSA MSP auxiliary record.

In addition to CARC 201 and Group Code PR, when denying a claim based upon the existence of an open LMSA or NFMSA MSP record, your MAC will include the following Remittance Advice Remark Codes (RARCs) as appropriate to the situation:

- N723—Patient must use Liability Set Aside (LSA) funds to pay for the medical service or item.
- N724—Patient must use No-Fault Set-Aside (NFSA) funds to pay for the medical service or item.

Where appropriate, MACs may override and make payment for claim lines or claims on which:

- Auto/no-fault insurance set-asides diagnosis codes do not apply, or
- Liability insurance set-asides diagnosis codes do not apply, or are not related, or
- When the LMSA and NFMSA benefits are exhausted/terminated per CARC or RARC and payment information found on the incoming claim as cited in
  
- CR9009.

On institutional claims, if the MAC is attempting to allow payment on the claim, the MAC will include an “N” on the ‘001’ Total revenue charge line of the claim.

Additional Information


QMB Indicator in the Medicare Fee-For-Service Claims Processing System

MLN Matters® Number: MM9911
Related Change Request (CR) #: CR 9911
Effective Date: for claims processed on or after October 2, 2017
Related CR Release Date: February 3, 2017
Related CR Transmittal #: R3715CP
Implementation Date: October 2, 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) 9911 modifies the Medicare claims processing systems to help providers more readily identify the Qualified Medicare Beneficiary (QMB) status of each patient and to support providers’ ability to follow QMB billing requirements. Beneficiaries enrolled in the QMB program are not liable to pay Medicare cost-sharing for all Medicare A/B claims. CR 9911 adds an indicator of QMB status to Medicare’s claims processing systems. This system enhancement will trigger notifications to providers (through the Provider Remittance Advice) and to beneficiaries (through the Medicare Summary Notice) to reflect that the beneficiary is enrolled in the QMB program and has no Medicare cost-sharing liability. Make sure that your billing staffs are aware of these changes.

Background

QMB is a Medicaid program that assists low-income beneficiaries with Medicare premiums and cost-sharing. In 2015, 7.2 million persons (more than one out of every ten Medicare beneficiaries) were enrolled in the QMB program.

Under federal law, Medicare providers may not bill individuals enrolled in the QMB program for Medicare deductibles, coinsurance, or copayments, under any circumstances. (See Sections 1902(n)(3)(B); 1902(n)(3)(C); 1905(p)(3); 1866(a)(1)(A); 1848(b)(3)(A) of the Social Security Act.) State Medicaid programs may pay providers for Medicare deductibles, coinsurance, and copayments. However, as permitted by Federal law, states can limit provider reimbursement for Medicare cost-sharing under certain circumstances. Nonetheless, 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 an individual enrolled in the QMB program.

CR 9911 aims to support Medicare providers’ ability to meet these requirements by modifying the Medicare claims processing system to clearly identify the QMB status of all Medicare patients. Currently, neither the Medicare eligibility systems (the HIPAA Eligibility Transaction System (HETS)), nor the claims processing systems (the FFS Shared Systems), notify providers about their patient’s QMB status and lack of Medicare cost-sharing liability. Similarly, Medicare Summary Notices (MSNs) do not inform those enrolled in the QMB program that they do not owe Medicare cost-sharing for covered medical items and services.

CR 9911 includes modifications to the FFS claims processing systems and the “Medicare Claims Processing Manual” to generate notifications to Medicare providers and beneficiaries regarding beneficiary QMB status and lack of liability for cost-sharing.

With the implementation of CR 9911, Medicare’s Common Working File (CWF) will obtain QMB indicators so the claims processing systems will have access to this information.

- CWF will provide the claims processing systems the QMB indicators if the dates of service coincide with a QMB coverage period (one of the occurrences) for the following claim types: Part B professional claims; Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) claims; and outpatient institutional Types of Bill (TOB) 012x, 013x, 014x, 022x, 023x, 034x, 071x, 072x, 074x, 075x, 076x, 077x, and 085x); home health claims (TOB 032x) only if the revenue code for the line item is 0274, 029x, or 060x; and Skilled Nursing Facility (SNF) claims (based on occurrence code 50 date for revenue code 0022 lines on TOBs 018x and 021x).
- CWF will provide the claims processing systems the QMB indicator if the “through date” falls within a QMB coverage period (one of the occurrences) for inpatient hospital claims (TOB 011x) and religious non-medical health care institution claims (TOB 041x).

The QMB indicators will initiate new messages on the Remittance Advice that reflect the beneficiary’s QMB status and lack of liability for Medicare cost-sharing with three new Remittance Advice Remark Codes (RARC) that are specific to those enrolled in QMB. As appropriate, one or more of the following new codes will be returned:

- N781 – No deductible may be collected as patient is a Medicaid/Qualified Medicare Beneficiary. Review your records for any wrongfully collected coinsurance, deductible or co-payments.
- N782 – No coinsurance may be collected as patient is a Medicaid/Qualified Medicare Beneficiary. Review your records for any wrongfully collected coinsurance, deductible or co-payments.
- N783 – No co-payment may be collected as patient is a Medicaid/Qualified Medicare Beneficiary. Review your records for any wrongfully collected coinsurance, deductible or co-payments.
In addition, the MACs will include a Claim Adjustment Reason Code of 209 (“Per regulatory or other agreement. The provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to patient if collected. (Use only with Group code OA (Other Adjustment)).

Finally, CR 9911 will modify the MSN to inform beneficiaries if they are enrolled in QMB and cannot be billed for Medicare cost-sharing for covered items and services.

Additional Information

For more information regarding billing rules applicable to individuals enrolled in the QMB Program, see the MLN Matters® article, SE1128, at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se1128.pdf.

The Process of Prior Authorization
MLN Matters® Number: MM9940
Related Change Request (CR) #: CR 9940
Related CR Release Date: January 20, 2017
Effective Date: February 21, 2017
Related CR Transmittal #: R698PI
Implementation Date: February 21, 2017

Provider Types Affected
This MLN Matters® Article is intended for providers ordering certain DMEPOS items and suppliers submitting claims to Medicare Administrative Contractors (MACs) for items furnished to Medicare beneficiaries.

What You Need to Know
Change Request (CR) 9940 updates the Centers for Medicare & Medicaid Services (CMS) “Program Integrity Manual” to permit the MACs to conduct prior authorization processes, as so directed by CMS through individualized operational instructions. As of January 2017, Prior Authorization of Certain Durable Medical Equipment, Prosthetic, Orthotic, and Supply Items, frequently subject to unnecessary utilization, is the only permanent (non-demonstration) prior authorization program approved for implementation. Make sure your billing staff is aware of these changes.

Background
Prior authorization is a process through which a request for provisional affirmation of coverage is submitted to a medical review contractor for review before the item or service is furnished to the beneficiary and before the claim is submitted for processing. It is a process that permits the submitter/requester (for example, provider, supplier, beneficiary) to send in medical documentation, in advance of the item or service being rendered, and subsequently billed, in order to verify its eligibility for Medicare claim payment. For any item or service to be covered by Medicare it must:

- Be eligible for a defined Medicare benefit category
- Be medically reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member
- Meet all other applicable Medicare coverage, coding and payment requirements

Contractors shall, at the direction of CMS or other authorizing entity, conduct prior authorizations and alert the requester/submitter of any potential issues with the information submitted.

- A prior authorization request decision can be either a provisional affirmative or a non-affirmative decision.
• A provisional affirmative decision is a preliminary finding that a future claim submitted to Medicare for the item or service likely meets Medicare's coverage, coding, and payment requirements.

• A non-affirmative decision is a finding that the submitted information/documentation does not meet Medicare’s coverage, coding, and payment requirements, and if a claim associated with the prior authorization is submitted for payment, it would not be paid. MACs shall provide notification of the reason for the non-affirmation, if a request is non-affirmative, to the submitter/requester. If a prior authorization request receives a non-affirmative decision, the prior authorization request can be resubmitted an unlimited number of times.

Prior authorization may also be a condition of payment. This means that claims submitted without an indication that the submitter/requester received a prior authorization decision (that is, Unique Tracking Number (UTN)) will be denied payment.

Each prior authorization program will have an associated Operational Guide that will be available on the CMS website. In addition, MACs will educate stakeholders each time a new prior authorization program is launched. That education will include the requisite information and timeframes for prior authorization submissions and the vehicle to be used to submit such information to the MAC.

Prior Authorization Program for DME MACs

A prior authorization program for certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) items that are frequently subject to unnecessary utilization is described in 42 CFR 414.234. Among other things, this section establishes a Master List of certain DMEPOS items meeting inclusion criteria and potentially subject to prior authorization. CMS will select Healthcare Common Procedure Coding System (HCPCS) codes from the Prior Authorization Master List to be placed on the Required Prior Authorization List, and such codes will be subject to prior authorization as a condition of payment.

In selecting HCPCS codes, CMS may consider factors such as geographic location, item utilization or cost, system capabilities, administrative burden, emerging trends, vulnerabilities identified in official agency reports, or other data analysis.

• The Prior Authorization Master List is the list of DMEPOS items that have been identified using the inclusion criteria described in 42 CFR 414.234.

• The List of Required DMEPOS Prior Authorization Items contains those items selected from the Prior Authorization Master List to be implemented in the Prior Authorization Program. The List of Required DMEPOS Prior Authorization Items will be updated as additional codes are selected for prior authorization.

• CMS may suspend prior authorization requirements generally or for a particular item or items at any time and without undertaking rulemaking. CMS provides notification of the suspension of the prior authorization requirements via Federal Register notice and posting on the CMS prior authorization website.


Additional Information

Billing for Advance Care Planning Claims

MLN Matters® Number: MM10000
Related Change Request (CR) #: CR 10000
Related CR Release Date: May 17, 2017
Effective Date: January 1, 2016
Related CR Transmittal #: R3739CP
Implementation Date: June 19, 2017

Provider Types Affected
This MLN Matters® Article is intended for providers who submit claims to Medicare Administrative Contractors (MACs) for Advance Care Planning (ACP) services provided as an optional element of the Annual Wellness Visit (AWV) to Medicare beneficiaries.

Provider Action Needed
Change Request (CR) 10000 provides billing instructions for ACP when furnished as an optional element of an AWV. Make sure that your billing staffs are aware of the billing instructions.

Background
The Centers for Medicare & Medicaid Services (CMS) has made the CPT code 99497 (Advance care planning, including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by a physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate) for ACP separately payable for Medicare OPPS claims when the service meets the criteria for separate payment under OPPS. The change in policy will be implemented through the annual Medicare Physician Fee Schedule Database (MPFSDB) update.

ACP with Other Services
Effective January 1, 2016, payment for the service described by CPT code 99497 is conditionally packaged under the OPPS and is consequently assigned to a conditionally packaged payment status indicator of “Q1.” When this service is furnished with another service paid under the OPPS, payment is packaged.

ACP Service Only
When ACP is the only service furnished, payment is made separately.

ACP Service with Add-on Code
CPT code 99498 (Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure)) is an add-on code and therefore, payment for the service described by this code is unconditionally packaged (assigned status indicator “N”) in the OPPS in accordance with 42 CFR 419.2(b)(18).

ACP Service with AWV
CMS is also including voluntary ACP as an optional element of the AWV. ACP services furnished on the same day and by the same provider as an AWV are considered a preventive service. Therefore, the deductible and coinsurance are not applied to the codes used to report ACP services when performed as part of an AWV. Additionally, when ACP services are furnished on the same day and by the same provider as an AWV, they are reimbursed under the MPFSDB rates.

Voluntary ACP means the face-to-face service between a physician (or other qualified health care professional) and the patient discussing advance directives, with or without completing relevant legal forms. An advance directive is a document appointing an agent and/or recording the wishes of a patient pertaining to his/her medical treatment at a future time should he/she lack decisional capacity at that time.
Voluntary ACP, upon agreement with the patient, is an optional element of the AWV. When ACP services are provided as a part of an AWV, practitioners should report CPT code 99497 (plus add-on code 99498 for each additional 30 minutes, if applicable) for the ACP services in addition to either of the AWV codes G0438 and code G0439. When voluntary ACP services are furnished as a part of an AWV, the coinsurance and deductible do not apply for ACP. The deductible and coinsurance does apply when ACP is not furnished as part of a covered AWV.

Note: The deductible and coinsurance for ACP will only be waived when billed on the same day and on the same claim as an AWV (code G0438 or G0439) and must also be furnished by the same provider. Waiver of the deductible and coinsurance for ACP is limited to once per year. Payment for an AWV is limited to once per year. If the AWV billed with ACP is denied for exceeding the once per year limit, the deductible and coinsurance will be applied to the ACP.

Summary of Changes
Beginning in CY 2016, CPT code 99497 used to describe ACP is conditionally packaged under the OPPS when it is not part of the AWV, and is consequently assigned to a conditionally packaged payment status indicator of “Q1.”

When this service is furnished with another service paid under the OPPS, payment is packaged.

When it is the only service furnished, payment is made separately. CPT code 99498 is unconditionally packaged (assigned status indicator “N”) when it is not part of the AWV.

Beginning in CY 2016, CPT codes 99497 and 99498 used to describe ACP will be separately payable under the MPFS for OPPS claims when billed as part of the AWV on the same date of service by the same provider.

Additional Information

You may also want to review MLN Matters® Article MM9271 (Advance Care Planning (ACP) as an Optional Element of an Annual Wellness Visit (AWV)).

Clarification of Patient Discharge Status Codes and Hospital Transfer Policies – Rescinded

MLN Matters® Number: SE0801 Rescinded
This article was rescinded on March 15, 2017. Information on the inpatient transfer policy is located in the “Medicare Claims Processing Manual” (100-04), Chapter 3. For questions concerning clarification on the proper usage of patient discharge status codes, providers should be utilizing the “UB-04 Manual” which is maintained by the National Uniform Billing Committee.

Provider Types Affected
Providers billing Medicare Fiscal Intermediaries (FIs) or Part A/B Medicare Administrative Contractors (A/B MACs).
ICD-10 Coding Revisions to NCDs

MLN Matters® Number: MM9861
Related Change Request (CR) #: CR 9861
Related CR Release Date: February 3, 2017
Effective Date: October 1, 2016 – Unless otherwise noted in individual requirements
Related CR Transmittal #: R1792OTN
Implementation Date: March 3, 2017 – MAC local systems; April 3, 2017 – FISS, MCS, CWF Shared systems

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) 9861 is the 10th maintenance update of 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, CR9631, and CR9751; 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, MM9631, MM9751 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 those NCDs against ICD-10 coding. 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.

CR9861 makes adjustments to the following 16 NCDs:
• NCD 40.1 – Diabetes Outpatient Self-Management Training
• NCD 40.7 – Outpatient Intravenous Insulin Treatment
• NCD 80.2 – Photodynamic Therapy (also NCD 80.2.1, 80.3, 80.3.1 )
• NCD 80.11 – Vitrectomy
• NCD 100.1 – Bariatric Surgery
• NCD 110.4 – Extracorporeal Photopheresis
• NCD 110.18 – Aprepitant
• NCD 110.23 – Stem Cell Transplantation
• NCD 180.1 – Medical Nutrition Therapy
• NCD 190.1 – Histocompatibility Testing
• NCD 210.3 – Colorectal Cancer Screening
• NCD 220.4 – Mammograms
• NCD 220.6.17 – Positron Emission Tomography (PET) for Solid Tumors
• NCD 260.3.1 – Islet Cell Transplants
• NCD 260.5 – Intestinal and Multi-Visceral Transplants
• NCD 270.6 – Infrared Therapy Devices

The spreadsheets for the above NCDs are available at

You should remember that coding and payment areas of the Medicare Program 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 Code (RARC) N386 with Claim Adjustment Reason Code (CARC) 50, 96, and/or 119, with Group Code PR (Patient Responsibility) or Group Code CO (Contractual Obligation), as appropriate.

Your MAC will not search their files to adjust previously processed claims but will adjust any claims that you bring to their attention if found appropriate to do so.

Additional Information

Healthcare Provider Taxonomy Codes (HPTCs) April 2017 Code Set Update

MLN Matters® Number: MM9869
Related Change Request (CR) #: CR 9869
Related CR Release Date: February 24, 2017
Effective Date: July 1, 2017
Related CR Transmittal #: R3723CP
Implementation Date: July 3, 2017

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 and Hospice MACs and Durable Medical Equipment MACs, for services provided to Medicare beneficiaries.

Provider Action Needed
Change Request (CR) 9869 instructs MACs to obtain the most recent Healthcare Provider Taxonomy Code (HPTC) set and to update their internal HPTC tables and/or reference files.

Background
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that covered entities use the standards adopted under this law for electronically transmitting certain health care transactions, including health care claims. The standards include implementation guides which dictate when and how data must be sent, including specifying the code sets which must be used. The institutional and professional claim electronic standard implementation guides (X12 837-I and 837-P) each require use of valid codes contained in the HPTC set when there is a need to report provider type or physician, practitioner, or supplier specialty for a claim.

The National Uniform Claim Committee (NUCC) maintains the HPTC set for standardized classification of health care providers, and updates it twice a year with changes effective April 1 and October 1. These changes include the addition of a new code and addition of definitions to existing codes.
You should note that:

- Valid HPTCs are those that the NUCC has approved for current use.
- Terminated codes are not approved for use after a specific date.
- Newly approved codes are not approved for use prior to the effective date of the code set update in which each new code first appears.
- Specialty and/or provider type codes issued by any entity other than the NUCC are not valid.

CR9869 implements the NUCC HPTC code set that is effective on April 1, 2017, and instructs MACs to obtain the most recent HPTC set and use it to update their internal HPTC tables and/or reference files. MACs will implement the April 2017 HPTC update as soon as they can after April 1, 2017, but not beyond July 3, 2017. The HPTC set is available for view or for download from the Washington Publishing Company (WPC) at http://www.wpc-edi.com/codes.

When reviewing the Health Care Provider Taxonomy code set online, you can identify revisions made since the last release by the color code:

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

Additional Information

ICD-10 Coding Revisions to NCDs
MLN Matters® Number: MM9982
Related Change Request (CR) #: CR 9982
Related CR Release Date: February 17, 2017
Effective Date: July 1, 2017 (Unless otherwise noted in individual NCDs)
Related CR Transmittal #: R17980TN
Implementation Date: March 20, 2017, for MAC edits and July 3, 2017, for Shared Systems

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.

What You Need to Know
Change Request (CR) 9982 is the 11th maintenance update of 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, CR9631, CR 9751, and CR9861; 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, MM9631, MM9751, and MM9861 contain information pertaining to these CRs.

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 those NCDs against ICD-10 coding. 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.

CR9982 makes coding and clarifying adjustments to the following NCDs:

- **NCD20.31** – Intensive Cardiac Rehabilitation (ICR)
- **NCD20.31.1** – ICR Pritkin Program
- **NCD20.31.2** – ICR Ornish Program
- **NCD20.31.3** – ICR Benson-Henry Program
- **NCD20.34** – Left Atrial Appendage Closure
- **NCD190.3** – Cytogenetic Studies
- **NCD260.3.1** – Islet Cell Transplants in Clinical Trials
- **NCD270.1** – Electrical Stimulation & Electromagnetic Therapy for Treatment of Wounds
- **NCD220.4** – Mammograms


Please remember that coding and payment areas of the Medicare Program 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 (CMS) and are not intended to change the original intent of the NCD. The exception to this is when coding revisions are released as official implementation of new or reconsidered NCD policy following a formal national coverage analysis.

Your MACs will use default Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) messages where appropriate. MACs will complete all tasks that involve updates to local system edits/tables associated with the attached NCDs in this CR.

MACs will use default CAQH CORE messages where appropriate:


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

- **Group Code PR** (Patient Responsibility) assigning financial responsibility to the beneficiary (if a claim is received with occurrence code 32, or with occurrence code 32 and a GA modifier, indicating a signed ABN is on file).

Your MAC will not search their files to adjust previously processed claims but will adjust any claims that you bring to their attention if appropriate to do so.

### Additional Information

DecisionDx-UM Billing Guidelines

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

Summary: Guidelines for billing DecisionDx-UM™.

Effective Date: January 1, 2017

View the complete Noridian coverage article, DecisionDx-UM Billing Guidelines

- 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

High Resolution Anoscopy Article Retirement – Effective March 1, 2017

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

Medicare Coverage Database Number: A53959

Article Title: High Resolution Anoscopy

Effective Date: March 1, 2017

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

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

- Go to https://med.noridianmedicare.com/web/jfa/policies/coverage-articles.
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
  - On the “Medicare Coverage Articles” page, select the state of interest in the table under “Retired Articles.”
  - This link will redirect you to the CMS website.
- Locate the above-listed CMS Medicare Coverage Database (MCD) number and article title and select the title of interest.
MolDX: bioTheranostics Cancer TYPE ID Billing and Coding Guidelines – R3

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

Summary of Changes: Replaced assigned ID with DEX Z-Code™ identifier, added instruction for Part A claim submission.

Effective Date: December 8, 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

MolDX: FDA Approved ALK Companion Diagnostic Tests Billing and Coding Guidelines – R1

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

Summary of Changes: Updated instructions for Part A and B claim submission.

Effective Date: 1/1/2017

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

MolDX: MMACHC Test Billing and Coding Guidelines

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

**Article Summary:** MMACHC testing does not meet the clinical utility requirements for a Medicare Benefit and is considered a statutorily excluded service.

**Effective Date:** 4/15/2017

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

**MolDX: VEGFR2 Tests Billing and Coding Guidelines**

The MolDX: VEGFR2 Tests Billing and Coding Guidelines coverage article has been published for notice under contract numbers: 02101 (AK), 02201 (ID), 02301(OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601 (WY) in the CMS Medicare Coverage Database (MCD) and on our (Noridian) website.

**Article Summary:** Vascular endothelial growth factor, subtype 2, (VEGFR2) receptor has been found to be oncogenic. Current studies have targeted VEGFR2 as a potential therapeutic option. However, at present there is insufficient evidence to establish a clear association between VEGFR2 mutations and treatment response. Therefore, the MolDX Team has determined VEGFR2 testing is a statutorily excluded service. MolDX will also deny panels of tests that include the VEGFR2 receptor.

**Effective Date:** June 01, 2017

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

**Pegfilgrastim (Neulasta) J2505**

The Pegfilgrastim (Neulasta) J2505 coverage article has been published for notice under contract numbers: 02101 (AK), 02201 (ID), 02301(OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601 (WY).

**Effective Date:** January 26, 2017

**Article Summary:** View the coverage and medical necessity of the same day dosing and less than 14-day dosing of Pegfilgrastim (Neulasta) J2505.

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 column (This link will redirect you to the CMS website.)
  • Once in the CMS MCD, select corresponding article title

Sclerosing of Varicose Veins – R8
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: A53079
Article Title: Sclerosing of Varicose Veins
Effective Date: January 1, 2017

Summary of Article: Revision of article to further clarify that CPT® 37421 is not an acceptable choice of procedure code for treatment of symptoms of varicose veins of the lower extremity regardless of the method used.

View the locally hosted Noridian Medicare Coverage Articles webpage:

• Go to the Noridian https://med.noridianmedicare.com/web/jfa/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

Self-Administered Drug Exclusion List – R11
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: February 28, 2017

Summary of Changes: Added the following HCPCS J3590 and C9399
• C9399, J3590 – Asfotase-alfa (Strensiq™)
• C9399, J3590 – Daclizumab (Zinbryta™)
• C9399, J3590 – Ixekizumab (Taltz™)
• C9399, J3590 – Adalimumab-atto (Amjevita™)

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).
Therapy Evaluation and Assessment Services – R2

The Therapy Evaluation and Assessment 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: A52773

Effective Date: January 1, 2017

Summary of Changes: Effective 01/01/17, this revised article combines JFA A52760 into the JFB A52773 article so that both JFA and JFB contract numbers will have the same final MCD article number for the 2017 CPT updates. In addition, see the following added or deleted CPT/HCPCS codes.

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 Active article and comprehensive revision history for this corresponding article
• Scroll to bottom of webpage
• Select state/contract of interest the Active column (This link will redirect you to the CMS website.)
• Once in the CMS MCD, select corresponding article title

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.
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

Changes in PECOS E-Signature Timeline – Effective January 9, 2017
Providers will start experiencing faster rejections if they fail to submit signatures for Internet-based PECOS applications in a timely manner. A new provision, implemented on January 9, 2017, means providers have 20 calendar days to submit signatures for applications submitted in PECOS. The new deadline is part of CMS Change Request 9776.

A PECOS application is not considered “received” until all the signatures are accurately submitted. If any of the signatures are not submitted either by an e-signature or a paper certification statement, within the 20 calendar days, the application will be rejected. This means:
• The application has not been submitted
• The targeted effective date for new enrollments could be missed
• A revalidation due date may be missed

When a PECOS application is rejected due to a missing signature, providers use the “Correct & Resubmit” button to resubmit the application. Here are the steps, from the PECOS Welcome Page.
• Select My Associates
• Then click on “View Enrollments” located next to the enrollment record that submitted the application
• Scroll down on the “My Enrollments Page” to find the “Correct & Resubmit” button.

Go to the Noridian PECOS webpage to learn more about the advantages of submitting electronic applications.
Provider Enrollment Revalidation – Cycle 2 – Revised

MLN Matters® Number: SE1605 Revised
This article was revised on March 15, 2017, to update the table on page 6 and added additional information after that table. All other information is unchanged.

Provider Types Affected
This Medicare Learning Network (MLN) Matters® Special Edition Article is intended for all providers and suppliers who are enrolled in Medicare and required to revalidate through their Medicare Administrative Contractors (MACs), including Home Health & Hospice MACs (HH&H MACs), Medicare Carriers, Fiscal Intermediaries, and the National Supplier Clearinghouse (NSC). These contractors are collectively referred to as MACs in this article.

Provider Action Needed

Impact to You
Section 6401 (a) of the Affordable Care Act established a requirement for all enrolled providers/suppliers to revalidate their Medicare enrollment information under new enrollment screening criteria. The Centers for Medicare & Medicaid Services (CMS) has completed its initial round of revalidations and will be resuming regular revalidation cycles in accordance with 42 CFR §424.515. In an effort to streamline the revalidation process and reduce provider/supplier burden, CMS has implemented several revalidation processing improvements that are captured within this article.

What You Need to Know
Special Note: The Medicare provider enrollment revalidation effort does not change other aspects of the enrollment process. Providers/suppliers should continue to submit changes (for example, changes of ownership, change in practice location or reassignments, final adverse action, changes in authorized or delegated officials or, any other changes) as they always have. If you also receive a request for revalidation from the MAC, respond separately to that request.

What You Need To Do
6. Check http://go.cms.gov/MedicareRevalidation for the provider/suppliers due for revalidation;
7. If the provider/supplier has a due date listed, CMS encourages you to submit your revalidation within six months of your due date or when you receive notification from your MAC to revalidate. When either of these occur:
   • Submit a revalidation application through Internet-based PECOS located at https://pecos.cms.hhs.gov/pecos/login.do, the fastest and most efficient way to submit your revalidation information. Electronically sign the revalidation application and upload your supporting documentation or sign the paper certification statement and mail it along with your supporting documentation to your MAC; or
   • Complete the appropriate CMS-855 application available at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html;
   • If applicable, pay your fee by going to https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do; and
   • Respond to all development requests from your MAC timely to avoid a hold on your Medicare payments and possible deactivation of your Medicare billing privileges.

Background
Section 6401 (a) of the Affordable Care Act established a requirement for all enrolled providers/suppliers to revalidate their Medicare enrollment information under new enrollment screening criteria. CMS has completed its initial round of revalidations and will be resuming regular revalidation cycles in accordance with 42 CFR §424.515. This cycle of revalidation applies to those providers/suppliers that are currently and actively enrolled.

What's ahead for your next Medicare enrollment revalidation?
Established Due Dates for Revalidation

CMS has established due dates by which the provider/supplier’s revalidation application must reach the MAC in order for them to remain in compliance with Medicare’s provider enrollment requirements. The due dates will generally be on the last day of a month (for example, June 30, July 31 or August 31). Submit your revalidation application to your MAC within 6 months of your due date to avoid a hold on your Medicare payments and possible deactivation of your Medicare billing privileges. Generally, this due date will remain with the provider/supplier throughout subsequent revalidation cycles.

The list will be available at [http://go.cms.gov/MedicareRevalidation](http://go.cms.gov/MedicareRevalidation) and will include all enrolled providers/suppliers. Those due for revalidation will display a revalidation due date, all other providers/suppliers not up for revalidation will display a “TBD” (To Be Determined) in the due date field. In addition, a crosswalk to the organizations that the individual provider reassigns benefits will also be available at [http://go.cms.gov/MedicareRevalidation](http://go.cms.gov/MedicareRevalidation) on the CMS website.

IMPORTANT: The list identifies billing providers/suppliers only that are required to revalidate. If you are enrolled solely to order, certify, and/or prescribe via the CMS-855O application or have opted out of Medicare, you will not be asked to revalidate and will not be reflected on the list.

Due dates are established based on your last successful revalidation or initial enrollment (approximately 3 years for DME suppliers and 5 years for all other providers/suppliers).

In addition, the MAC will send a revalidation notice within 2-3 months prior to your revalidation due date either by email (to email addresses reported on your prior applications) or regular mail (at least two of your reported addresses: correspondence, special payments and/or your primary practice address) indicating the provider/supplier’s due date.

Revalidation notices sent via email will indicate “URGENT: Medicare Provider Enrollment Revalidation Request” in the subject line to differentiate from other emails. If all of the emails addresses on file are returned as undeliverable, your MAC will send a paper revalidation notice to at least two of your reported addresses: correspondence, special payments and/or primary practice address.

NOTE: Providers/suppliers who are within 2 months of their listed due dates on [http://go.cms.gov/MedicareRevalidation](http://go.cms.gov/MedicareRevalidation) but have not received a notice from their MAC to revalidate, are encouraged to submit their revalidation application.

To assist with submitting complete revalidation applications, revalidation notices for individual group members, will list the identifying information of the organizations that the individual reassigns benefits.

Large Group Coordination

Large groups (200+ members) accepting reassigned benefits from providers/suppliers identified on the CMS list will receive a letter from their MACs listing the providers linked to their group that are required to revalidate for the upcoming 6 month period. A spreadsheet detailing the applicable provider’s Name, National Provider Identifier (NPI) and Specialty will also be provided. CMS encourages the groups to work with their practicing practitioners to ensure that the revalidation application is submitted prior to the due date. We encourage all groups to work together as only one application from each provider/supplier is required, but the provider must list all groups they are reassigning to on the revalidation application submitted for processing. MACs will have dedicated provider enrollment staff to assist in the large group revalidations.

Groups with less than 200 reassignments will not receive a letter or spreadsheet from their MAC, but can utilize PECOS or the CMS list available on [http://go.cms.gov/MedicareRevalidation](http://go.cms.gov/MedicareRevalidation) to determine their provider/supplier’s revalidation due dates.
Unsolicited Revalidation Submissions

All unsolicited revalidation applications submitted more than 6 months in advance of the provider/supplier’s due date will be returned.

- What is an unsolicited revalidation?
  - If you are not due for revalidation in the current 6 month period, your due date will be listed as “TBD” (To Be Determined). This means that you do not yet have a due date for revalidation. Please do not submit a revalidation application if there is NOT a listed due date.
  - Any off-cycle or ad hoc revalidations specifically requested by CMS or the MAC are not considered unsolicited revalidations.
  - If your intention is to submit a change to your provider enrollment record, you must submit a ‘change of information’ application using the appropriate CMS-855 form.

Submitting Your Revalidation Application

IMPORTANT: Each provider/supplier is required to revalidate their entire Medicare enrollment record.

A provider/supplier’s enrollment record includes information such as the provider’s individual practice locations and every group that benefits are reassigned (that is, the group submits claims and receives payments directly for services provided). This means the provider/supplier is recertifying and revalidating all of the information in the enrollment record, including all assigned NPIs and Provider Transaction Access Numbers (PTANs).

If you are an individual who reassigns benefits to more than one group or entity, you must include all organizations to which you reassign your benefits on one revalidation application. If you have someone else completing your revalidation application for you, encourage coordination with all entities to which you reassign benefits to ensure your reassignments remain intact.

The fastest and most efficient way to submit your revalidation information is by using the Internet-based PECOS.

To revalidate via the Internet-based PECOS, go to [https://pecos.cms.hhs.gov/pecos/login.do](https://pecos.cms.hhs.gov/pecos/login.do). PECOS allows you to review information currently on file and update and submit your revalidation via the Internet. Once completed, YOU MUST electronically sign the revalidation application and upload any supporting documents or print, sign, date, and mail the paper certification statement along with all required supporting documentation to your appropriate MAC IMMEDIATELY.

PECOS ensures accurate and timelier processing of all types of enrollment applications, including revalidation applications. It provides a far superior alternative to the antiquated paper application process.

To locate the paper enrollment applications, refer to [https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html](https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html) on the CMS website.

Getting Access to PECOS

To use PECOS, you must get approved to access the system with the proper credentials which are obtained through the Identity and Access Management System, commonly referred to as “I&A”. The I&A system ensures you are properly set up to submit PECOS applications. Once you have established an I&A account you can then use PECOS to submit your revalidation application as well as other enrollment application submissions.

To learn more about establishing an I&A account or to verify your ability to submit applications using PECOS, please refer to [https://www.cms.gov/Outreach-and-Education/Medicare-Learning-NetworkMLN/MLNProducts/Downloads/MedEnroll_PECOS_PhysNonPhys_FactSheet_ICN903764.pdf](https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/contact_list.pdf). If you have questions regarding filling out your application via PECOS, please contact the MAC that sent you the revalidation notice. You may also find a list of MAC’s at [https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/contact_list.pdf](https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/contact_list.pdf).

For questions about accessing PECOS (such as login, forgot username/password) or I&A, contact the External User Services (EUS) help desk at 1-866-484-8049 or at [EUSSupport@cgi.com](mailto:EUSSupport@cgi.com).
**Deactivations Due to Non-Response to Revalidation or Development Requests**

It is important that you submit a complete revalidation application by your requested due date and you respond to all development requests from your MACs timely. Failure to submit a complete revalidation application or respond timely to development requests will result in possible deactivation of your Medicare enrollment.

If your application is received substantially after the due date, or if you provide additional requested information substantially after the due date (including an allotted time period for US or other mail receipt) your provider enrollment record may be deactivated. Providers/suppliers deactivated will be required to submit a new full and complete application in order to reestablish their provider enrollment record and related Medicare billing privileges. The providersupplier will maintain their original PTAN; however, an interruption in billing will occur during the period of deactivation resulting in a gap in coverage.

**NOTE:** The reactivation date after a period of deactivation will be based on the receipt date of the new full and complete application. Retroactive billing privileges back to the period of deactivation will not be granted. Services provided to Medicare patients during the period between deactivation and reactivation are the provider’s liability.

**Revalidation Timeline and Example**

Providers/suppliers may use the following table/chart as a guide for the sequence of events through the revalidation progression.

<table>
<thead>
<tr>
<th>Action</th>
<th>Timeframe</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revalidation list posted</td>
<td>Approximately 6 months to due date</td>
<td>March 30, 2017</td>
</tr>
<tr>
<td>Issue large group notifications</td>
<td>Approximately 6 months to due date</td>
<td>March 30, 2017</td>
</tr>
<tr>
<td>MAC sends email/letter notification</td>
<td>75 – 90 days to due date</td>
<td>July 2 – 17, 2017</td>
</tr>
<tr>
<td>MAC sends letter for undeliverable emails</td>
<td>75 – 90 days to due date</td>
<td>July 2 – 17, 2017</td>
</tr>
<tr>
<td>Revalidation due date</td>
<td>September 30, 2017</td>
<td></td>
</tr>
<tr>
<td>Apply payment hold/issue reminder letter (group members)</td>
<td>Within 25 days after due date</td>
<td>October 25, 2017</td>
</tr>
<tr>
<td>Deactivate</td>
<td>60 – 75 days after due date</td>
<td>7</td>
</tr>
</tbody>
</table>

**Deactivations Due to Non-Billing**

Providers/suppliers that have not billed Medicare for the previous 12 consecutive months will have their Medicare billing privileges deactivated in accordance with 42 CFR §424.540. The effective date of deactivation will be 5 days from the date of the corresponding deactivation letter issued by the MACs notifying the providers/suppliers of the deactivation action.

Providers/suppliers who Medicare billing privileges are deactivated will be required to submit a new full and complete application in order to reestablish their provider enrollment record and related Medicare billing privileges. The provider/supplier will maintain their original PTAN; however, an interruption in billing will occur during the period of deactivation resulting in a gap in coverage.

**Application Fees**

Institutional providers of medical or other items or services and suppliers are required to submit an application fee for revalidations. The application fee is $560.00 for Calendar Year (CY) 2017. CMS has defined “institutional provider” to mean any provider or supplier that submits an application via PECOS or a paper Medicare enrollment application using the CMS-855A, CMS-855B (except physician and non-physician practitioner organizations), or CMS-855S forms.
All institutional providers (that is, all providers except physicians, non-physicians practitioners, physician group practices and non-physician practitioner group practices) and suppliers who respond to a revalidation request must submit the 2017 enrollment fee (reference 42 CFR 424.514) with their revalidation application. You may submit your fee by ACH debit, or credit card. To pay your application fee, go to https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do and submit payment as directed. A confirmation screen will display indicating that payment was successfully made. This confirmation screen is your receipt and you should print it for your records. CMS strongly recommends that you include this receipt with your uploaded documents on PECOS or mail it to the MAC along with the Certification Statement for the enrollment application. CMS will notify the MAC that the application fee has been paid. Revalidations are processed only when fees have cleared.

SUMMARY

CMS will post the revalidation due dates for the upcoming revalidation cycle on http://go.cms.gov/MedicareRevalidation for all providers/suppliers. This list will be refreshed periodically. Check this list regularly for updates.

MACs will continue to send revalidation notices (either by email or mail) within 2-3 months prior to your revalidation due date. When responding to revalidation requests, be sure to revalidate your entire Medicare enrollment record, including all reassignment and practice locations. If you have multiple reassignments/billing structures, you must coordinate the revalidation application submission with all parties.

If a revalidation application is received but incomplete, the MACs will develop for the missing information. If the missing information is not received within 30 days of the request, the MACs will deactivate the provider/supplier’s billing privileges.

If a revalidation application is not received by the due date, the MAC may place a hold on your Medicare payments and deactivate your Medicare billing privileges.

If the provider/supplier has not billed Medicare for the previous 12 consecutive months, the MAC will deactivate their Medicare billing privileges.

If billing privileges are deactivated, a reactivation will result in the same PTAN but an interruption in billing during the period of deactivation. This will result in a gap in coverage.

If the revalidation application is approved, the provider/supplier will be revalidated and no further action is needed.

Additional Information

To find out whether a provider/supplier has been mailed a revalidation notice go to http://go.cms.gov/MedicareRevalidation on the CMS website.


For more information about the enrollment process and required fees, refer to MLN Matters® Article MM7350, which is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7350.pdf on the CMS website.

For more information about the application fee payment process, refer to MLN Matters® Article SE1130, which is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1130.pdf on the CMS website.

The MLN fact sheet titled “The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Provider and Supplier Organizations” is designed to provide education to provider and supplier organizations on how to use Internet-based PECOS to enroll in the Medicare Program and is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_PECOS_ProviderSup_FactSheet_ICN903767.pdf on the CMS website.

To access PECOS, your Authorized Official must register with the PECOS Identification and Authentication system. To register for the first time go to https://pecos.cms.hhs.gov/pecos/PecosIAConfirm.do?transferReason=CreateLogin to create an account.
ENROLLMENT

For additional information about the enrollment process and Internet-based PECOS, please visit the Medicare Provider-Supplier Enrollment webpage at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html.

If you have questions, contact your MAC. Medicare provider enrollment contact information for each State can be found at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/contact_list.pdf.

FQHC PPS

FQHC PPS – Recurring File Updates – Revised

MLN Matters® Number: MM9831 Revised
Related Change Request (CR) #: CR 9831
Related CR Release Date: January 4, 2017
Effective Date: January 1, 2017
Related CR Transmittal #: R3688CP
Implementation Date: January 3, 2017

This article was revised on January 5, 2017, to reflect the revised CR9831 issued on January 4. The CR revision corrected a typographical error in the FY2015 payment rate for grandfathered tribal FQHCs. In addition, 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 Federally Qualified Health Centers (FQHCs) submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed
Change Request (CR) 9831 updates the FQHC PPS base payment rate and the Geographic Adjustment Factors (GAFs) for the FQHC Pricer for Calendar Year (CY) 2017. Please ensure your billing staffs are aware of these changes.

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

Payment for Grandfathered Tribal Federally Qualified Health Centers (FQHCs) that were Provider-Based Clinics on or Before April 7, 2000
Effective for dates of service on or after January 1, 2016, Indian Health Service (IHS) and tribal facilities and organizations that met the conditions of Section 413.65(m) on or before April 7, 2000, and have a change in their status on or after April 7, 2000 from IHS to tribal operation, or vice versa, or the realignment of a facility from one IHS or tribal hospital to another IHS or tribal hospital such that the organization no longer meets the Conditions of Participation (CoPs), may seek to become certified as grandfathered tribal FQHCs. These grandfathered tribal FQHCs would be required to meet all FQHC certification and payment requirements. The grandfathered PPS rate equals the Medicare outpatient per visit payment rate paid to them as a provider-based department, as set annually by the IHS.
FQHC PPS Rate

Under the FQHC PPS, Medicare pays FQHCs based on the lesser of their actual charges or the PPS rate for all FQHC services furnished to a beneficiary on the same day when a medically-necessary, face-to-face FQHC visit is furnished to a Medicare beneficiary. The Social Security Act (Section 1834(o)(2)(B)(iii)) requires that the payment for the first year after the implementation year be increased by the percentage increase in the Medicare Economic Index (MEI). The Social Security Act (Section 1834(o)(2)(B)(iii)) also requires that in subsequent years, the FQHC PPS base payment rate will be increased by the percentage increase in a market basket of FQHC goods and services, or if such an index is not available, by the percentage increase in the MEI. In the Calendar Year (CY) 2017 Physician Fee Schedule (PFS) Final Rule, CMS finalized a proposal to update the FQHC PPS base payment rate using a 2013-based FQHC market basket.

- Based on historical data through second quarter 2016, the final FQHC market basket for CY 2017 is 1.8 percent.
- From January 1, 2017, through December 31, 2017, the FQHC PPS base payment rate is $163.49.
- The 2017 base payment rate reflects a 1.8 percent increase above the 2016 base payment rate of $160.60.

In accordance with the Social Security Act (Section 1834(o)(1)(A)), the FQHC PPS base rate is adjusted for each FQHC by the FQHC GAF, based on the Geographic Practice Cost Indices (GPCIs) used to adjust payment under the PFS. The FQHC GAF is adapted from the work and practice expense GPCIs, and are updated when the work and practice expense GPCIs are updated for the PFS. For CY 2017, the FQHC GAFs have been updated in order to be consistent with the statutory requirements.

Grandfathered Tribal FQHC PPS Rate

Grandfathered tribal FQHCs are paid the lesser of their charges or a grandfathered tribal FQHC PPS rate for all FQHC services furnished to a beneficiary during a medically-necessary, face-to-face FQHC visit. From January 1, 2016, through December 31, 2016, the grandfathered tribal FQHC PPS rate is $324. FQHC claims (TOB 77X) for grandfathered tribal FQHCs submitted with dates of service on or after January 1, 2016, through December 31, 2016 paid at the CY 2015 rate of $307 must be adjusted and paid at the CY 2016 rate of $324. Grandfathered tribal FQHC claims with dates of service on or after January 1, 2017, through December 31, 2017, should be paid at the CY 2016 rate of $324 until CMS provides an updated payment rate for CY 2017. The grandfathered tribal FQHC PPS rate will not be adjusted by the FQHC PPS GAFs or be eligible for the special payment adjustments under the FQHC PPS for new patients, patients receiving an IPPE or an AWV. The rate is also ineligible for exceptions to the single per diem payment that is available to FQHCs paid under the FQHC PPS. In addition, the FQHC market basket adjustment that is applied annually to the FQHC PPS base rate, will not apply to the grandfathered tribal FQHC PPS rate.

Additional Information


FQHC PPS – Recurring File Updates

MLN Matters® Number: MM10021
Related Change Request (CR) Number: CR10021
Related CR Release Date: March 10, 2017
Effective Date: July 1, 2017
Related CR Transmittal Number: R3734CP
Implementation Date: July 3, 2017

Provider Type Affected

This MLN Matters® Article is intended for Federally Qualified Health Centers (FQHCs) submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.
Provider Action Needed
Change Request (CR) 10021 instructs MACs to adjust all FQHC claims (77X) for GFT FQHCs submitted with dates of service on or after January 1, 2017, through June 30, 2017, paid at the previous rate. These adjustments will be completed 45 days after the implementation of CR 10021. Make sure your billing staff is aware of these changes.

Background
Effective for dates of service on or after January 1, 2016, Indian Health Service (IHS) and tribal facilities and organizations may seek to become certified as a Grandfathered Tribal (GFT) Federally Qualified Health Center (FQHC) if the facility or organization:

- Met the conditions of 42CFR §413.65(m) (Requirements for a Determination That a Facility or an Organization Has Provider-Based Status) on or before April 7, 2000, and
- Had a change in their status on or after April 7, 2000 from IHS to tribal operation (or vice versa), or the realignment of a facility from one IHS or tribal hospital to another IHS or tribal hospital, and
- No longer meets the Medicare Conditions of Participation (CoPs).

These GFT FQHCs would be required to meet all FQHC certification and payment requirements. The grandfathered Prospective Payment System (PPS) rate equals the Medicare outpatient per visit payment rate paid to them as a provider-based department, as set annually by the IHS. GFT FQHCs are paid the lesser of their charges (or a GFT FQHC PPS rate) for all FQHC services furnished to a beneficiary during a medically-necessary face-to-face FQHC visit.

Note: From January 1, 2017, through December 31, 2017, the GFT FQHC PPS rate is $349.

FQHC claims (TOB 77X) for GFT FQHCs that are submitted with dates of service on or after January 1, 2017, through June 30, 2017, and paid at the Calendar Year (CY) 2016 rate of $324 must be adjusted and paid at the CY 2017 rate of $349.

GFT FQHC claims that are submitted with dates of service on or after January 1, 2018, through December 31, 2018, should be paid at the CY 2017 rate of $349 until the Centers for Medicare & Medicaid Services (CMS) provides an updated payment rate for CY 2018.

The GFT FQHC PPS rate will not be adjusted by the FQHC PPS Geographic Adjustment Factors (GAFs) or be eligible for the special payment adjustments under the FQHC PPS for new patients, or patients receiving an Initial Preventive Physical Exam (IPPE) or an Annual Wellness Visit (AWV).

The rate is also ineligible for exceptions to the single per diem payment that is available to FQHCs paid under the FQHC PPS. In addition, the FQHC market basket adjustment that is applied annually to the FQHC PPS base rate, will not apply to the GFT FQHC PPS rate.

MACs will adjust FQHC claims (77X) for GTF FQHCs submitted with dates of service on or after January 1, 2017, through June 30, 2017, paid at the previous rate. These adjustments will be completed 45 days after the implementation of CR10021.

Additional Information
**Laboratory NCD Edit Software – Changes for July 2017**

**MLN Matters® Number:** MM10036  
**Related Change Request (CR) Number:** CR10036  
**Related CR Release Date:** March 17, 2017  
**Effective Date:** October 1, 2016  
**Related CR Transmittal Number:** R3738CP  
**Implementation Date:** July 3, 2017

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

**What You Need To Know**  
This article is based on Change Request (CR) 10036 which announces the changes that will be included in the July 2017 quarterly release of the edit module for clinical diagnostic laboratory services. This is a Recurring Update Notification that applies to Chapter 16, Section 120.2, of the “Medicare Claims Processing Manual.” Make sure your billing staffs are aware of these changes.

**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. Nationally uniform software was developed and incorporated in the Medicare shared systems so that laboratory claims subject to one of the 23 NCDs (“Medicare National Coverage Manual”, Sections 190.12 – 190.34) were processed uniformly throughout the nation effective April 1, 2003.

In accordance with Chapter 16, S120.2, Publication 100-04, the laboratory edit module is updated quarterly as necessary to reflect ministerial coding updates and substantive changes to the NCDs developed through the NCD process. The changes are a result of coding analysis decisions developed under the procedures for maintenance of codes in the negotiated NCDs and biannual updates of the ICD-10-CM codes.

CR10036 communicates requirements to shared system maintainers (SSMs) and contractors notifying them of changes to the laboratory edit module to update it for changes in laboratory NCD code lists for July 2017. These changes become effective for services furnished on or after October 1, 2016, and are as follows:

- ICD-10-CM code R73.03 will be added to the list of ICD-10-CM codes that are covered by Medicare for the Glycated Hemoglobin/Glycated Protein (190.21) NCD.
- ICD-10-CM code R73.03 will be removed from the list of ICD-10-CM codes that are covered by Medicare for the Hepatitis Panel/Acute Hepatitis Panel (190.33) NCD.

**Additional Information**  
Beneficiary Liability and Cost Report Days for Subclause (II) LTCHs

MLN Matters® Number: MM9912
Related Change Request (CR) #: CR 9912
Related CR Release Date: February 3, 2017
Effective Date: January 1, 2017
Related CR Transmittal #: R1791OTN
Implementation Date: July 3, 2017

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

Provider Action Needed
Change request (CR) 9912 announces that, effective with cost reporting periods beginning on or after October 1, 2016, for a subclause (II) LTCH, the Medicare payment would only apply to the LTCH’s costs incurred for the days used to calculate the Medicare payment (that is, days for which the patient has a benefit day available). Make sure that your billing staffs are aware of these changes.

Background
In the Fiscal Year (FY) 2015 Inpatient Prospective Payment System (IPPS)/Long-Term Care Hospital Prospective Payment System (LTCH PPS) Final Rule, CMS-1607-F, the Centers for Medicare & Medicaid Services (CMS) established a payment adjustment under the LTCH PPS for hospitals “classified under subclause (II) of subsection (d)(1)(B)(iv)” of the Social Security Act (the Act) (referred to as “subclause (II) LTCHs), effective for cost reporting periods beginning in FY 2015 and beyond.

Under this payment adjustment, payments to subclause (II) LTCHs are adjusted so that their LTCH PPS payments are generally equivalent to an amount determined under the reasonable cost-based reimbursement rules for both operating and capital-related costs under 42 CFR Part 413. In the FY 2017 IPPS/LTCH PPS Final Rule, CMS revised the policy concerning beneficiary liability, which results in corresponding changes relating to cost report days, for subclause (II) LTCHs (see §412.507).

Section 15008 of the 21st Century Cures Act, enacted December 13, 2016, reclassifies hospitals which had previously been classified as “subclause (II) LTCHs” as their own category of IPPS-excluded hospitals (at section 1886(d)(1)(B)(vi) of the Act). Also, this provision codifies, effective January 1, 2015, the reasonable cost-based payment adjustment CMS implemented in 42 CFR 412.526, and requires Medicare claims be processed as paid on a reasonable cost basis for discharge occurring on or after January 1, 2017.

Under the current policy, for a subclause (II) LTCH, the Medicare payment applies to the LTCH’s costs incurred for all days in the “inlier” period regardless of whether the beneficiary has a benefit day available. This policy, which was implemented in CR9401, will continue to apply for utilization days in cost reporting periods beginning before October 1, 2016, that is, through December 31, 2016, for a subclause (II) LTCH with a calendar year cost reporting period.

Under the revisions in the FY 2017 final rule and consistent with Section 15008 of the 21st Century Cures Act, effective with cost reporting periods beginning on or after October 1, 2016, for a subclause (II) LTCH, the Medicare payment would only apply to the LTCH’s costs incurred for the days used to calculate the Medicare payment (that is, days for which the patient has a benefit day available). For a subclause (II) LTCH with a calendar year cost reporting period, the revised policy will become effective for utilization days beginning January 1, 2017.

Note: Under this revised policy, whether the LTCH discharge would qualify for a high-cost outlier payment will no longer effect beneficiary liability.

Additional Information
**MEDICAL POLICIES**

**4Kscore Assay Draft LCD Published for Review and Comments**

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

**Medicare Coverage Database Number:** DL37122

**LCD Title:** 4Kscore Assay

**Comment period:** February 8 – April 10, 2017


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

- policya.drafts@noridian.com
- Noridian Medicare JF Part A
  - Attention: Draft LCD Comments
  - PO Box 6781
  - Fargo, ND 58103-6781

**Benign Skin Lesion Removal (Excludes Actinic Keratosis and Mohs) LCD – R7**

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

**Medicare Coverage Database (MCD) Number:** L33979

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

**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**

- L72.3 Sebaceous cyst is listed both in Group I and Group II. It is removed from Group I.
- L91.0 Hypertrophic scar is moved from Group I and added to Group II.
- L91.8 Other hypertrophic disorders of the skin is added to Group II. It was added to the previous JF LCD but was not included in the draft or final LCD when JE and JF contracts were combined making the policy consistent between the two contracts.

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

**Bladder/Urothelial Tumor Markers Final LCD – Effective May 16, 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:** L36680

**LCD Title:** Bladder/Urothelial Tumor Markers Original Draft Title: Bladder Tumor Markers
Effective Date: 05/16/2017

Summary of LCD: This policy has been updated with the following changes:

- ICD-10 code Z85.81 – Personal history of malignant neoplasm of bladder no longer requires a secondary diagnosis with the primary neoplastic diagnosis.
- In the Coverage Indications, Limitations and/or Medical Necessity section of the the following changes were made:
  - Under Diagnostic and Surveillance Tests, the number 6 was a typographically error in the sentence starting with Scientific studies demonstrate the sensitivity of BTA and NMP-22; and
  - Under the Limitations, the following changes were made:
    - The first paragraph now states, “Cystoscopy in conjunction with bladder tumor markers is standard practice to evaluate patients with symptoms suggesting bladder cancer and to monitor treated patients for recurrence or progression. Exceptions, such as high grade bladder cancers s/p radical cystectomy, do exist which preclude cystoscopy prior to testing. Testing indications, limitations and frequency do not apply to urine cytology.
    - The second paragraph now reads, “Bladder cancer tumor markers performed by immunoassay, molecular or FISH testing are not covered for screening of all patients with hematuria. Bladder tumor markers are not expected to be performed until other diagnostic studies fail to identify the etiology of the hematuria. Urine cytology is not considered a bladder tumor marker.”
  - Changed “initial diagnosis” under the Utilization Guidelines to read ... initial/most recent occurrence and treatment.

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

- Go to https://med.noridianmedicare.com/web/jfa/policies/lcd/future
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
  - On the “Future LCDs” page, select the coordinating state and locate the above listed CMS MCD number or LCD title.
  - This link will redirect you to the state specific Future Effective LCD on the CMS website.

Cataract Surgery in Adults Draft LCD Published for Review and Comments

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

Medicare Coverage Database Number: DL37027

LCD Title: Cataract Surgery in Adults

Comment period: February 8, 2017– April 10, 2017


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

- policya.drafts@noridian.com
- Noridian Medicare JF Part A
  Attention: Draft LCD Comments
  PO Box 6781
  Fargo, ND 58103-6781
**MEDICAL POLICIES**

**Controlled Substance Monitoring and Drugs of Abuse Testing – 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:** L36707

**LCD Title:** Controlled Substance Monitoring and Drugs of Abuse Testing

**Effective Date:** January 1, 2017

**Summary of Changes:**

Revised for 2017 CPT code changes:

- Codes Deleted: G0477, G0478 and G0479
- Codes added: G0659, 80305, 80306 and 80307

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- 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

**Intravenous Immune Globulin (IVIg) NCD – R1**

The following Noridian coverage requirements for the Intravenous Immune Globulin for the Treatment of Autoimmune Mucocutaneous Blistering Diseases 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:** Intravenous Immune Globulin for the Treatment of Autoimmune Mucocutaneous Blistering Diseases (250.3)

**Summary of Changes:** Diagnosis L14 is deleted effective 5/20/2015 per CR 9252, dated 12/3/2015. The Part A article (A54642) is retired and Part A contract numbers are added to the Part B article (A54643).

**Effective Date:** May 20, 2015

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.

**Mohs Micrographic Surgery 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:** L35704

**LCD Title:** Mohs Micrographic Surgery

**Effective Date:** October 1, 2015
**Summary of Changes:** LCD revised to add:
- ICD-10-CM code C43.21 – Malignant melanoma of right ear and external auricular canal
- ICD-10-CM code C43.22 – Malignant melanoma of left ear and external auricular canal

To access the Noridian Active LCDs from our website, follow the instructions below.
- Go to https://med.noridianmedicare.com/web/jfa/policies/lcd/active.
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  - On the “Active LCDs” page, locate the above listed LCD title.
  - This link will redirect you to the state specific Active LCD on the CMS website.

**MolDX: APC and MUTYH Gene Testing Final LCD – Effective May 15, 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:** L36884

**LCD Title:** MolDX: APC and MUTYH Gene Testing

**Effective Date:** May 15, 2017

**Summary of LCD:** This policy provides Medicare coverage for APC and MUTYH gene testing for individuals suspected to have Familial Adenomatous Polyposis (FAP), Attenuated FAP (AFAP) or MYH-associated polyposis (MAP) with a personal history of ≥20 adenomas over a lifetime.

To access the Noridian Future Effective LCDs from our website, follow the instructions below.
- Go to https://med.noridianmedicare.com/web/jfa/policies/lcd/future
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
  - On the “Future LCDs” page, select the coordinating state and locate the above listed CMS MCD number or LCD title.
  - This link will redirect you to the state specific Future Effective LCD on the CMS website.

**MolDX: Biomarkers in Cardiovascular Risk Assessment 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), 033001 (ND), 03401 (SD), 03501 (UT), 03601 (WY).

**Medicare Coverage Database (MCD) Number:** L36362

**LCD Title:** MolDX: Biomarkers in Cardiovascular Risk Assessment

**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:
- 83704: Lipoprotein, blood; quantitation of lipoprotein particle number(s) (eg, by nuclear magnetic resonance spectroscopy), includes lipoprotein particle subclass(es), when performed

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  - Locate and select above listed LCD title
MEDICAL POLICIES

MolDX – CDD: NSCLC, Comprehensive Genomic Profile Testing LCD – R1

The following JF Local Coverage Determination (LCD) has been revised under contractor numbers 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: L36198

LCD Title: MolDX – CDD: NSCLC, Comprehensive Genomic Profile Testing

Effective Date: December 22, 2016

Summary of Changes: LCD revised to remove registry requirements, expanded coverage to include smokers with NSCLC and added references #16 and 17 to the “Sources of Information and Basis for Decision”.

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

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

MolDX – CDD: Oncotype DX® Breast Cancer for DCIS (Genomic Health ™) 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: L36947

LCD Title: MolDX – CDD: Oncotype DX® Breast Cancer for DCIS (Genomic Health ™)

Effective Date: March 27, 2017

Summary of Changes: This LCD has been updated to include ICD-10 code D05.12, Intraductal carcinoma in situ of left breast.

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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

MolDX – CDD: Oncotype DX Breast Cancer for DCIS (Genomic Health) Final LCD – Effective March 27, 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: L36947

LCD Title: MolDX – CDD: Oncotype DX Breast Cancer for DCIS (Genomic Health)

Effective Date: March 27, 2017
Summary of LCD: This LCD provides limited coverage for the Oncotype DX® DCIS assay (Genomic Health, Inc., Redwood City, CA) for women diagnosed with DCIS who are planning on having breast conserving surgery and considering adjuvant radiation therapy.

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

- Go to [https://med.noridianmedicare.com/web/jfa/policies/lcd/future](https://med.noridianmedicare.com/web/jfa/policies/lcd/future)
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  - This link will redirect you to the state specific Future Effective LCD on the CMS website.


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: L36891

LCD Title: MolDX-CDD: Percepta© Bronchial Genomic Classifier

Effective Date: May 15, 2017

Summary of LCD: This Medicare contractor will provide limited coverage for the Percepta Bronchial Genomic Classifier (Veracyte, Inc., South San Francisco, CA) to identify patients with clinical low – or intermediate-risk of malignancy, after a non-diagnostic bronchoscopy, who may be followed with CT surveillance in lieu of further invasive biopsies or surgery. A patient’s clinical risk of malignancy may be ascertained by the McWilliams or Gould risk assessment models. Coverage does not include clinical high risk patients or patients with known lung cancer.

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)
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  - On the “Future LCDs” page, select the coordinating state and locate the above listed CMS MCD number or LCD title.
  - This link will redirect you to the state specific Future Effective LCD on the CMS website.

MolDX: Chromosome 1p/19q Deletion 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: L36542

LCD Title: MolDX: Chromosome 1p/19q Deletion

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:

- 81402: Molecular pathology procedure, level 3 (eg, >10 snps, 2-10 methylated variants, or 2-10 somatic variants [typically using non-sequencing target variant analysis], immunoglobulin and t-cell receptor gene rearrangements, duplication/deletion variants of 1 exon, loss of heterozygosity [loh], uniparental disomy [upd])
MEDICAL POLICIES

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**MolDX: Comprehensive Genomic Profiling to Guide Treatment in Patients with Metastatic Colorectal Cancer Draft LCD Published for Review and Comments**

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

**Medicare Coverage Database Number:** DL37107

**LCD Title:** MolDX: Comprehensive Genomic Profiling to Guide Treatment in Patients with Metastatic Colorectal Cancer

**Comment period:** February 8 – April 10, 2017


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

- policya.drafts@noridian.com
- Noridian Medicare JF Part A
  Attention: Draft LCD Comments
  PO Box 6781
  Fargo, ND 58103-6781

**MolDX: Comprehensive Genomic Profiling to Guide Treatment in Patients with Metastatic Melanoma Draft LCD Published for Review and Comments**

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

**Medicare Coverage Database Number:** DL37111

**LCD Title:** MolDX: Comprehensive Genomic Profiling to Guide Treatment in Patients with Metastatic Melanoma

**Comment period:** February 8 – April 10, 2017


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

- policya.drafts@noridian.com
- Noridian Medicare JF Part A
  Attention: Draft LCD Comments
  PO Box 6781
  Fargo, ND 58103-6781
**MEDICAL POLICIES**

**MolDX: DecisionDx-UM (Uveal Melanoma) Draft LCD Published for Review and Comments**

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

**Medicare Coverage Database Number:** DL37072

**LCD Title:** MolDX: DecisionDx-UM (Uveal Melanoma)

**Comment period:** February 8 – April 10, 2017


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

- policya.drafts@noridian.com
- Noridian Medicare JF Part A
  Attention: Draft LCD Comments
  PO Box 6781
  Fargo, ND 58103-6781

**MolDX: Genetic Testing for BCR-ABL Negative Myeloproliferative Disease 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:** L36186

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

**Effective Date:** January 1, 2017

**Summary of Changes:** This LCD has been updated to include and/or remove CPT/HCPCS codes. It has also been revised to correct minor typographical errors.

New/Revised CPT/HCPCS codes

- 81402: Molecular pathology procedure, level 3 (eg, >10 snps, 2-10 methylated variants, or 2-10 somatic variants [typically using non-sequencing target variant analysis], immunoglobulin and t-cell receptor gene rearrangements, duplication/deletion variants of 1 exon, loss of heterozygosity [loh], uniparental disomy [upd])

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**MolDX: Genetic Testing for BCR-ABL Negative Myeloproliferative Disease 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).
MEDICAL POLICIES

**Medicare Coverage Database (MCD) Number:** L36186  
**LCD Title:** MolDX: Genetic Testing for BCR-ABL Negative Myeloproliferative Disease  
**Effective Date:** January 1, 2017  
**Summary of Changes:** Changed MPD to MPL in reference to the MPL gene mutation. MPD refers to myeloproliferative disease.

To access the Noridian Active LCDs from our website, follow the instructions below:
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
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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 of the page and locating the LCD title.

**MolDX – Genetic Testing for Lynch Syndrome 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:** L36374  
**LCD Title:** MolDX – Genetic Testing for Lynch Syndrome  
**Effective Date:** December 15, 2016  
**Summary of Changes:** Added “endometrial cancer” to the end of the first paragraph under Coverage Indications, Limitations and/or Medical Necessity. Redefined age limitation of patient, added more clarity for NGS “hotspot”, updated reference numbers 13, 14, and added new references.

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

**MolDX: Molecular Diagnostic Tests (MDT) 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:** L36256  
**LCD Title:** MolDX: Molecular Diagnostic Tests (MDT)  
**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**
- 81327: SEPT9 (Septin9) (eg, colorectal cancer) methylation analysis
• **81402**: Molecular pathology procedure, Level 3 (eg, >10 SNPs, 2-10 methylated variants, or 2-10 somatic variants [typically using non-sequencing/target variant analysis]), immunoglobulin and T-cell receptor gene rearrangements, duplication/deletion variants of 1 exon, loss of heterozygosity (LOH), uniparental disomy (UPD)
  - Chromosome 1p-19q (eg, glial tumors), deletion analysis
  - Chromosome 1q (eg, D18S55, D18S58, D18S61, D18S64, and D18S69) (eg, colon cancer), allelic imbalance assessment (ie, loss of heterozygosity)
  - COL1A1/PDGFB (tt[17:22]) (eg, dermatofibrosarcoma protuberans), translocation analysis, multiple breakpoints, qualitative, and quantitative, if performed
  - ESR1/PGR (receptor 1/progesterone receptor) ratio (eg, breast cancer)
  - IGH@/BCL2 (tt[14;18]) (eg, follicular lymphoma), translocation analysis; major breakpoint region (MBR) and minor cluster region (mcr) breakpoints, qualitative or quantitative
  - MPL (myeloproliferative leukemia virus oncogene, thrombopoietin receptor, TPOR) (eg, myeloproliferative disorder), common variants (eg, W515A, W515K, W515L, W515R)
  - TRD@ (T cell antigen receptor, delta) (eg, leukemia and lymphoma), gene rearrangement analysis, evaluation to detect abnormal clonal population
  - Uniparental disomy (UPD) (eg, Russell-Silver syndrome, Prader-Willi/Angelman syndrome), short tandem repeat (STR) analysis

• **81407**: Molecular pathology procedure, Level 8 (eg, analysis of 26-50 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of >50 exons, sequence analysis of multiple genes on one platform)
  - ABCB8 (ATP-binding cassette, sub-family C [CFTR/MRP], member 8) (eg, familial hyperinsulinism), full gene sequence
  - AGL (amylo-alpha-1, 6-glucosidase, 4-alpha-glucanotransferase) (eg, glycogen storage disease type III), full gene sequence
  - AHI1 (Abelson helper integration site 1) (eg, Joubert syndrome), full gene sequence
  - ASPM (asp [abnormal spindle] homolog, microcephaly associated [Drosophila]) (eg, primary microcephaly), full gene sequence
  - CACNA1A (calcium channel, voltage-dependent, P/Q type, alpha 1A subunit) (eg, familial hemiplegic migraine), full gene sequence
  - CHD7 (chromodomain helicase DNA binding protein 7) (eg, CHARGE syndrome), full gene sequence
  - COL4A4 (collagen, type IV, alpha 4) (eg, Alport syndrome), full gene sequence
  - COL4A5 (collagen, type IV, alpha 5) (eg, Alport syndrome), duplication/deletion analysis
  - COL6A1 (collagen, type VI, alpha 1) (eg, collagen type VI-related disorders), full gene sequence
  - COL6A2 (collagen, type VI, alpha 2) (eg, collagen type VI-related disorders), full gene sequence
  - COL6A3 (collagen, type VI, alpha 3) (eg, collagen type VI-related disorders), full gene sequence
  - CREBBP (CREB binding protein) (eg, Rubinstein-Taybi syndrome), full gene sequence
  - F8 (coagulation factor VIII) (eg, hemophilia A), full gene sequence
  - JAG1 (jagged 1) (eg, Alagille syndrome), full gene sequence
  - KDM5C (lysine [K]-specific demethylase 5C) (eg, X-linked mental retardation), full gene sequence
  - KIAA0196 (KIAA0196) (eg, spastic paraplegia), full gene sequence
  - L1CAM (L1 cell adhesion molecule) (eg, MASA syndrome, X-linked hydrocephaly), full gene sequence
  - LAMB2 (laminin, beta 2 [laminin S]) (eg, Pierson syndrome), full gene sequence
  - MYBPC3 (myosin binding protein C, cardiac) (eg, familial hypertrophic cardiomyopathy), full gene sequence
  - MYH6 (myosin, heavy chain 6, cardiac muscle, alpha) (eg, familial dilated cardiomyopathy), full gene sequence
  - MYH7 (myosin, heavy chain 7, cardiac muscle, beta) (eg, familial hypertrophic cardiomyopathy, Liang distal myopathy), full gene sequence
  - MYOTA (myosin VIIA) (eg, Usher syndrome, type 1), full gene sequence
  - NOTCH1 (notch 1) (eg, aortic valve disease), full gene sequence
NPHS1 (nephrosis 1, congenital, Finnish type [nephrin]) (eg, congenital Finnish nephrosis), full gene sequence
OPA1 (optic atrophy 1) (eg, optic atrophy), full gene sequence
PCDH15 (protocadherin-related 15) (eg, Usher syndrome, type 1), full gene sequence
PKD1 (polycystic kidney disease 1 [autosomal dominant]) (eg, polycystic kidney disease), full gene sequence
PLCE1 (phospholipase C, epsilon 1) (eg, nephrotic syndrome type 3), full gene sequence
SCN1A (sodium channel, voltage-gated, type 1, alpha subunit) (eg, generalized epilepsy with febrile seizures), full gene sequence
SCN5A (sodium channel, voltage-gated, type V, alpha subunit) (eg, familial dilated cardiomyopathy), full gene sequence
SLC12A1 (solute carrier family 12 [sodium/potassium/chloride transporters], member 1) (eg, Bartter syndrome), full gene sequence
SLC12A3 (solute carrier family 12 [sodium/chloride transporters], member 3) (eg, Gitelman syndrome), full gene sequence
SPG11 (spastic paraplegia 11 [autosomal recessive]) (eg, spastic paraplegia), full gene sequence
SPTBN2 (spectrin, beta, non-erythrocytic 2) (eg, spinocerebellar ataxia), full gene sequence
TMEM67 (transmembrane protein 67) (eg, Joubert syndrome), full gene sequence
TSC2 (tuberous sclerosis 2) (eg, tuberous sclerosis), full gene sequence
USH1C (Usher syndrome 1C [autosomal recessive, severe]) (eg, Usher syndrome, type 1), full gene sequence
VPS13B (vacuolar protein sorting 13 homolog B [yeast]) (eg, Cohen syndrome), duplication/deletion analysis
WDR62 (WD repeat domain 62) (eg, primary autosomal recessive microcephaly), full gene sequence

- 81413: Cardiac ion channelopathies (eg, Brugada syndrome, long QT syndrome, short QT syndrome, catecholaminergic polymorphic ventricular tachycardia); genomic sequence analysis panel, must include sequencing of at least 10 genes, including ANK2, CASQ2, CAV3, KCNE1, KCNE2, KCNH2, KCNJ2, KCNQ1, RYR2, and SCN5A
- 81414: Cardiac ion channelopathies (eg, Brugada syndrome, long QT syndrome, short QT syndrome, catecholaminergic polymorphic ventricular tachycardia); full sequence analysis panel, must include analysis of at least 2 genes, including KCNH2 and KCNQ1
- 81422: Fetal chromosomal microdeletion(s) genomic sequence analysis (eg, DiGeorge syndrome, Cri-du-chat syndrome), circulating cell-free fetal DNA in maternal blood
- 81439: Inherited cardiomyopathy (eg, hypertrophic cardiomyopathy, dilated cardiomyopathy, arrhythmogenic right ventricular cardiomyopathy) genomic sequence analysis panel, must include sequencing of at least 5 genes, including DSG2, MYBPC3, MYH7, PKP2, and TTN
- 81539: Oncology (high-grade prostate cancer), biochemical assay of four proteins (Total PSA, Free PSA, Intact PSA, and human kallikrein-2 [hK2]), utilizing plasma or serum, prognostic algorithm reported as a probability score

Deleted CPT/HCPCS codes
- 0010M: Infectious dis hcv 6 assays
- 81280: Long QT syndrome gene analyses (eg, KCNQ1, KCNH2, SCN5A, KCNE1, KCNE2, KCNJ2, CACNA1C, CAV3, SCN4B, AKAP, SNTA1, and ANK2); full sequence analysis
- 81281: Long QT syndrome gene analyses (eg, KCNQ1, KCNH2, SCN5A, KCNE1, KCNE2, KCNJ2, CACNA1C, CAV3, SCN4B, AKAP, SNTA1, and ANK2); known familial sequence
- 81282: Long QT syndrome gene analyses (eg, KCNQ1, KCNH2, SCN5A, KCNE1, KCNE2, KCNJ2, CACNA1C, CAV3, SCN4B, AKAP, SNTA1, and ANK2); duplication/deletion variants

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**MolDX: NRAS Genetic Testing LCD – R1 and 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:** L36339  
**LCD Title:** MolDX – NRAS Genetic Testing  
**Effective Date:** January 19, 2017  
**Summary of Changes:** Added primary and secondary diagnoses codes under ICD-10 Codes that Support Medical Necessity:

**Group 1:**
- C77.0-C77.9 Secondary and unspecified malignant neoplasm of lymph nodes
- C78.00-C78.89 – Secondary malignant neoplasm of respiratory and digestive organs
- C79.00-C79.9 Secondary malignant of other and unspecified sites

**Group 2:**
- C18.0-C18.9 – Malignant neoplasm of colon
- C19 – Malignant neoplasm of recto-sigmoid junction
- C20 – Malignant neoplasm of rectum

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- Go to [https://med.noridianmedicare.com/web/jfa/policies/lcd/active](https://med.noridianmedicare.com/web/jfa/policies/lcd/active)
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**MolDX: Prolaris Prostate Cancer Genomic Assay for Men with Favorable Intermediate Risk Disease Draft LCD Published for Review and Comments**

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

**Medicare Coverage Database Number:** DL37082  
**LCD Title:** MolDX: Prolaris™ Prostate Cancer Genomic Assay for Men with Favorable Intermediate Risk Disease  
**Comment period:** February 8 – April 10, 2017


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

- policya.drafts@noridian.com
- Noridian Medicare JF Part A  
  Attention: Draft LCD Comments  
  PO Box 6781  
  Fargo, ND 58103-6781
MEDICAL POLICIES

MolDX: Vita Risk Pharmacogenetic Test for Dry Age-related Macular Degeneration (AMD) Draft LCD Published for Review and Comments

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

Medicare Coverage Database Number: DL37064

LCD Title: MolDX: Vita Risk™ Pharmacogenetic Test for Dry Age-related Macular Degeneration (AMD)

Comment period: February 8 – April 10, 2017


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

- policya.drafts@noridian.com
- Noridian Medicare JF Part A
  Attention: Draft LCD Comments
  PO Box 6781
  Fargo, ND 58103-6781

Plastic Surgery Draft LCD Published for Review and Comments

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

Medicare Coverage Database Number: DL37020

LCD Title: Plastic Surgery

Comment period: February 8, 2017– April 10, 2017

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

- policya.drafts@noridian.com
- Noridian Medicare JF Part A
  Attention: Draft LCD Comments
  PO Box 6781
  Fargo, ND 58103-6781

**Positron Emission Tomography Scans Coverage – R8**

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 HCPCS codes A9587 and A9588 and to remove instruction to bill Fluciclovine F-18 and Gallium Ga-68 with HCPCS code J9340, per CR 9861.

The following diagnoses were deleted, per CR 9861:

- List I: C00.2, C00.5, C03.9, C34.00, C34.10, C34.30, C34.80, C34.90, C43.20, C43.60, C43.70, C44.121, C44.191, C44.201, C44.221, C44.291, C50.029, C50.119, C50.129, C50.219, C50.229, C50.319, C50.329, C50.419, C50.429, C50.519, C50.529, C50.619, C50.629, C50.819, C50.829, C50.919, C50.929, C56.9, D03.10, D03.20, D03.60, D03.70
- List II: C40.00, C40.10, C40.20, C40.30, C40.80, C40.90, C44.601, C44.611, C44.621, C44.691, C44.701, C44.721, C44.791, C46.50, C47.10, C47.20, C49.10, C49.20, C57.00, C57.10, C57.20, C62.00, C62.10, C62.90, C63.00, C63.10, C64.9, C65.9, C66.9, C69.00, C69.10, C69.20, C69.30, C69.40, C69.50, C69.60, C69.80, C69.90, C72.20, C72.30, C72.40, C74.00, C74.10, C74.90, C76.40, C76.50, C78.00, C79.00, C79.60, C79.70, C4A.10, C4A.20, C4A.60, C4A.70

Replaced HCPCS code C9461 with A9515, per CR 9930.

The coding relating to CPT code 78608 and non-oncologic indications was corrected to state that clinical trial requirements pertain only to diagnosis G31.84.

ICD-10 codes C93.Z0, C93.Z1 and C93.Z2 were added to List III. These diagnoses were previously covered when listed as a code range. When the article was updated to remove code ranges and add singular specific diagnoses, they were inadvertently left out.

**Effective Date:** January 1, 2017

Read the complete National Coverage Determination requirements article.

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

**Positron Emission Tomography Scans Coverage – R9**

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 Title:** Positron Emission Tomography Scans Coverage (220.6)
Summary of Changes: Added A9515, A9587 and A9588 to the HCPCS code section. PI and PS modifier usage was clarified for these tracers.

The following diagnosis is added for List VI: Z85.46 eff 10/1/15. The following diagnosis is added to List V, eff 10/1/15: D47.Z1.

The following diagnoses are added as covered for A9587 effective 4/1/2017: C78.00, C78.01, C78.02, C78.1, C78.2, C78.30, C78.39, C78.4, C78.5, C78.6, C78.7, C78.80 and C78.89.

Read the complete National Coverage Determination requirements article.

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

Repetitive Transcranial Magnetic Stimulation (rTMS) in Adults with Treatment Resistant Major Depressive Disorder Draft LCD Published for Review and Comments

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

Medicare Coverage Database Number: DL37088

LCD Title: Repetitive Transcranial Magnetic Stimulation (rTMS) in Adults with Treatment Resistant Major Depressive Disorder

Comment period: February 8 – April 10, 2017


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

• policya.drafts@noridian.com

• Noridian Medicare JF Part A Attention: Draft LCD Comments
PO Box 6781
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Serum Magnesium Final LCD – Effective March 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: L36700

LCD Title: Serum Magnesium

Effective Date: March 13, 2017

Summary of LCD: LCD L34059 was retired effective March 12, 2017. This new LCD number combines the JF Part A policy and the new JF Part B LCD so both JFA and JFB contract numbers will have the same final MCD LCD number L36700. This LCD added and deleted the following codes and updated the Coverage Indications, Limitations and/or Medical Necessity, Group 1 Paragraph and Group Asterisk sections.
**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 severe proliferative diabetic retinopathy without macular edema, right eye
- **E08.3492** – Diabetes mellitus due to underlying condition with severe proliferative diabetic retinopathy without macular edema, left eye
- **E08.3493** – Diabetes mellitus due to underlying condition with severe proliferative diabetic retinopathy without 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 mild nonproliferative diabetic retinopathy without macular edema, right eye
• 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
• E09.3311 – Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, right eye
• E09.3312 – Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, left eye
• E09.3313 – Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, bilateral
• E09.3391 – Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, right eye
• E09.3392 – Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, left eye
• E09.3393 – Drug or chemical induced diabetes mellitus with moderate 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
• 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 severe nonproliferative diabetic retinopathy with macular edema, right eye
• E10.3412 – Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, left eye
• E10.3413 – Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with 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
• E10.3591 – 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 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, right eye
• E11.3212 – Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, left eye
• E11.3213 – Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with 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
• O99.321 – Drug use complicating pregnancy, first trimester
• O99.322 – Drug use complicating pregnancy, second trimester
• O99.323 – Drug use complicating pregnancy, third trimester
• O99.324 – Drug use complicating childbirth
• O99.325 – Drug use complicating the puerperium
• The 7th character D-subsequent and/or S to the following ICD-10-CM codes
  • T36.0X5A – Adverse effect of penicillins, initial encounter
  • T36.1X5A – Adverse effect of cephalosporins and other beta-lactam antibiotics, initial encounter
  • T36.2X5A – Adverse effect of chloramphenicol group, initial encounter
  • T36.3X5A – Adverse effect of macrolides, initial encounter
  • T36.4X5A – Adverse effect of tetracyclines, initial encounter
  • T36.5X5A – Adverse effect of aminoglycosides, initial encounter
  • T36.6X5A – Adverse effect of rifampicins, initial encounter
  • T36.7X5A – Adverse effect of antifungal antibiotics, systemically used, initial encounter
  • T36.8X5A – Adverse effect of other systemic antibiotics, initial encounter
  • T37.0X5A – Adverse effect of sulfonamides, initial encounter
  • T37.1X5A – Adverse effect of antimycobacterial drugs, initial encounter
  • T37.2X5A – Adverse effect of antimalarials and drugs acting on other blood protozoa, initial encounter
  • T37.3X5A – Adverse effect of other antiprotozoal drugs, initial encounter
- T37.4X5A – Adverse effect of anthelminthics, initial encounter
- T37.5X5A – Adverse effect of antiviral drugs, initial encounter
- T37.8X5A – Adverse effect of other specified systemic anti-infectives and antiparasitics, initial encounter
- T38.0X5A – Adverse effect of glucocorticoids and synthetic analogues, initial encounter
- T38.1X5A – Adverse effect of thyroid hormones and substitutes, initial encounter
- T38.2X5A – Adverse effect of antithyroid drugs, initial encounter
- T38.3X5A – Adverse effect of insulin and oral hypoglycemic [antidiabetic] drugs, initial encounter
- T38.4X5A – Adverse effect of oral contraceptives, initial encounter
- T38.5X5A – Adverse effect of other estrogens and progestogens, initial encounter
- T38.6X5A – Adverse effect of antigenadotrophins, antiestrogens, antiandrogens, not elsewhere classified, initial encounter
- T38.7X5A – Adverse effect of androgens and anabolic congeners, initial encounter
- T38.815A – Adverse effect of anterior pituitary [adenohypophyseal] hormones, initial encounter
- T38.895A – Adverse effect of other hormones and synthetic substitutes, initial encounter
- T39.095A – Adverse effect of salicylates, initial encounter
- T39.1X5A – Adverse effect of 4-Aminophenol derivatives, initial encounter
- T39.2X5A – Adverse effect of pyrazolone derivatives, initial encounter
- T39.315A – Adverse effect of propionic acid derivatives, initial encounter
- T39.395A – Adverse effect of other nonsteroidal anti-inflammatory drugs [NSAID], initial encounter
- T39.4X5A – Adverse effect of antirheumatics, not elsewhere classified, initial encounter
- T39.8X5A – Adverse effect of other nonopioid analgesics and antipyretics, not elsewhere classified, initial encounter
- T40.0X5A – Adverse effect of opium, initial encounter
- T40.2X5A – Adverse effect of other opioids, initial encounter
- T40.3X5A – Adverse effect of methadone, initial encounter
- T40.4X5A – Adverse effect of other synthetic narcotics, initial encounter
- T40.5X5A – Adverse effect of cocaine, initial encounter
- T40.6X5A – Adverse effect of other narcotics, initial encounter
- T40.995A – Adverse effect of other psychodysleptics [hallucinogens], initial encounter
- T41.5X5A – Adverse effect of therapeutic gases, initial encounter
- T42.0X5A – Adverse effect of hydantoin derivatives, initial encounter
- T42.1X5A – Adverse effect of iminostilbenes, initial encounter
- T42.2X5A – Adverse effect of succinimides and oxazolidinediones, initial encounter
- T42.3X5A – Adverse effect of barbiturates, initial encounter
- T42.4X5A – Adverse effect of benzodiazepines, initial encounter
- T42.5X5A – Adverse effect of mixed antiepileptics, initial encounter
- T42.65A – Adverse effect of other antiepileptic and sedative-hypnotic drugs, initial encounter
- T42.8X5A – Adverse effect of antiparkinsonism drugs and other central muscle-tone depressants, initial encounter
MEDICAL POLICIES

- T43.015A – Adverse effect of tricyclic antidepressants, initial encounter
- T43.025A – Adverse effect of tetracyclic antidepressants, initial encounter
- T43.1X5A – Adverse effect of monoamine-oxidase-inhibitor antidepressants, initial encounter
- T43.215A – Adverse effect of selective serotonin and norepinephrine reuptake inhibitors, initial encounter
- T43.225A – Adverse effect of selective serotonin reuptake inhibitors, initial encounter
- T43.295A – Adverse effect of other antidepressants, initial encounter
- T43.3X5A – Adverse effect of phenothiazine antipsychotics and neuroleptics, initial encounter
- T43.4X5A – Adverse effect of butyrophenone and thiothixene neuroleptics, initial encounter
- T43.595A – Adverse effect of other antipsychotics and neuroleptics, initial encounter
- T43.615A – Adverse effect of caffeine, initial encounter
- T43.625A – Adverse effect of amphetamines, initial encounter
- T43.635A – Adverse effect of methylphenidate, initial encounter
- T43.695A – Adverse effect of other psychostimulants, initial encounter
- T43.8X5A – Adverse effect of other psychotropic drugs, initial encounter
- T44.0X5A – Adverse effect of anticholinesterase agents, initial encounter
- T44.1X5A – Adverse effect of other parasympathomimetics [cholinergics], initial encounter
- T44.2X5A – Adverse effect of ganglionic blocking drugs, initial encounter
- T44.3X5A – Adverse effect of other parasympatholytics [anticholinergics and antimuscarinics] and spasmolytics, initial encounter
- T44.4X5A – Adverse effect of predominantly alpha-adrenoreceptor agonists, initial encounter
- T44.5X5A – Adverse effect of predominantly beta-adrenoreceptor agonists, initial encounter
- T44.6X5A – Adverse effect of alpha-adrenoreceptor antagonists, initial encounter
- T44.7X5A – Adverse effect of beta-adrenoreceptor antagonists, initial encounter
- T44.8X5A – Adverse effect of centrally-acting and adrenergic-neuron-blocking agents, initial encounter
- T44.995A – Adverse effect of other drug primarily affecting the autonomic nervous system, initial encounter
- T45.0X5A – Adverse effect of antiallergic and antiemetic drugs, initial encounter
- T45.1X5A – Adverse effect of antineoplastic and immunosuppressive drugs, initial encounter
- T45.2X5A – Adverse effect of vitamins, initial encounter
- T45.3X5A – Adverse effect of enzymes, initial encounter
- T45.4X5A – Adverse effect of iron and its compounds, initial encounter
- T45.515A – Adverse effect of anticoagulants, initial encounter
- T45.525A – Adverse effect of antithrombotic drugs, initial encounter
- T45.615A – Adverse effect of thrombolytic drugs, initial encounter
- T45.625A – Adverse effect of hemostatic drug, initial encounter
- T45.695A – Adverse effect of other fibrinolysis-affecting drugs, initial encounter
- T45.8X5A – Adverse effect of other primarily systemic and hematological agents, initial encounter
- T46.0X5A – Adverse effect of cardiac-stimulant glycosides and drugs of similar action, initial encounter
• T46.1X5A – Adverse effect of calcium-channel blockers, initial encounter
• T46.2X5A – Adverse effect of other antidysrhythmic drugs, initial encounter
• T46.3X5A – Adverse effect of coronary vasodilators, initial encounter
• T46.4X5A – Adverse effect of angiotensin-converting-enzyme inhibitors, initial encounter
• T46.5X5A – Adverse effect of other antihypertensive drugs, initial encounter
• T46.6X5A – Adverse effect of antihyperlipidemic and antiarteriosclerotic drugs, initial encounter
• T46.7X5A – Adverse effect of peripheral vasodilators, initial encounter
• T46.8X5A – Adverse effect of varicose veins, including sclerosing agents, initial encounter
• T46.995A – Adverse effect of other agents primarily affecting the cardiovascular system, initial encounter
• T47.0X5A – Adverse effect of histamine H2-receptor blockers, initial encounter
• T47.1X5A – Adverse effect of other antacids and anti-secretory drugs, initial encounter
• T47.2X5A – Adverse effect of stimulant laxatives, initial encounter
• T47.3X5A – Adverse effect of saline and osmotic laxatives, initial encounter
• T47.4X5A – Adverse effect of other laxatives, initial encounter
• T47.5X5A – Adverse effect of digestants, initial encounter
• T47.6X5A – Adverse effect of antidiarrheal drugs, initial encounter
• T47.7X5A – Adverse effect of emetics, initial encounter
• T47.8X5A – Adverse effect of other agents primarily affecting gastrointestinal system, initial encounter
• T48.0X5A – Adverse effect of oxytocic drugs, initial encounter
• T48.1X5A – Adverse effect of skeletal muscle relaxants [neuromuscular blocking agents], initial encounter
• T48.295A – Adverse effect of other drugs acting on muscles, initial encounter
• T48.3X5A – Adverse effect of antitussives, initial encounter
• T48.4X5A – Adverse effect of expectorants, initial encounter
• T48.5X5A – Adverse effect of other anti-common-cold drugs, initial encounter
• T48.6X5A – Adverse effect of antiasthmatics, initial encounter
• T48.995A – Adverse effect of other agents primarily acting on the respiratory system, initial encounter
• T49.0X5A – Adverse effect of local antifungal, anti-infective and anti-inflammatory drugs, initial encounter
• T49.1X5A – Adverse effect of antipruritics, initial encounter
• T50.0X5A – Adverse effect of mineralocorticoids and their antagonists, initial encounter
• T50.1X5A – Adverse effect of loop [high-ceiling] diuretics, initial encounter
• T50.2X5A – Adverse effect of carbonic-anhydrase inhibitors, benzothiadiazides and other diuretics, initial encounter
• T50.3X5A – Adverse effect of electrolyte, caloric and water-balance agents, initial encounter
• T50.4X5A – Adverse effect of drugs affecting uric acid metabolism, initial encounter
• T50.5X5A – Adverse effect of appetite depressants, initial encounter
• T50.6X5A – Adverse effect of antidotes and chelating agents, initial encounter
• T50.7X5A – Adverse effect of analeptics and opioid receptor antagonists, initial encounter
• T50.8X5A – Adverse effect of diagnostic agents, initial encounter
• T79.4XXA – Traumatic shock, initial encounter
• T81.12XA – Postprocedural septic shock, initial encounter
• Z79.2 – Long term (current) use of antibiotics
• Z79.4 – Long term (current) use of insulin
• Z79.51 – Long term (current) use of inhaled steroids
• Z79.52 – Long term (current) use of systemic steroids
• Z79.83 – Long term (current) use of bisphosphonates
• Z79.84 – Long term (current) use of oral hypoglycemic drugs
• Z79.891 – Long term (current) use of opiate analgesic
• Z92.21 – Personal history of antineoplastic chemotherapy
• Z92.22 – Personal history of monoclonal drug therapy

**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 severe nonproliferative diabetic retinopathy with macular edema
• E09.349 – Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy without macular edema
• E09.349 – Drug or chemical induced diabetes mellitus with severe nonproliferative 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
MEDICAL POLICIES

• K52.2 – Allergic and dietetic gastroenteritis and colitis
• K90.4 – Malabsorption due to intolerance, not elsewhere classified

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

• Go to https://med.noridianmedicare.com/web/jfa/policies/lcd/future
  • The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
  • On the “Future LCDs” page, select the coordinating state and locate the above listed CMS MCD number or LCD title.
  • This link will redirect you to the state specific Future Effective LCD on the CMS website.

**Treatment of Varicose Veins of the Lower Extremities – R8**

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

**Medicare Coverage Database (MCD) Number:** L34010

**LCD Title:** Treatment of Varicose Veins of the Lower Extremities

**Effective Date:** January 1, 2017

**Summary of Changes:** Coding clarification in Group 1 Paragraph to indicate 36299* is used for sclerotherapy with mechanical agitation (e.g. Clarivein® device) prior to January 1, 2017. On and after this date use the AMA assigned codes 36473 and 36474 to report this procedure.

View the locally hosted Noridian Future Active LCD PDF.

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

**JFA Trigger Point Injections Final LCD – Effective 05/26/2017**

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:** L36859

**LCD Title:** Trigger Point Injections

**Effective Date:** May 26, 2017

**Summary of LCD:** Finalization of Draft LCD DL36859 with no changes from Draft.

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

• Go to https://med.noridianmedicare.com/web/jfa/policies/lcd/future
  • The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
  • On the “Future LCDs” page, select the coordinating state and locate the above listed CMS MCD number or LCD title.
  • This link will redirect you to the state specific Future Effective LCD on the CMS website.
Visual Electrophysiology Testing Draft LCD Published for Review and Comments

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

**Medicare Coverage Database Number:** DL37116

**LCD Title:** Visual Electrophysiology Testing

**Comment period:** February 8 – April 10, 2017


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

- policya.drafts@noridian.com
- Noridian Medicare JF Part A
  Attention: Draft LCD Comments
  PO Box 6781
  Fargo, ND 58103-6781

MLN® CONNECTS

MLN Connects® – January 5, 2017

**CMS Provider Education Message:**

**Editor’s Note:**
Best wishes for a happy and healthy 2017. Your MLN Connects® Provider eNews has a new name and design for the new year. Let us know what you think. MLN Connects still delivers the weekly Medicare news you expect but with a fresh new style from the Medicare Learning Network® (MLN).

**MLN Connects®** for Thursday, January 5, 2017

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**News & Announcements**

- Apply for Clinical Practice Improvement Activities and Measurement Study by January 31
- Updated ESRD PPS Website
- Comparative Billing Report on Physical Therapy in February
- EHR Incentive Programs: New Attestation Resources
- Implementation Guide for QRDA-III Eligible Clinician Programs Available
- January Quarterly Provider Update Available
- Get Your Patients Off to a Healthy Start in 2017

**Provider Compliance**

- Duplicate Claims Will Not Be Paid

**Claims, Pricers & Codes**

- Fee Schedule Amounts for Group 3 Power Wheelchair Accessories and Cushions
Upcoming Events
• ESRD QIP: Payment Year 2020 Final Rule Call — January 17
• Home Health Groupings Model Technical Report Call — January 18
• Hospice Quality Reporting Program Provider Training — January 18
• Home Health Quality of Patient Care Star Rating Call — January 19
• Medicare Quality Programs: Transitioning from PQRS to MIPS Call — January 24

Medicare Learning Network Publications & Multimedia
• Quality Payment Program Video Presentation — New
• Hospital Settlement Call: Audio Recording and Transcript — New
• Medicare Overpayments Fact Sheet — Revised
• PECOS for Provider and Supplier Organizations Fact Sheet — Revised
• Long-Term Care Hospital Prospective Payment System Booklet — Reminder
• Advanced Practice Registered Nurses, Anesthesiologist Assistants, and Physician Assistants Booklet — Reminder

MLN Connects® – January 12, 2017
MLN Connects® for Thursday, January 12, 2017
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News & Announcements
• Addressing the Opioid Epidemic: Keeping Medicare and Medicaid Beneficiaries Healthy
• Post-Acute Care TOH Quality Measures Pilot Study: Respond by January 17
• Clinical Laboratories: Prepare Now to Report Lab Data through March 31
• Chronic Care Management Services Changes for 2017
• eCQI Resource Center Integrated with USHIK
• eCQM Value Sets for 2017 Performance Period: Addendum Available
• Medicare Quality Programs: ICD-10 Code Updates and Impact to 4th Quarter 2016
• January is Cervical Health Awareness Month

Provider Compliance
• CMS Provider Minute: CT Scans Video

Upcoming Events
• ESRD QIP: Payment Year 2020 Final Rule Call — January 17
• Home Health Groupings Model Technical Report Call — January 18
• Home Health Quality of Patient Care Star Rating Call — January 19
• Medicare Quality Programs: Transitioning from PQRS to MIPS Call — January 24

Medicare Learning Network Publications & Multimedia
• Additional Guidance for Clinical Laboratories as Data Reporting Begins MLN Matters® Article — New
• Revised CMS 855S Application: DMEPOS Suppliers MLN Matters® Article — New
• Chronic Care Management Services Changes for 2017 Fact Sheet — New
• How to Use the Medicare Coverage Database Booklet — Revised
MLN® CONNECTS

- SNF Prospective Payment System Booklet — Revised
- Acute Care Hospital Inpatient Prospective Payment System Booklet — Revised
- HH Prospective Payment System Booklet — Revised
- IRF Prospective Payment System Fact Sheet — Revised
- Chronic Care Management Services Fact Sheet — Revised
- Medicare Vision Services Fact Sheet — Revised
- Swing Bed Services Fact Sheet — Revised
- Mass Immunizers and Roster Billing Fact Sheet — Revised

MLN Connects® – January 19, 2017
MLN Connects® for Thursday, January 19, 2017
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News & Announcements
- Over 40 Million Medicare Beneficiaries Utilized Free Preventive Services in 2016
- Prosthetics and Custom Fabricated Orthotics Practitioners and Suppliers: Establishment of Special Payment Provisions and Requirements
- eCQM Data: Extension of 2016 Reporting Deadline to March 13
- EHR Incentive Program: Attest to 2016 Program Requirements by February 28
- EHR Incentive Programs: Calculations for Objectives and Measures Requiring Patient Action
- CMS Releases ESRD QIP Performance Score Reports for PY 2017
- New Care Management Webpage
- Provider Enrollment Application Fee Amount for CY 2017
- 2017 Annual Stationary Oxygen Budget Neutrality Calculations
- Glaucoma Awareness Month: Make a Resolution for Healthy Vision

Provider Compliance
- Hospice Election Statements Lack Required Information or Have Other Vulnerabilities

Claims, Pricers & Codes
- OPPS Hospital Claim Issues

Upcoming Events
- Medicare Quality Programs: Transitioning from PQRS to MIPS Call — January 24

Medicare Learning Network Publications & Multimedia
- Medicare Parts C and D General Compliance Web-Based Training Course — Revised
- Combating Medicare Parts C and D Fraud, Waste, and Abuse Web-Based Training Course — Revised
- Health Care Professional Frequently Used Web Pages Educational Tool — Revised
MLN Connects® – February 2, 2017
MLN Connects® for Thursday, February 2, 2017
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News & Announcements
• Clinical Laboratories: Prepare Now to Report Lab Data through March 31
• Updated Clinical Laboratory Fee Schedule Website
• Teaching Hospitals Receiving FTE Resident Caps Due to Hospital Closures
• February is American Heart Month

Provider Compliance
• Hospital Discharge Day Management Services

Upcoming Events
• Understanding and Promoting the Value of Chronic Care Management Services Call — February 21
• Looking Ahead: The IMPACT Act in 2017 Call — February 23

Medicare Learning Network Publications & Multimedia
• Telehealth Services Fact Sheet — Revised
• Inpatient Rehabilitation Facility Prospective Payment System Fact Sheet — Revised
• Home Oxygen Therapy Booklet — Revised
• MLN Suite of Products & Resources for Rural Health Providers Educational Tool — Revised

MLN Connects® – February 9, 2017
MLN Connects® for Thursday, February 9, 2017
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News & Announcements
• Clinical Laboratories: Easier to Report Lab Data

Upcoming Events
• Understanding and Promoting the Value of Chronic Care Management Services Call — February 21
• Looking Ahead: The IMPACT Act in 2017 Call — February 23

MLN Connects® – February 16, 2017
MLN Connects® for Thursday, February 16, 2017
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News & Announcements
• Influenza Activity Continues: Are Your Patients Protected?

Upcoming Events
• Understanding and Promoting the Value of Chronic Care Management Services Call — February 21
• What’s New with Physician Compare Webinar — February 21 and 23
• Looking Ahead: The IMPACT Act in 2017 Call — February 23
MLN® CONNECTS

Medicare Learning Network Publications & Multimedia
- Medicare Home Health Benefit Booklet — Revised
- Medicare Costs at a Glance: 2017 Educational Tool — Revised
- CMS Provider Minute Video: Nasal Endoscopy — Reminder

MLN Connects® – February 23, 2017
MLN Connects® for Thursday, February 23, 2017
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News & Announcements
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- NHSN Data Submission Deadline for IRF and LTCH QRP: Extended to May 15

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- Reporting Changes in Ownership

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- National Partnership to Improve Dementia Care and QAPI Call — March 21
- Comparative Billing Report on Physical Therapy Webinar — March 29

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- Collecting Data on Sexual Orientation and Gender Identity in Health Care Settings Web-Based Training Course — New
- Audio Recordings and Transcripts from Recent Calls — New
- Medicare Outpatient Observation Notice Instructions MLN Matters® Article — Revised
- Acute Care and the IPPS Web-Based Training Course — Revised

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- Transitional Care Management Services Fact Sheet — Revised
- MREP Software Fact Sheet — Reminder
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- Clinical Laboratories: Report Lab Data through March 31
- New Release of PEPPER for Short-term Acute Care Hospitals
- Hospice Quality Reporting Program: Rerun Your Quality Measure Reports
- LTCHs: Exceptions to Moratorium on Increasing Beds
- Therapeutic Continuous Glucose Monitors Classified as Durable Medical Equipment
- Influenza Activity Continues: Are Your Patients Protected?

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- Chiropractic Services: High Improper Payment Rate within Medicare FFS Part B

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- April 2017 Average Sales Price Files Available

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- National Partnership to Improve Dementia Care and QAPI Call — March 21
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- DMEPOS Adjusted Fee Methodology for Non-Bid Areas: Stakeholder Input on Section 16008 of the 21st Century Cures Act Call — March 23
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- Medicare Enrollment Resources Educational Tool — New
- Chronic Care Management Services Call: Audio Recording and Transcript — New
- IMPACT Act Call: Audio Recording and Transcript — New
- Suite of Products & Resources Educational Tools — Revised
- Federally Qualified Health Center Fact Sheet — Revised
- PECOS for DMEPOS Suppliers Fact Sheet — Revised
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• Inpatient Skilled Nursing Facility Denials

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• DMEPOS Adjusted Fee Methodology for Non-Bid Areas: Stakeholder Input on Section 16008 of the 21st Century Cures Act Call — March 23
• IMPACT Act: Standardized Patient Assessment Data Activities Call — March 29
• Medicare Shared Savings Program ACO: Preparing to Apply for the 2018 Program Year Call — April 6
• Open Payments: Prepare to Review Reported Data Call — April 13
• Medicare Shared Savings Program ACO: Completing the 2018 Application Process Call — April 19
• Comparative Billing Report Webinar on Sudomotor-Function Testing — May 10

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• Rural Health Clinic Fact Sheet — Revised

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• Connected Care: New Educational Initiative to Raise Awareness of Chronic Care Management
• Quality Payment Program: New Materials
• IRF and LTCH Compare Quarterly Refresh

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• Preventive Services CMS Provider Minute Video

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- Provider Enrollment Revalidation: Cycle 2 MLN Matters® Article — Revised
- Medicare-Required SNF PPS Assessments Educational Tool — Revised
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- MIPS Annual Call for Measures and Activities through June 30
- CMS Voluntary Self-Referral Disclosure Protocol: New Form
- Provider Compliance
- Billing For Stem Cell Transplants

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- MIPS Cost Measure Development Listening Session — April 5
- Medicare Shared Savings Program ACO: Preparing to Apply for the 2018 Program Year Call — April 6
- Open Payments: Prepare to Review Reported Data Call — April 13
- Medicare Shared Savings Program ACO: Completing the 2018 Application Process Call — April 19
- Global Surgery: Required Data Reporting for Post-Operative Care Call — April 25
- Emergency Preparedness Requirements Final Rule Training Call — April 27

Medicare Learning Network Publications & Multimedia
- NPI: What You Need to Know Booklet — New
- IRF-PAI Call: Video Presentation — New
- ESRD QIP Call: Follow-up Questions and Answers — New
- SNF Consolidated Billing Web-Based Training Course — Revised
- Remittance Advice Resources and FAQs Fact Sheet — Revised
- Reading a Professional Remittance Advice Booklet— Revised
- Medicare Home Health Benefit Booklet — Revised
- MLN Learning Management System FAQs Booklet — Revised
- Medicare Enrollment for Physicians and Other Part B Suppliers Booklet — Reminder
- Medicare Enrollment for Institutional Providers Booklet — Reminder
- Safeguard Your Identity and Privacy Using PECOS Booklet — Reminder
Multi-Factor Authentication Required on Noridian Medicare Portal – Beginning April 1, 2017

Beginning April 1, 2017 the Noridian Medicare Portal (NMP) will require a multi-factor authentication (MFA) process for users each time you need to log into NMP. MFA adds a second layer of security to your NMP account. The MFA process issues a one-time passcode that will be delivered to you via email, voice phone call or text message (SMS). By adding this additional security feature, your NMP account will remain secure even if your password is obtained by someone else without your knowledge.

Due to the nature of the information obtained in NMP, the Centers of Medicare and Medicaid Services (CMS) has informed all Medicare Administrative Contractors (MACs) that this feature is mandatory. Noridian will be rolling this out to providers starting March 20 – September 30, 2017. Providers will be notified one week in advance of when they need to start using the MFA if you have not already enrolled.

Users will be required to provide up to two additional methods, or factors, for authentication when accessing NMP. The first method is the email address that is currently on your NMP account. The additional delivery methods available are email, voice phone call and text message (SMS). Noridian requires at least two methods to provide a backup delivery method if you are not able to use your primary or default method. After enrollment in MFA has been completed, each time you log into the portal, you will need to provide your Username, password and the one-time passcode received via email, voice phone call or text message.

Additional information and instructions are provided on the Noridian Medicare Portal page of your Jurisdictions Noridian website. Users may also contact Noridian User Security at the below phone numbers.

- Jurisdiction A: 866-419-9458
- Jurisdiction D: 877-320-0390
- Jurisdiction E: 855-609-9960
- Jurisdiction F: 877-908-8431

Advance Care Planning Implementation for OPPS Claims

MLN Matters® Number: MM9862
Related Change Request (CR) #: CR 9862
Related CR Release Date: February 10, 2017
Effective Date: January 1, 2016
Related CR Transmittal #: R1795OTN
Implementation Date: July 3, 2017

Provider Types Affected
This MLN Matters® Article is intended for physicians and providers submitting claims on Type of Bill 13x to Medicare Administrative Contractors (MACs) for Advance Care Planning (ACP) services payable under the Outpatient Prospective Payment System (OPPS).

Provider Action Needed
This article is based on Change Request (CR) 9862 which implements system changes necessary to process Advance Care Planning (ACP) services for OPPS claims. Make sure that your billing staffs are aware of these changes.
Background
The Centers for Medicare & Medicaid Services (CMS) made Current Procedural Terminology (CPT) code 99497 for Advance Care Planning (ACP) separately payable for OPPS claims when the service meets the criteria for separate payment under the OPPS. This policy changes will be implemented through the annual Medicare Physician Fee Schedule Database (MPFSDB) update.

Effective for dates of service on or after January 1, 2016, payment for CPT code 99497 (Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate) is conditionally packaged under the OPPS and is consequently assigned to a conditionally packaged payment status indicator of “Q1.” When this service is furnished with another service paid under the OPPS, payment is packaged; when it is the only service furnished, payment is made separately.

CPT code 99498 (Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure)) is an add-on code and therefore payment for the service described by this code is unconditionally packaged (assigned status indicator “N”) in the OPPS in accordance with 42 CFR 419.2(b)(18).

CMS is including voluntary ACP as an optional element of the Annual Wellness Visit (AWV). ACP services furnished on the same day and by the same provider as an AWV are considered a preventive service. Therefore, the deductible and coinsurance are not applied to the codes used to report ACP services when performed as part of an AWV and billed with a covered AWV code. However, if the AWV payment is denied, MACs will apply the deductible and coinsurance. Remember that the deductible and coinsurance for ACP billed with an AWV can only be waived once a year. When ACP services are furnished on the same day and by the same provider as a covered AWV, they are reimbursed under the MPFSDB rates.

Voluntary ACP means the face-to-face service between a physician (or other qualified health care professional) and the patient discussing advance directives, with or without completing relevant legal forms. An advance directive is a document appointing an agent and/or recording the wishes of a patient pertaining to his/her medical treatment at a future time should he/she lack decisional capacity at that time.

Voluntary ACP, upon agreement with the patient, is an optional element of the AWV. When ACP services are provided as a part of an AWV, practitioners would report CPT code 99497 (plus add-on code 99498 for each additional 30 minutes, if applicable) for the ACP services in addition to either of the HCPCS AWV codes G0438 (Annual wellness visit; includes a Personalized Prevention Plan of Service (PPPS), initial visit) and G0439 (Annual wellness visit, includes a Personalized Prevention Plan of Service (PPPS), subsequent visit). When voluntary ACP services are furnished as a part of an AWV, the coinsurance and deductible do not apply for ACP. The deductible and coinsurance does apply when ACP is not furnished as part of a covered AWV.

MACs will adjust claims ACP claims processed incorrectly from January 1, 2016 forward when ACP was an optional element of the Annual Wellness Visit (AWV).

Additional Information
Hospital OPPS – January 2017 Update

MLN Matters® Number: MM9930
Related Change Request (CR) #: CR 9930
Related CR Release Date: December 22, 2016
Effective Date: January 1, 2017
Related CR Transmittal #: R232BP, R3685CP
Implementation Date: January 3, 2017

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

Provider Action Needed
This article is based on Change Request (CR) 9930 which describes changes to the OPPS to be implemented in the January 2017 update. Make sure your billing staffs are aware of these changes.

Background
Change Request (CR) 9930 describes changes and billing instructions for various payment policies being implemented in the January 2017 OPPS update. The January 2017 Integrated Outpatient Code Editor (I/OCE) and OPPS Pricer will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in CR 9930.

Key Changes in CR9930
Key changes to and billing instructions for various payment policies implemented in the January 2017 OPPS updates are as follows:

New Device Pass-Through Policies

a. New Device Pass-Through Categories

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

b. Policy

In the Calendar Year (CY) 2017 Outpatient Prospective Payment System/Ambulatory Surgical Center (OPPS/ASC) final rule with comment period that was published in the Federal Register on November 14, 2016, CMS adopted a policy to revise the pass-through payment time period by having the pass-through start date begin with the date of first payment and by allowing pass-through status to expire on a quarterly basis, such that the duration of device pass-through payment will be as close to 3 years as possible.

In addition, in calculating the pass-through payment, the “Implantable Devices Charged to Patients Cost-to-Charge Ratio (CCR)” will replace the hospital-specific CCR, when available and device offsets will be calculated from the HCPCS payment rate, instead of the APC payment rate (81 FR 79655 through 79657). Refer to the CY 2017 OPPS/ASC final rule with comment period for complete details of these policy changes for device pass-through that will become effective on January 1, 2017. Effective January 1, 2017, there are three device categories eligible for pass-through payment: (1) HCPCS code C2623 (Catheter, transluminal angioplasty, drug-coated, non-laser); (2) HCPCS code C2613 (Lung biopsy plug with delivery system); and (3) HCPCS code C1822 (Generator, neurostimulator (implantable), high frequency, with rechargeable battery and charging system). Also, refer to https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/passthrough_payment.html for the most current device pass-through information.
c. Transitional Pass-Through Payments for Designated Devices

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

Device Intensive Procedures

Effective January 1, 2017, CMS will assign device-intensive status at the HCPCS code level for all procedures requiring the implantation of a medical device, in which the individual HCPCS level device offset is greater than 40 percent. All new procedures requiring the insertion of an implantable medical device will be assigned a default device offset percentage of at least 41 percent, and be assigned device intensive status, until claims data is available. In certain rare instances, CMS may temporarily assign a higher offset percentage, if warranted, with additional information. Effective January 1, 2017, CMS will no longer assign device-intensive status based upon the APC level device offset percentage.

In light of this policy change, CMS is modifying Sections 20.6.4 and 61.2 of Chapter 4 of the “Medical Claims Processing Manual.”

Argus Retinal Prosthesis Add-on Code (C1842)

Effective January 1, 2017, CMS is creating HCPCS code C1842 (Retinal prosthesis, includes all internal and external components; add-on to C1841) and assigning it a status indicator (SI) of N. HCPCS code C1842 was created to resolve a claims processing issue for ASCs and should not be reported on institutional claims by hospital outpatient department providers.

Additionally, although HCPCS code C1842 was not included in the CY 2017 Annual HCPCS file, the code has been included in the January 2017 I/OCE. Therefore, MACs will add this code to their HCPCS system.

Services Eligible for New Technology APC Assignment and Payments

Under OPPS, services eligible for payment through New Technology APCs are those codes that are assigned to the series of New Technology APCs published in Addendum A of the latest OPPS update. OPPS considers any HCPCS code assigned to the APCs below to be a “new technology procedure or service.” As of January 1, 2017, the range of New Technology APCs include:

- APCs 1491 through 1500
- APCs 1502 through 1537
- APCs 1539 through 1585
- APCs 1589 through 1599
- APCs 1901 through 1906

The application for consideration as a New Technology procedure or service is available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service Payment/HospitalOutpatientPPS/passthrough_payment.html. Under the “Downloads” section, refer to the document titled “For a New Technology Ambulatory Payment Classification (APC) Designation Under the Hospital Outpatient Prospective Payment System (OPPS)” for information on the requirements for submitting an application.

The list of HCPCS codes and payment rates assigned to New Technology APCs are in Addendum B of the latest OPPS update regulation each year at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html.

Expiration of modifier “L1” for unrelated lab tests in the OPPS

As a result of the CY 2014 OPPS policy to package laboratory services in the hospital outpatient setting, the “L1” modifier was used on type of bill (TOB) 13x to identify unrelated laboratory tests that were ordered for a different diagnosis and by a different practitioner than the other OPPS services on the claim.
In the CY 2016 OPPS final rule, CMS established status indicator “Q4,” which conditionally packaged clinical diagnostic laboratory services. Status indicator “Q4” designates packaged APC payment when billed on the same claim as a HCPCS code assigned status indicator “J1,” “J2,” “S,” “T,” “V,” “Q1,” “Q2,” or “Q3.” The “Q4” status indicator was created to identify 13X bill type claims where there are only laboratory HCPCS codes that appear on the clinical laboratory fee schedule (CLFS); to automatically change their status indicator to “A”; and to pay them separately at the CLFS payment rates. In the CY 2017 OPPS/ASC final rule with comment period, CMS finalized a policy to eliminate the L1 modifier. Beginning January 1, 2017, CMS is discontinuing the use of the “L1” modifier to identify unrelated laboratory tests on claims.

Conditional packaging change to apply at claim level
When conditional packaging was initially adopted under the OPPS, it was based on the date of service associated with other items and services furnished on the claim. When CMS established the comprehensive APCs in the CY 2015 OPPS, packaging was applied on a claim basis. To promote consistency and ensure appropriate packaging under OPPS policy, CMS finalized a change in the CY 2017 OPPS to apply conditional packaging for status indicators “Q1” and “Q2” on a claim basis.

Exception for laboratory packaging in the OPPS for Advanced Diagnostic Laboratory Tests (ADLTs)
Beginning in the CY 2014 OPPS, CMS established that laboratory tests for molecular pathology tests described by CPT codes in the ranges of 81200 through 81383, 81400 through 81408, and 81479 are not packaged in the OPPS.

In the CY 2017 OPPS, CMS is expanding the laboratory packaging exclusion that currently applies to Molecular Pathology tests (described by CPT codes in the ranges of 81200 through 81383, 81400 through 81408, and 81479) to all laboratory tests designated as advanced diagnostic laboratory tests (ADLTs) that meet the criteria of the Social Security Act (Section 1834A(d)(5)(A)).

FX Modifier (X-ray Taken Using Film)
In accordance with provisions allowed under Section 1833(t)(16)(F)(iv) of the Social Security Act, CMS has established a new modifier “FX” to identify imaging services that are X-rays taken using film. Effective January 1, 2017, hospitals are required to use this modifier on claims for imaging services that are X-rays.

The use of this modifier will result in a payment reduction of 20 percent in CY 2017 for the X-ray services taken using film when the service is paid separately. The use of the FX modifier and subsequent reduction in payment under the OPPS is applicable to all imaging services that are X-rays taken using film. All imaging services that are X-rays are listed in Addendum B of the CY 2017 OPPS/ASC Final Rule. CMS is updating the “Medicare Claims Processing Manual”, Chapter 4, Section 20.6.13, to include this new modifier.

Computed Tomography (CT) Modifier (“Computed tomography services furnished using equipment that does not meet each of the attributes of the National Electrical Manufacturers Association (NEMA) XR–29–2013 standard“)
In accordance with the Social Security Act (Section 1834(p)), CMS established modifier “CT”, effective January 1, 2016, to identify CT scans that are furnished on equipment that does not meet the National Electrical Manufacturers Association (NEMA) Standard XR-29-2013, entitled “Standard Attributes on CT Equipment Related to Dose Optimization and Management.” Hospitals are required to use this modifier on claims for CT scans described by applicable HCPCS codes that are furnished on non-NEMA Standard XR-29-2013-compliant equipment. The applicable CT services are identified by HCPCS codes 70450 through 70498; 71250 through 71275; 72125 through 72133; 72191 through 72194; 73200 through 73206; 73700 through 73706; 74150 through 74178; 74261 through 74263; and 75571 through 75574 (and any succeeding codes).

Effective January 1, 2017, the use of this modifier will result in a payment reduction of 15 percent for the applicable CT services when the service is paid separately. The 15 percent payment reduction will also be applied to the APC payment for the HCPCS codes listed above that are subject to the multiple imaging composite policy. This includes procedures assigned to the two APCs (8005 and 8006) in the CT and CT angiography (CTA) imaging family.
Billing for Items and Services Furnished at Off-Campus Hospital Outpatient Departments

In accordance with the Social Security Act (Section 1833(t)(21)), as added by Section 603 of the Bipartisan Budget Act of 2015 (Pub. L. 114-74), CMS has established a new modifier “PN” (Nonexcepted service provided at an off-campus, outpatient, provider-based department of a hospital) to identify and pay nonexcepted items and services billed on an institutional claim. Effective January 1, 2017, non-excepted off-campus provider-based departments of a hospital are required to report this modifier on each claim line for non-excepted items and services. The use of modifier “PN” will trigger a payment rate under the Medicare Physician Fee Schedule. CMS expects the PN modifier to be reported with each nonexcepted item and service including those for which payment will not be adjusted, such as separately payable drugs, clinical laboratory tests, and therapy services.

Excepted off-campus provider-based departments of a hospital must continue to report existing modifier “PO” (Services, procedures and/or surgeries provided at off-campus provider-based outpatient departments) for all excepted items and services furnished. Use of the off-campus provider-based department (PBD) modifier became mandatory beginning January 1, 2016.

CMS would not expect off-campus PBDs to report both the PO and PN modifiers on the same claim line. However, if services reported on a claim reflect items and services furnished from both an excepted and a nonexcepted off-campus PBD of the hospital, the PO modifier should be used on the excepted claim lines and the PN modifier should be used on the nonexcepted claim lines.

Neither the PO nor the PN modifier is to be reported by the following hospital departments:

- A dedicated emergency department as defined in existing regulations at 42 CFR 489.24(b)
- A PBD that is “on the campus,” or within 250 yards, of the hospital or a remote location of the hospital as defined under 42 CFR 413.65

Partial Hospitalization Program (PHP)

a. Update to PHP Per Diem Costs

The CY 2017 OPPS/ASC final rule with comment period replaces the existing two-tiered APC structure for PHPs with a single APC by provider type for providing three or more services per day. Specifically, CMS is replacing existing Community Mental Health Center (CMHC) APCs 5851 (Level 1 Partial Hospitalization (3 services)) and 5852 (Level 2 Partial Hospitalization (4 or more services)) with a new CMHC APC 5853 (Partial Hospitalization (3 or More Services Per Day)), and replacing existing hospital-based PHP APCs 5861 (Level 1 Partial Hospitalization (3 services)) and 5862 (Level 2 Partial Hospitalization (4 or more services)) with a new hospital-based PHP APC 5863 (Partial Hospitalization (3 or More Services Per Day)).

b. CMHC Provider-Level Outlier Cap

The CY 2017 OPPS/ASC final rule with comment period implements a CMHC outlier payment cap to be applied at the provider level. In any given year, an individual CMHC will receive no more than 8 percent of its CMHC total per diem payments in outlier payments. The provider-level cap on CMHC outlier payments would be managed by the claims processing system. The existing outlier reconciliation process remains in place to adjust outlier payments at final cost report settlement, based on changes in the provider’s CCR.

c. PHP Payments under Section 603 (Off-Campus Policy)

The Social Security Act (Section 1861(ff)(3)(A)) specifies that a PHP is a program furnished by a hospital, to its outpatients, or by a CMHC. The Social Security Act (Section 1833(t)(1)(I)(B)(ii)) provides the Secretary with the authority to designate the outpatient department services to be covered under the OPPS. As a part of the OPPS, hospital-based (HB), PHPs are affected by this new legislation. CMHCs are not affected because they are not a hospital or a department/unit of a hospital. The CY 2017 OPPS/ASC final rule with comment adopts payment for non-excepted hospital-based PHPs under the MPFS, paying the CMHC per diem rate for APC 5853, for providing 3 or more PHP services per day.
Changes to Policies related to Allogeneic Hematopoietic Stem Cell Transplantation (HSCT)

a. Allogeneic Hematopoietic Stem Cell Transplantation (HSCT) (C-APC 5244)

Effective January 1, 2017, CMS is assigning procedures described by CPT code 38240 (Hematopoietic progenitor cell (HPC); allogeneic transplantation per donor) to newly established comprehensive APC (C-APC) 5244 (Level 4 Blood Product Exchange and Related Services). CPT code 38240 will be assigned status indicator “J1”. The assignment of CPT code 38240 to C-APC 5244 and status indicator “J1” will allow for all other OPPS payable services and items reported on the claim (including donor acquisition costs) to be deemed adjunctive services representing components of a comprehensive service and result in a single prospective payment through C-APC 5244 for the comprehensive service based on the costs of all reported services on the claim.

b. New Revenue Code 0815 for Allogeneic Stem Cell Acquisition Services

Effective January 1, 2017, hospitals are required to report revenue code 0815 when billing donor acquisition costs associated with allogeneic hematopoietic stem cell transplantation (HSCT). CMS is also implementing a code edit (edit 100) effective January 1, 2017, that will require donor acquisition charges for allogeneic HSCT reported with revenue code 0815 to be included on a claim with CPT code 38240 (Hematopoietic progenitor cell (HPC); allogeneic transplantation per donor). Donor acquisition charges for allogeneic HSCT are described in the “Medicare Claims Processing Manual”, Chapter 4, Section 231.11. Revenue code 0819 is no longer required for the reporting of donor acquisition charges for allogeneic HSCT. CMS is updating the “Medicare Claims Processing Manual”, Chapter 4, Section 231.11 and Chapter 3, Section 90.3.1 to reflect the new billing guidelines for allogeneic HSCT.

Drugs, Biologicals, and Radiopharmaceuticals

a. New CY 2017 HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Radiopharmaceuticals

For CY 2017, several new HCPCS codes have been created for reporting drugs and biologicals in the hospital outpatient setting, where there have not previously been specific codes available. These new codes are listed in Table 1 below.

Table 1 – New CY 2017 HCPCS Codes Effective for Certain Drugs, Biologicals, and Radiopharmaceuticals

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<tr>
<td>C9461</td>
<td>Choline C 11, diagnostic, per study dose</td>
<td>A9515</td>
<td>Choline c-11, diagnostic, per study dose up to 20 millicuries</td>
</tr>
<tr>
<td>A9599</td>
<td>Radiopharmaceutical, diagnostic, for beta-amyloid positron emission tomography (pet) imaging, per study dose</td>
<td>A9599</td>
<td>Radiopharmaceutical, diagnostic, for beta-amyloid positron emission tomography (pet) imaging, per study dose, not otherwise specified</td>
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b. Other Changes to CY 2017 HCPCS and CPT Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals

Many HCPCS and CPT codes for drugs, biologicals, and radiopharmaceuticals have undergone changes in their HCPCS and CPT code descriptors that will be effective in CY 2017. In addition, several temporary HCPCS C-codes have been deleted effective December 31, 2016, and replaced with permanent HCPCS codes in CY 2017. Hospitals should pay close attention to accurate billing for units of service consistent with the dosages contained in the long descriptors of the active CY 2017 HCPCS and CPT codes.

Table 2 below notes the drugs, biologicals, and radiopharmaceuticals that have undergone changes in their HCPCS/CPT code, their long descriptor, or both. Each product’s CY 2016 HCPCS/CPT code and long descriptor are noted in the two left hand columns. The CY 2017 HCPCS/CPT code and long descriptor are noted in the adjacent right hand columns.

Table 2 – Other CY 2017 HCPCS and CPT Code Changes for Certain Drugs, Biologicals, and Radiopharmaceuticals

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<tr>
<td>C9461</td>
<td>Choline C 11, diagnostic, per study dose</td>
<td>A9515</td>
<td>Choline c-11, diagnostic, per study dose up to 20 millicuries</td>
</tr>
<tr>
<td>A9599</td>
<td>Radiopharmaceutical, diagnostic, for beta-amyloid positron emission tomography (pet) imaging, per study dose</td>
<td>A9599</td>
<td>Radiopharmaceutical, diagnostic, for beta-amyloid positron emission tomography (pet) imaging, per study dose, not otherwise specified</td>
</tr>
<tr>
<td>------------------------</td>
<td>--------------------------</td>
<td>------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>C9121</td>
<td>Injection, argatroban, per 5 mg</td>
<td>J0883</td>
<td>Injection, argatroban, 1 mg (for non-esrd use)</td>
</tr>
<tr>
<td>C9121</td>
<td>Injection, argatroban, per 5 mg</td>
<td>J0884</td>
<td>Injection, argatroban, 1 mg (for esrd on dialysis)</td>
</tr>
<tr>
<td>C9137</td>
<td>Injection, Factor VIII (antihemophilic factor, recombinant) PEGylated, 1 I.U.</td>
<td>J7207</td>
<td>Injection, factor viii, (antihemophilic factor, recombinant), pegylated, 1 i.u.</td>
</tr>
<tr>
<td>C9138</td>
<td>Injection, Factor VIII (antihemophilic factor, recombinant) (Nuwig), 1 I.U.</td>
<td>J7209</td>
<td>Injection, factor viii, (antihemophilic factor, recombinant), (Nuwig), 1 i.u.</td>
</tr>
<tr>
<td>C9139</td>
<td>Injection, factor ix, albumin fusion protein (recombinant), idelvion, 1 i.u.</td>
<td>J7202</td>
<td>Injection, factor ix, albumin fusion protein, (recombinant), idelvion, 1 i.u.</td>
</tr>
<tr>
<td>C9349</td>
<td>Puraply, and puraply antimicrobial, any type, per square centimeter</td>
<td>Q4172</td>
<td>Puraply or puraply am, per square centimeter</td>
</tr>
<tr>
<td>C9470</td>
<td>Injection, aripiprazole lauroxil, 1 mg</td>
<td>J1942</td>
<td>Injection, aripiprazole lauroxil, 1 mg</td>
</tr>
<tr>
<td>C9471</td>
<td>Hyaluronan or derivative, Hymovis, for intra-articular injection, 1 mg</td>
<td>J7322</td>
<td>Hyaluronan or derivative, hymovis, for intra-articular injection, 1 mg</td>
</tr>
<tr>
<td>C9472</td>
<td>Injection, talimogene laherparepvec, 1 million plaque forming units (PFU)</td>
<td>J9325</td>
<td>Injection, talimogene laherparepvec, per 1 million plaque forming units</td>
</tr>
<tr>
<td>C9473</td>
<td>Injection, mepolizumab, 1 mg</td>
<td>J2182</td>
<td>Injection, mepolizumab, 1 mg</td>
</tr>
<tr>
<td>C9474</td>
<td>Injection, irinotecan liposome, 1 mg</td>
<td>J9205</td>
<td>Injection, irinotecan liposome, 1 mg</td>
</tr>
<tr>
<td>C9475</td>
<td>Injection, nectumumab, 1 mg</td>
<td>J9295</td>
<td>Injection, nectumumab, 1 mg</td>
</tr>
<tr>
<td>C9476</td>
<td>Injection, daratumumab, 10 mg</td>
<td>J9145</td>
<td>Injection, daratumumab, 10 mg</td>
</tr>
<tr>
<td>C9477</td>
<td>Injection, elotuzumab, 1 mg</td>
<td>J9176</td>
<td>Injection, elotuzumab, 1 mg</td>
</tr>
<tr>
<td>C9478</td>
<td>Injection, sebelipase alfa, 1 mg</td>
<td>J2840</td>
<td>Injection, sebelipase alfa, 1 mg</td>
</tr>
<tr>
<td>C9479</td>
<td>Instillation, ciprofloxacin otic suspension, 6 mg</td>
<td>J7342</td>
<td>Installation, ciprofloxacin otic suspension, 6 mg</td>
</tr>
<tr>
<td>C9480</td>
<td>Injection, trabectedin, 0.1 mg</td>
<td>J9352</td>
<td>Injection, trabectedin, 0.1 mg</td>
</tr>
<tr>
<td>C9481</td>
<td>Injection, reslizumab, 1 mg</td>
<td>J2786</td>
<td>Injection, reslizumab, 1 mg</td>
</tr>
<tr>
<td>J0571</td>
<td>Buprenorphine, oral, 1 mg</td>
<td>J0571</td>
<td>Buprenorphine oral 1 mg</td>
</tr>
<tr>
<td>J0573</td>
<td>Buprenorphine/naloxone, oral, greater than 3 mg, but less than or equal to 3.1 to 6 mg</td>
<td>J0573</td>
<td>Buprenorphine/naloxone, oral, greater than 3 mg, but less than or equal to 6 mg buprenorphine</td>
</tr>
<tr>
<td>J3357</td>
<td>Injection, ustekinumab, 1 mg</td>
<td>J3357</td>
<td>Ustekinumab, for subcutaneous injection, 1 mg</td>
</tr>
<tr>
<td>J1745</td>
<td>Injection, infliximab, 10 mg</td>
<td>J1745</td>
<td>Injection, infliximab, excludes biosimilar, 10 mg</td>
</tr>
<tr>
<td>J7201</td>
<td>Injection, factor ix, fc fusion protein (recombinant), per iu</td>
<td>J7201</td>
<td>Injection, factor ix, fc fusion protein (recombinant), Alprolix, per iu</td>
</tr>
<tr>
<td>J7340</td>
<td>Carbidopa 5 mg/levodopa 20 mg enteral suspension</td>
<td>J7340</td>
<td>Carbidopa 5 mg/levodopa 20 mg enteral suspension, 100 ml</td>
</tr>
</tbody>
</table>
c. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) 
Effective January 1, 2017

For CY 2017, payment for nonpass-through drugs, biologicals and therapeutic radiopharmaceuticals continues to be made at a single rate of ASP plus 6 percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical. In addition, in CY 2017, a single payment of ASP plus 6 percent continues to be made for pass-through drugs, biologicals and radiopharmaceuticals to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items. Payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. Effective January 1, 2017, payment rates for many drugs and biologicals have changed from the values published in the CY 2017 OPPS/ASC final rule with comment period as a result of the new ASP calculations based on sales price submissions from the third quarter of CY 2016. In cases where adjustments to payment rates are necessary, changes to the payment rates will be incorporated in the January 2017 Fiscal Intermediary Standard System (FISS) release. CMS is not publishing the updated payment rates in this CR implementing the January 2017 update of the OPPS. However, the updated payment rates effective January 1, 2017, are available in the January 2017 update of the OPPS Addendum A and Addendum B at http://www.cms.gov/HospitalOutpatientPPS/.

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d. Drugs and Biologicals Based on ASP Methodology with Restated Payment Rates

Some drugs and biologicals based on ASP methodology will have payment rates that are corrected retroactively. These retroactive corrections typically occur on a quarterly basis. The list of drugs and biologicals with corrected payments rates will be accessible on the first date of the quarter at https://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/HospitalOutpatientPPS/OPPS-Restated-Payment-Rates.html. Providers may resubmit claims that were impacted by adjustments to previous quarter’s payment files.

e. Biosimilar Biological Product Payment Policy

Effective January 1, 2017, the payment rate for a biosimilar biological product under the OPPS will continue to be the same as the payment rate in the physician office setting, (that is, calculated as the ASP of the biosimilar(s) described by the HCPCS code plus 6 percent of the ASP of the reference product). Biosimilar biological products are also be eligible for transitional pass-through payment; however, pass-through payment will be made to the first eligible biosimilar biological product to a reference product. Subsequent biosimilar biological products to a reference product will not meet the newness criterion, and therefore, will be ineligible for pass-through payment.

As a reminder, OPPS claims for separately paid biosimilar biological products are required to include a modifier (see Table 3, below) that identifies the manufacturer of the specific product. The modifier does not affect payment determination, but is used to distinguish between biosimilar products that appear in the same HCPCS code but are made by different manufacturers.
### Table 3 – Biosimilar Biological Product Payment and Required Modifiers

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>SI</th>
<th>APC</th>
<th>HCPCS Code Effective Date</th>
<th>HCPCS Modifier</th>
<th>HCPCS Modifier Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5101</td>
<td>Inj filgrastim g – csf biosim</td>
<td>Injection, Filgrastim (G-CSF), Biosimilar, 1 microgram</td>
<td>G</td>
<td>1822</td>
<td>03/06/2015</td>
<td>ZA – Novartis/Sandoz</td>
<td>01/01/2016</td>
</tr>
<tr>
<td>Q5102</td>
<td>Inj., infliximab biosimilar</td>
<td>Injection, Infliximab, Biosimilar, 10 mg</td>
<td>K</td>
<td>1847</td>
<td>04/05/2016</td>
<td>ZB – Pfizer/Hospira</td>
<td>04/01/2016</td>
</tr>
</tbody>
</table>

#### f. Billing and Payment for New Drugs, Biologicals, or Radiopharmaceuticals Approved by the Food and Drug Administration (FDA) but Before Assignment of a Product-Specific HCPCS Code

Hospital outpatient departments are allowed to bill for new drugs, biologicals, and therapeutic radiopharmaceuticals that are approved by the FDA on or after January 1, 2004, for which pass-through status has not been approved and a C-code and APC payment have not been assigned using the “unclassified” drug/biological HCPCS code C9399 (Unclassified drugs or biological). Drugs, biologicals, and therapeutic radiopharmaceuticals that are assigned to HCPCS code C9399 are contractor priced at 95 percent of AWP.

Diagnostic radiopharmaceuticals and contrast agents are policy packaged under the OPPS unless they have been granted pass-through status. Therefore, new diagnostic radiopharmaceuticals and contrast agents are an exception to the above policy and should not be billed with C9399 prior to the approval of pass-through status but, instead, should be billed with the appropriate “A” NOC code as described below.

Diagnostic Radiopharmaceuticals – All new diagnostic radiopharmaceuticals are assigned to either HCPCS code A9597 (Positron emission tomography radiopharmaceutical, diagnostic, for tumor identification, not otherwise classified), HCPCS code A9598 (Positron emission tomography radiopharmaceutical, diagnostic, for non-tumor identification, not otherwise classified), HCPCS code A9599 (Radiopharmaceutical, diagnostic, for beta-amyloid positron emission tomography (PET) imaging, per study dose), or HCPCS code J3490 (Unclassified drugs) (applicable to all new diagnostic radiopharmaceuticals used in non-beta-amyloid PET imaging). HCPCS code A9597, A9598, A9599, or J3490, whichever is applicable, should be used to bill a new diagnostic radiopharmaceutical until the new diagnostic radiopharmaceutical has been granted pass-through status and a C-code has been assigned. HCPCS codes A9597, A9598, A9599, and J3490 are assigned status indicator “N” and, therefore, the payment for a diagnostic radiopharmaceutical assigned to any of these HCPCS codes is packaged into the payment for the associated service.

Contrast Agents – All new contrast agents are assigned HCPCS code A9698 (Non-radioactive contrast imaging material, not otherwise classified, per study) or A9700 (Supply of injectable contrast material for use in echocardiography, per study). HCPCS code A9698 or A9700 should be used to bill a new contrast agent until the new contrast agent has been granted pass-through status and a C-code has been assigned. HCPCS code A9698 is assigned status indicator “N” and, therefore, the payment for a drug assigned to HCPCS code A9698 is packaged into the payment for the associated service. The status indicator for A9700 will change from SI=B (Not paid under OPPS) to SI=N (Payment is packaged into payment for other services) and, therefore, the payment for a drug assigned to HCPCS code A9700 is packaged into the payment for the associated service.
g. Skin Substitute Procedure Edits

The payment for skin substitute products that do not qualify for pass-through status will be packaged into the payment for the associated skin substitute application procedure. The skin substitute products are divided into two groups: 1) high cost skin substitute products and 2) low cost skin substitute products for packaging purposes. Table 4 lists the skin substitute products and their assignment as either a high cost or a low cost skin substitute product, when applicable. CMS will implement an OPPS edit that requires hospitals to report all high-cost skin substitute products in combination with one of the skin application procedures described by CPT codes 15271-15278 and to report all low-cost skin substitute products in combination with one of the skin application procedures described by HCPCS codes C5271-C5278. All pass-through skin substitute products are to be reported in combination with one of the skin application procedures described by CPT codes 15271-15278.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>CY 2017 Short Descriptor</th>
<th>CY 2017 SI</th>
<th>Low/High Cost Skin Substitute</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9363</td>
<td>Integra Meshed Bil Wound Mat</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4100</td>
<td>Skin Substitute, NOS</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4101</td>
<td>Apligraf</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4102</td>
<td>Oasis Wound Matrix</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4103</td>
<td>Oasis Burn Matrix</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4104</td>
<td>Integra BMWD</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4105</td>
<td>Integra DRT</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4106</td>
<td>Dermagraft</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4107</td>
<td>GraftJacket</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4108</td>
<td>Integra Matrix</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4110</td>
<td>Primatrix</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4111</td>
<td>Gammagraft</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4115</td>
<td>Alloskin</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4116</td>
<td>Alloderm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4117</td>
<td>Hyalomatrix</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4121</td>
<td>Theraskin</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4122</td>
<td>Dermacell</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4123</td>
<td>Alloskin</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4124</td>
<td>Oasis Tri-layer Wound Matrix</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4126</td>
<td>Memoderm/derma/tranz/integup</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4127</td>
<td>Talymed</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4128</td>
<td>Flexhd/Allopatchhd/Matrixhd</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4131</td>
<td>Epifix</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4132</td>
<td>Grafix Core</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4133</td>
<td>Grafix Prime</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4134</td>
<td>hMatrix</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4135</td>
<td>Mediskin</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4136</td>
<td>Ezderm</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4137</td>
<td>Amnioexcel or Biodexcel, 1cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4138</td>
<td>Biodfence DryFlex, 1cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>CY 2017 HCPCS Code</td>
<td>CY 2017 Short Descriptor</td>
<td>CY 2017 SI</td>
<td>Low/High Cost Skin Substitute</td>
</tr>
<tr>
<td>-------------------</td>
<td>--------------------------</td>
<td>-----------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>Q4140</td>
<td>Biodfence 1cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4141</td>
<td>Alloskin ac, 1cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4143*</td>
<td>Repriza, 1cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4146*</td>
<td>Tensix, 1CM</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4147</td>
<td>Architect ecm, 1cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4148</td>
<td>Neox 1k, 1cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4150</td>
<td>Allowrap DS or Dry 1 sq cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4151</td>
<td>AmnioBand, Guardian 1 sq cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4152</td>
<td>Dermapure 1 square cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4153</td>
<td>Dermavest 1 square cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4154</td>
<td>Biovance 1 square cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4156</td>
<td>Neox 100 1 square cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4157*</td>
<td>Revitalon 1 square cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4158*</td>
<td>MariGen 1 square cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4159</td>
<td>Affinity 1 square cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4160</td>
<td>NuShield 1 square cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4161</td>
<td>Bio-Connekt per square cm</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4162</td>
<td>Amnio bio and woundex flow</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4163*</td>
<td>Amnion bio and woundex sq cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4164</td>
<td>Helicoll, per square cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4165</td>
<td>Keramatrix, per square cm</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4166*</td>
<td>Cytal, per square cm</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4167*</td>
<td>Truskin, per square cm</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4168*</td>
<td>Amnioband, 1 mg</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4169*</td>
<td>Artacent wound, per square cm</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4170*</td>
<td>Cygnus, per square cm</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4171*</td>
<td>Interfyl, 1 mg</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4172</td>
<td>PuraPly, PuraPly antimic</td>
<td>G</td>
<td>High</td>
</tr>
<tr>
<td>Q4173*</td>
<td>Palingen or palingen xplus, per sq cm</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4175*</td>
<td>Miroderm, per square cm</td>
<td>N</td>
<td>Low</td>
</tr>
</tbody>
</table>

*HCPCS codes Q4166, Q4167, Q4168, Q4169, Q4170, Q4171, Q4173, and Q4175 were assigned to the low cost group in the CY 2017 OPPS/ASC final rule with comment period. Upon submission of updated pricing information, Q4143, Q4146, Q4157, Q4158, and Q4163 are assigned to the high cost group for CY 2017.

**h. Reassignment of Skin Substitute Products from the Low Cost Group to the High Cost Group - Retroactive Change**

One existing skin substitute product has been reassigned from the low cost skin substitute group to the high cost skin substitute group based on updated pricing information. The start date on this change is retroactive to October 1, 2016. The product is listed in Table 5 below.
Table 5 – Updated Skin Substitute Product Assignment to High Cost Status Retroactive to October 1, 2016

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>Status Indicator</th>
<th>Low/High Cost Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q4158</td>
<td>MariGen 1 square cm</td>
<td>N</td>
<td>High</td>
</tr>
</tbody>
</table>

**Changes to OPPS Pricer Logic**

a. Rural sole community hospitals and essential access community hospitals (EACHs) will continue to receive an additional 7.1 percent payment for most services in CY 2017. The rural SCH and EACH payment adjustment excludes drugs, biologicals, items, and services paid at charges reduced to cost, and items paid under the pass-through payment policy in accordance with the Social Security Act (Section 1833(t)(13)(B)), as added by Section 411 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA).

b. New OPPS payment rates and copayment amounts will be effective January 1, 2017. All copayment amounts will be limited to a maximum of 40 percent of the APC payment rate. Copayment amounts for each service cannot exceed the CY 2017 inpatient deductible of $1,316. For most OPPS services, copayments are set at 20 percent of the APC payment rate.

c. For hospital outlier payments under OPPS, there will be no change in the multiple threshold of 1.75 for 2017. This threshold of 1.75 is multiplied by the total line-item APC payment to determine eligibility for outlier payments. This factor also is used to determine the outlier payment, which is 50 percent of estimated cost less 1.75 times the APC payment amount. The payment formula is \( \frac{\text{cost} - (\text{APC payment} \times 1.75)}{2} \).

d. The fixed-dollar threshold for OPPS outlier payments increases in CY 2017 relative to CY 2016. The estimated cost of a service must be greater than the APC payment amount plus $3,825 in order to qualify for outlier payments.

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

f. Continuing CMS established policy for CY 2017, the OPPS Pricer will apply a reduced update ratio of 0.980 to the payment and copayment for hospitals that fail to meet their hospital outpatient quality data reporting requirements or that fail to meet CMS validation edits. The reduced payment amount will be used to calculate outlier payments.

g. Effective January 1, 2017, CMS is adopting the FY 2017 IPPS post-reclassification wage index values with application of out-commuting adjustment authorized by Section 505 of the MMA to non-IPPS hospitals discussed below.

h. Effective January 1, 2014, for claims with APCs, which require implantable devices and have significant device offsets (greater than 40 percent), a device offset cap will be applied based on the credit amount listed in the “FD” (Credit Received from the Manufacturer for a Replaced Medical Device) value code. The credit amount in value code “FD”, which reduces the APC payment for the applicable procedure, will be capped by the device offset amount for that APC. The offset amounts for the above referenced APCs are available on the CMS website.

i. Effective January 1, 2017 conditional packaging for status indicators “Q1” and “Q2” will apply at the claim level rather than the date-of-service level.

j. The Payment Rate field in the Pricer file will be expanded from 7 digits to 8 digits to accommodate APC payment rates greater than or equal to $100,000.
Update the Outpatient Provider Specific File (OPSF) for New Core-Based Statistical Area (CBSA) and Wage Indices for Non-IPPS Hospitals Eligible for the Out-Commuting Adjustment Authorized by Section 505 of the MMA

CR9930 provides instructions to the MACs for updating the OPSF, effective 2017. This includes updating the CBSA in the provider records, as well as updating the “special wage index” value for those providers who qualify for the Section 505 adjustment as annotated in Table 6 in Attachment A of CR 9930.

NOTE: Although the Section 505 adjustment is static for each qualifying county for 3 years, the special wage index will need to be updated (using the final wage index in Table 6, Attachment A in CR9930) because the post-reclassification CBSA wage index has changed. Also, note that payment for Distinct Part Units (DPUs) located in an acute care hospital is based on the wage index for the labor market area where the hospital is located, even if the hospital has a reclassified wage index. If the DPU falls in a CBSA eligible to receive the section 505 out-commuting adjustment, the DPU’s final wage index should consist of the geographic wage index plus the appropriate out-commuting adjustment.

a) Updating the OPSF for Expiration of Transitional Outpatient Payments (TOPs)

Cancer and children’s hospitals are held harmless under the Social Security Act (Section 1833(t)(7)(D)(ii)) and continue to receive hold harmless TOPs permanently. For CY 2017, cancer hospitals will continue to receive an additional payment adjustment.

b) Updating the OPSF for the Hospital Outpatient Quality Reporting (HOQR) Program Requirements

Effective for OPPS services furnished on or after January 1, 2009, Subsection (d) hospitals that have failed to submit timely hospital outpatient quality data as required in the Social Security Act (Section 1833(t)(17)(A)) will receive payment under the OPPS that reflects a 2 percentage point deduction from the annual OPPS update for failure to meet the HOQR program requirements. This reduction will not apply to hospitals not required to submit quality data or hospitals that are not paid under the OPPS.

c) Updating the OPSF for the Outpatient CCR

As stated in Pub. 100-04, “Medicare Claims Processing Manual”, Chapter 4, Section 50.1, MACs must maintain the accuracy of the data and update the OPSF as changes occur in data element values, including changes to provider CCRs. The file of OPPS hospital upper limit CCRs and the file of Statewide CCRs are available at www.cms.gov/HospitalOutpatientPPS/ under “Annual Policy Files.”

d) Application of the Out Migration Adjustment for IPPS hospitals that also receive OPPS Payment

CR9930 provides instructions to the MACs regarding the application of the out migration adjustment for hospitals located in a county eligible for the out migration adjustment, if the hospital is NOT located in a rural county deemed as a Lugar county (only applicable to 1886(d) hospitals), or the hospital has NOT been approved to reclassify as rural under Section 1886(d)(8)(E) of the Social Security Act (42 CFR 412.103), or the hospital does NOT have an MGCRB reclassification.

Note: Hospitals that are LUGAR (and did not waive their LUGAR status) or qualify for MGCRB or 412.103 reclassification are not eligible for the out migration adjustment.

e) Updating the OPSF for Hospitals Reclassified as Rural Hospitals Under Section 412.103 and Hospitals Reclassified under the Medicare Geographic Classification Review Board (MGCRB)

An urban hospital that reclassifies as a rural hospital under Section 412.103 is considered rural for all OPPS purposes. Prior to April 21, 2016, the regulations at Section 412.230(a)(5)(ii) and Section 412.230(a)(5)(iii) prohibited hospitals from simultaneously receiving an urban to rural reclassification under Section 412.103 and a reclassification under the MGCRB. Also, the regulations did not allow a LUGAR hospital to keep its LUGAR status if it was approved for an urban to rural reclassification under Section 412.103. The court decisions in Geisinger Community Medical Center v. Secretary, United States Department of Health and Human Services, 794 F.3d 383 (3d Cir. 2015) and Lawrence + Memorial Hospital v. Burwell, No. 15-164, 2016 WL 423702 (2d Cir. Feb. 4, 2015) ruled as unlawful the regulation precluding a hospital from maintaining simultaneous MGCRB and Section 412.103 reclassifications.
Therefore, 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 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 Section 412.103 for IPPS payment and other purposes, and keep their existing MGCRB reclassification or LUGAR status.

At any point during a calendar year, MACs may be notified by the CMS Regional Offices of hospitals located in an urban CBSA that are approved to reclassify as rural under Section 1886(d)(8)(E) of the Social Security Act (Section 412.103). The regulations at Section 412.103(a)(c) provide the CMS Regional Offices with up to 60 days to review and approve an urban to rural reclassification request. If the request is approved by CMS Regional Office, the approval is effective as of the filing date of the request (typically specified in the CMS Regional Office’s approval letter).

**Instructions for Updating the OPSF if a Hospital is Approved for an Urban to Rural Reclassification Under Section 1886(d)(8)(E) of the Social Security Act (§ 412.103) with an Effective Date of April 21, 2016 and After for CY 2016**

CR9930 provides instruction to MACs for updating the OPSF when a hospital is approved for an urban to rural reclassification under Section 1886(d)(8)(E) of the Social Security Act (Section 412.103) with an effective date of April 21, 2016, and after for CY 2016.

**Instructions for Updating the OPSF for Treatment of Certain Urban Hospitals Reclassified as Rural Hospitals Under Section 412.103 in CY 2017 but with no other Reclassifications**

An urban hospital that reclassifies as a rural hospital under Section 412.103 is considered rural. In order to ensure correct payment under the OPPS, the rural CBSA (2-digit State code) in the Wage Index Location CBSA and the special payment indicator field must be updated. CR9930 provides instructions to MACs to make that update.

**Instructions for Updating the OPSF if a Hospital is Approved for an Urban to Rural Reclassification Under Section 1886(d)(8)(E) of the Social Security Act (Section 412.103) with an Effective Date of January 1, 2017, and After for CY 2017**

CR9930 provides instructions to the MACS for updating the OPSF using Table 7 in the attachment to CR9930.

**Instructions for Updating the OPSF if a Hospital Cancels an Urban to Rural Reclassification Under Section 1886(d)(8)(E) of the Social Security Act (Section 412.103)**

For a hospital that notifies the CMS Regional Office that it wishes to cancel its urban to rural reclassification under Section 1886(d)(8)(E) of the Social Security Act (42 CFR 412.103), CR9930 provides instructions to the MACS for updating their OPSF.

CR9930 also provides instructions to the MACs for updating the OPSF for hospitals that have both a MGCRB reclassification/LUGAR status and a Section 412.103 urban to rural reclassification and cancel their Urban to Rural reclassification under Section 1886 (d)(8)(E) of the Social Security Act (412.103) in the middle of the Fiscal Year.

**Coverage Determinations**

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

**Additional Information**


You may refer to [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/passsthrough_payment.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/passsthrough_payment.html) for the most current OPPS HCPCS Offset File.
Hospital OPPS April 2017 Update

MLN Matters® Number: MM 10005
Related Change Request (CR) #: CR 10005
Related CR Release Date: March 3, 2017
Effective Date: April 1, 2017
Related CR Transmittal #: R3728CP
Implementation Date: April 3, 2017

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

Provider Action Needed
Change Request (CR) 10005 describes changes to and billing instructions for various payment policies implemented in the April 2017 OPPS update. The April 2017 Integrated Outpatient Code Editor (I/OCE) will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier and Revenue Code additions, changes and deletions identified in CR 10005. Make sure your billing staff is aware of these changes.

Background
Key changes to and billing instructions for various payment policies implemented in the April 2017 OPPS updates are as follows:

Proprietary Laboratory Analyses (PLA) CPT Codes Effective February 1, 2017

The American Medical Association (AMA) Current Procedural Terminology (CPT) Editorial Panel established three new PLA CPT codes, specifically CPT codes 0001U, 0002U and 0003U. The long descriptors for the codes are listed in Table 1. Because the codes were effective February 1, 2017, they were not included in the January 2017 I/OCE update and the January 2017 OPPS Addendum B.

Table 1 – PLA CPT Codes Effective February 1, 2017

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Long Descriptor</th>
<th>OPPS SI</th>
</tr>
</thead>
<tbody>
<tr>
<td>0001U</td>
<td>Red blood cell antigen typing, DNA, human erythrocyte antigen gene analysis of 35 antigens from 11 blood groups, utilizing whole blood, common RBC alleles reported</td>
<td>A</td>
</tr>
<tr>
<td>0002U</td>
<td>Oncology (colorectal), quantitative assessment of three urine metabolites (ascorbic acid, succinic acid and carnitine) by liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring acquisition, algorithm reported as likelihood of adenomatous polyps</td>
<td>Q4</td>
</tr>
<tr>
<td>0003U</td>
<td>Oncology (ovarian) biochemical assays of five proteins (apolipoprotein A-1, CA 125 II, follicle stimulating hormone, human epididymis protein 4, transferrin), utilizing serum, algorithm reported as a likelihood score</td>
<td>Q4</td>
</tr>
</tbody>
</table>

Under the hospital OPPS, CPT code 0001U is assigned to status indicator “A” and CPT codes 0002U and 0003U are assigned to status indicator “Q4” (conditionally packaged laboratory tests) effective February 1, 2017. For more information on OPPS SI “A” and “Q4,” refer to OPPS Addendum D1 of the Calendar Year (CY) 2017 OPPS/ASC final rule for the latest definitions to the OPPS status indicators for CY 2017.

CPT codes 0001U, 0002U and 0003U have been added to the April 2017 I/OCE with an effective date of February 1, 2017. These codes, along with their short descriptors and status indicators, are also listed in the April 2017 OPPS Addendum B at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html.
Coding Changes for Presumptive Drug Tests Effective January 1, 2017

Prior to CY 2017, HCPCS codes G0477, G0478 and G0479 were used to describe presumptive drug tests. For the CY 2017 update, the AMA CPT Editorial Panel established three new CPT codes, specifically CPT codes 80305, 80306, and 80307, to describe the same presumptive drug tests as the HCPCS G-codes. Consequently, the HCPCS G-codes were terminated on December 31, 2016. Because CPT codes 80305, 80306 and 80307 describe the same presumptive drug tests as the HCPCS G-codes, the Centers for Medicare & Medicaid Services (CMS) assigned these new CPT codes to the same OPPS status indicator as its predecessor HCPCS G-codes effective January 1, 2017. Table 2 shows the HCPCS codes, long descriptors, status indicators, and replacement codes for the HCPCS G-codes.

Table 2 – Coding Changes for Presumptive Drug Tests Effective January 1, 2017

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Long Descriptor</th>
<th>OPPS SI</th>
<th>Add Date</th>
<th>Termination Date</th>
<th>Replacement Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0477</td>
<td>Drug test(s), presumptive, any number of drug classes; any number of devices or procedures, (e.g., immunoassay) capable of being read by direct optical observation only (e.g., dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service</td>
<td>N/A</td>
<td>01/01/2016</td>
<td>12/31/2016</td>
<td>80305</td>
</tr>
<tr>
<td>G0478</td>
<td>Drug test(s), presumptive, any number of drug classes; any number of devices or procedures, (e.g., immunoassay) read by instrument-assisted direct optical observation (e.g., dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service</td>
<td>N/A</td>
<td>01/01/2016</td>
<td>12/31/2016</td>
<td>80306</td>
</tr>
<tr>
<td>G0479</td>
<td>Drug test(s), presumptive, any number of drug classes; any number of devices or procedures by instrumented chemistry analyzers utilizing immunoassay, enzyme assay, tof, maldi, ltdt, desi, dart, ghpc, gc mass spectrometry), includes sample validation when performed, per date of service</td>
<td>N/A</td>
<td>01/01/2016</td>
<td>12/31/2016</td>
<td>80307</td>
</tr>
<tr>
<td>80305</td>
<td>Drug test(s), presumptive, any number of drug classes, any number of devices or procedures (e.g., immunoassay); capable of being read by direct optical observation only (e.g., dipsticks, cups, cards, cartridges) includes sample validation when performed, per date of service</td>
<td>Q4</td>
<td>01/01/2017</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>HCPCS</td>
<td>Long Descriptor</td>
<td>OPPS SI</td>
<td>Add Date</td>
<td>Termination Date</td>
<td>Replacement Code</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------</td>
<td>------------</td>
<td>------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>80306</td>
<td>Drug test(s), presumptive, any number of drug classes, any number of devices or procedures (e.g., immunoassay); read by instrument assisted direct optical observation (e.g., dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service</td>
<td>Q4</td>
<td>01/01/2017</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>80307</td>
<td>Drug test(s), presumptive, any number of drug classes, any number of devices or procedures, by instrument chemistry analyzers (e.g., utilizing immunoassay [e.g., eia, elisa, emit, fpia, ia, kims, rial], chromatography (e.g., gc, hplc), and mass spectrometry either with or without chromatography, (e.g., dart, desi, gc-ms, gc-ms/ms, lc-ms, lc-ms/ms, ldtd, maldi, tof) includes sample validation when performed, per date of service</td>
<td>Q4</td>
<td>01/01/2017</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Because CMS was unable to delete HCPCS codes G0477, G0478 and G0479 in the January 2017 I/OCE update, CMS is deleting these codes in the April 2017 I/OCE update effective December 31, 2016. The short descriptors for CPT codes 80305, 80306 and 80307, along with their status indicators, are available in the April 2017 OPPS Addendum B.

**Clarification regarding HCPCS Code G0498**

Under the OPPS, HCPCS code G0498 is assigned status indicator “S” (Procedure or Service, Not discounted when multiple) effective January 1, 2016. HCPCS code 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 (for example, home, domiciliary, rest home or assisted living) is intended to describe a service where the facility incurred a facility expense specific to the provision of the non-implantable, external infusion pump. Because HCPCS code G0498 includes the chemotherapy administration, providers should not report HCPCS code G0498 with CPT code 96416 (Initiation of prolonged chemotherapy infusion – more than 8 hours – requiring use of a portable or implantable pump). In addition, a hospital should append modifier 52 (reduced service) to HCPCS code G0498 when a component of the service is not performed.

As a reminder, hospitals are expected to report all drug administration CPT codes in a manner consistent with their descriptors, CPT instructions and correct coding principles. Also, hospitals are reminded to bill for all services provided using the HCPCS code(s) that most accurately describe the service(s) they provided.

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

As stated in the January 2017 update, HCPCS code C1842 (Retinal prosthesis, includes all internal and external components; add-on to C1841) was established to resolve a claims processing issue for Ambulatory Surgery Centers (ASC) and should not be reported on institutional claims by hospital outpatient department providers. Therefore, the status indicator for HCPCS code C1842 will change from status indicator (SI)=N (Paid under OPPS; payment is packaged into payment for other services) to SI=E1 (Not paid by Medicare when submitted on outpatient claims (any outpatient bill type) in the April 2017 update. This correction to status indicator will be retroactive to January 1, 2017.
Drugs, Biologicals and Radiopharmaceuticals

A. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective April 1, 2017

For CY 2017, payment for nonpass-through drugs, biologicals and therapeutic radiopharmaceuticals is made at a single rate of ASP + 6 percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical. In CY 2017, a single payment of ASP + 6 percent for pass-through drugs, biologicals and radiopharmaceuticals is made to provide payment for both the acquisition cost and pharmacy overhead cost of these pass-through items. Payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. Updated payment rates effective April 1, 2017, and drug price restatements are available in the April 2017 update of the OPPS Addendum A and Addendum B.

B. Drugs and Biologicals with OPPS Pass-Through Status Effective April 1, 2017

Seven drugs and biologicals have been granted OPPS pass-through status effective April 1, 2017. These items, along with their descriptors and Ambulatory Payment Classification (APC) assignments, are identified in Table 3.

Table 3 – Drugs and Biologicals with OPPS Pass-Through Status Effective April 1, 2017

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
<th>APC</th>
<th>Status Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9484</td>
<td>Injection, eteplirsen, 10 mg</td>
<td>9484</td>
<td>G</td>
</tr>
<tr>
<td>C9485</td>
<td>Injection, olaratumab, 10 mg</td>
<td>9485</td>
<td>G</td>
</tr>
<tr>
<td>C9486</td>
<td>Injection, granisetron extended release, 0.1 mg</td>
<td>9486</td>
<td>G</td>
</tr>
<tr>
<td>C9487</td>
<td>Ustekinumab, for intravenous injection, 1 mg</td>
<td>9487</td>
<td>G</td>
</tr>
<tr>
<td>C9488</td>
<td>Injection, conivaptan hydrochloride, 1 mg</td>
<td>9488</td>
<td>G</td>
</tr>
<tr>
<td>J7328</td>
<td>Hyaluronan or derivative, gel-syn, for intra-articular injection, 0.1 mg</td>
<td>1862</td>
<td>G</td>
</tr>
<tr>
<td>Q5102</td>
<td>Injection, infliximab, biosimilar, 10 mg</td>
<td>1847</td>
<td>G</td>
</tr>
</tbody>
</table>

C. Drugs and Biologicals Based on ASP Methodology with Restated Payment Rates

Some drugs and biologicals based on ASP methodology will have payment rates that are corrected retroactively. These retroactive corrections typically occur on a quarterly basis. The list of drugs and biologicals with corrected payments rates will be accessible at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/OPPS-Restated-Payment-Rates.html on the first date of the quarter. Providers may resubmit claims that were impacted by adjustments to previous quarter’s payment files.

D. Revised Status Indicator for HCPCS Code J1130

The status indicator for HCPCS code J1130 (Injection, diclofenac sodium, 0.5 mg) will change from SI=E2 (Items and Services for which pricing information and claims data are not available) to SI=K (Paid under OPPS; separate APC payment) in the April 2017 update. This correction to status indicator will be retroactive to January 1, 2017. See Table 4.

Table 4 – Revised Status Indicator for HCPCS Code J1130

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
<th>APC</th>
<th>Status Indicator</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>J1130</td>
<td>Injection, diclofenac sodium, 0.5 mg</td>
<td>1863</td>
<td>K</td>
<td>01/01/2017</td>
</tr>
</tbody>
</table>

E. HCPCS code C9744

As a reminder to hospital providers, HCPCS code C9744 (Ultrasound, abdominal, with contrast) may be used to describe use of a contrast agent in ultrasonography of the liver, kidneys and/or bladder.

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

Four skin substitute products have been reassigned from the low cost skin substitute group to the high cost skin substitute group based on updated pricing information. The HCPCS codes are Q4161, Q4169, Q4173 and Q4175. These products are listed in Table 5.
Table 5 – Reassignment of Skin Substitute Product from the Low Cost Group to the High Cost Group Effective April 1, 2017

<table>
<thead>
<tr>
<th>CY 2017 HCPCS Code</th>
<th>CY 2017 Short Descriptor</th>
<th>CY 2017 SI</th>
<th>Low/High Cost Skin Substitute</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q4161</td>
<td>Bio-Connekt per square cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4169</td>
<td>Artacent wound, per square cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4173</td>
<td>Palingen or palingen xplus, per sq cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4175</td>
<td>Miroderm, per square cm</td>
<td>N</td>
<td>High</td>
</tr>
</tbody>
</table>

G. Removal of Skin Substitute Product from the High/Low Cost Skin Substitute Table

One HCPCS code, Q4171, was inadvertently included in the High/Low Cost Skin Substitute table. Effective April 2017, Q4171 is removed from the High/Low Cost Skin Substitute table. This product is listed in Table 6.

Table 6 – Skin Substitute Product removed from High/Low Cost Skin Substitute Table Effective April 1, 2017

<table>
<thead>
<tr>
<th>CY 2017 HCPCS Code</th>
<th>CY 2017 Short Descriptor</th>
<th>CY 2017 SI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q4171</td>
<td>Interfyl, 1 mg</td>
<td>N</td>
</tr>
</tbody>
</table>

Coverage Determinations

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

Additional Information


REIMBURSEMENT

Modifications to the National COB Agreement Crossover Process – Revised

MLN Matters® Number: MM9681 Revised
Related Change Request (CR) #: CR 9681
Related CR Release Date: January 6, 2017
Effective Date: April 1, 2017
Related CR Transmittal #: R1770OTN
Implementation Date: April 3, 2017

This article was revised on January 9, 2017, to reflect the revised CR9681 issued on January 9. In the article, references to Type of Bill 82x are deleted from the last paragraph of the Background Section. In addition, the CR release date, transmittal number, and the Web address of CR9681 are revised. All other information remains the same.

Provider Types Affected

This MLN Matters® Article is intended for providers, including hospices, submitting institutional claims to Medicare Administrative Contractors (MACs) requiring Coordination of Benefits (COB) for services provided to Medicare beneficiaries.
Provider Action Needed
Change Request (CR) 9681 modifies Medicare’s Part A claims processing system to, among other things:

- Always ensure that a Remittance Advice Remark Code (RARC) accompanies claim denials tied to Claims Adjustment Reason Code (CARC) 16, as required.
- Prevent duplicate entry of hospital day counts expressed as value codes (for example, value code 80, 81, 82).
- Prevent reporting of Present on Admission (POA) indicators on outpatient Coordination of Benefits (COB) facility claims.

Make sure your billing staff is aware of these changes.

Background
The Council for Affordable Quality Healthcare Committee for Operating Rules for Information Exchange (CAQH CORE) dictates which CARC and RARC combinations must be used by all covered entities in the healthcare industry. Medicare routinely reports CARCs and RARCs on Health Insurance Portability and Accountability Act (HIPAA) Accredited Standards Institute (ASC) 835 Electronic Remittance Advice (ERA) transactions in accordance with HIPAA requirements. Medicare also includes CARCs and RARCs within HIPAA ASC 837-N claims transactions, including 837 Coordination of Benefits (COB) claims transactions. However, within 837 claims transactions, RARCs are referred to as “Claim Payment Reason Codes” and appear within the 2320 Medicare Inpatient Adjudication Information (MIA) and Medicare Outpatient Adjudication Information (MOA) segments.

As a result of systems issues, MACs are not always including a valid and relevant RARC in the 2320 MIA field when they deny Medicare claims. Medicare crossover claims are often being rejected by supplemental payers as a consequence. Though not the only example, this scenario seems to occur frequently when a claim service line is editing to deny with CARC code 16—“Claim lacks information or has submission/billing error(s) which is needed for adjudication......” CR9681 will ensure that at least one informational RARC is provided to comply with HIPAA and CAHQ/CORE requirements.

The Part A system is producing instances of duplicated hospital day counts on outbound 837 institutional COB/crossover claims. CR9681 remedies this situation. Important: Hospital billing staffs should avoid entering hospital day counts via Direct Data Entry (DDE) screens.

Lastly, at present there is no editing with the Part A system to prevent the entry of a POA indicator on incoming outpatient facility claims. CR9681 remedies this issue by returning to the provider (RTP) any outpatient claim (type of bill other than 11x, 18x, 21x, and 41x) that contains a POA indicator. **Important:** Billing vendors for hospitals should make it a practice to only include POA indicators on 11x, 18x, 21x, and 41x type of bill (TOB) claims submitted to Medicare.

Additional Information

**RARC, CARC, MREP and PC Print Update**
MLN Matters® Number: MM9878
Related Change Request (CR) #: CR 9878
Related CR Release Date: February 24, 2017
Effective Date: July 1, 2017
Related CR Transmittal #: R3725CP
Implementation Date: July 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) for services provided to Medicare beneficiaries.
Provider Action Needed
Change Request (CR) 9878 updates the Remittance Advice Remark Code (RARC) and Claim Adjustment Reason Code (CARC) lists. CR9878 also calls for an update to Medicare Remit Easy Print (MREP) and PC Print software. If you use MREP and/or PC Print software, be sure to obtain the latest version that is released on or before July 3, 2017. Make sure that your billing staffs are aware of these changes.

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 MACs to conduct updates based on the code update schedule that is published three times per year – around March 1, July 1, and November 1.

CR9878 provides notification indicating when updates to CARC and RARC lists are made available on the Washington Publishing Company (WPC) website. Medicare’s Shared System Maintainers (SSMs) have the responsibility to implement code deactivation, 1) making sure that any deactivated code is not used in original business messages, and 2) 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 CR9878, MACs must implement on the date specified on the WPC website.

A discrepancy between the dates may arise as the WPC website is only updated three times per year and may not match the CMS release schedule. For CR9878, MACs and SSMs must determine the changes that are included on the code list since the last code update CR (CR 9774) or its corresponding MM Article (MM9774).

Additional Information

Updates to the “Medicare Claims Processing Manual,” Pub. 100-04, Chapters 12, 17 and 23 to Correct Remittance Advice Messages
MLN Matters® Number: MM9906
Related Change Request (CR) #: CR 9906
Related CR Release Date: February 24, 2017
Effective Date: May 25, 2017
Related CR Transmittal #: R3721CP
Implementation Date: May 25, 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
This article is based on Change Request (CR) 9906, which revises Chapters 12, 17, and 23 of the “Medicare Claims Processing Manual” (the manual) to ensure that all remittance advice coding is consistent with national standard operating rules. It also provides a format for consistently showing remittance advice coding throughout this manual. MACs will ensure that they apply remittance advice coding as described in the revised manual sections. Make sure that your billing staffs are aware of these changes.
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 CARCs and RARCs, regulates the way in which group codes, Claims Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (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. This rule is authored by the Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE).

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. CR9906 updates Chapters 12, 17, and 23 of the manual to reflect the standard format and to correct any non-compliant code combinations.

Additional Information