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This Bulletin should be shared with all health care practitioners and managerial members of the provider/supplier staff. Bulletins are available at no-cost from our website at: http://www.med.noridianmedicare.com

Don’t be left in the dark, sign up for the Noridian e-mail listing to receive updates that contain the latest Medicare news. Visit the Noridian website and select “Subscribe” on the bottom right-hand corner of any page.

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<td>877-908-8431</td>
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MLN Matters Disclaimer Statement

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

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

Sources for “Medicare A News” Articles

The purpose of “Medicare A News” is to educate the Noridian Medicare Part A provider community. The educational articles can be advice written by Noridian staff or directives from CMS. Whenever we publish material from CMS, we will do our best to retain the wording given to us; however, due to limited space in our bulletins, we will occasionally edit this material. Noridian includes “Source” following CMS derived articles to allow for those interested in the original material to research it at the CMS website, http://www.cms.gov/manuals. 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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New Release of PEPPER Available for Hospices, SNFs, IRFs, IPFs, CAHs, LTCHs

The Q4FY16 release of the Program for Evaluating Payment Patterns Electronic Report (PEPPER) for hospices, skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs), inpatient psychiatric facilities (IPFs), critical access hospitals (CAHs) and long-term acute care hospitals (LTCHs) will be available beginning April 17, 2017.

Hospices, LTCHs and free-standing SNFs and IRFs: To obtain their PEPPER, the Chief Executive Officer, President, Administrator or Compliance Officer of the organization should:

2. Review the instructions and obtain the information required to authenticate access. Note: A new validation code will be required. A patient control number or medical record number from a claim for a traditional Medicare FFS beneficiary with a “from” or “through” date in July 1-September 30, 2016 will be required.
3. Visit the PEPPER Resources Portal.
4. Complete all the fields.
5. Download the PEPPER.

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

About PEPPER

PEPPER summarizes provider-specific data statistics for Medicare services that may be at risk for improper payments. Providers can use the data to support internal auditing and monitoring activities. Visit PEPPERResources.org to access updated resources for using PEPPER, including recorded web-based training sessions, sample PEPPERs and PEPPER User’s Guides, which are available on the applicable «Training and Resources» pages.

PEPPER is distributed by TMF® Health Quality Institute under contract with the Centers for Medicare & Medicaid Services.
**New ST PEPPER Now Available**

New Program for Evaluating Payment Patterns Electronic Reports (PEPPERs) are now available for short-term acute care hospitals. PEPPERs are distributed by TMF® Health Quality Institute under contract with CMS. These reports summarize provider-specific data statistics for Medicare services that may be at risk for improper payments. Providers can use the data to support internal auditing and monitoring activities. The PEPPER files were recently distributed through a QualityNet secure file exchange to hospital QualityNet Administrators and user accounts with the PEPPER recipient role.

For more information, including guides, recorded training sessions, information about QualityNet accounts, frequently asked questions, and examples of how other hospitals are using PEPPER, visit PEPPERresources.org. If you have questions or need help obtaining your report, visit the Help Desk. Send us your feedback or suggestions.

**Advance Beneficiary Notice of Noncoverage – New Version Effective June 21, 2017**

Effective June 21, 2017, providers must use the most recent version of the Advance Beneficiary Notice of Noncoverage (ABN) Form CMS-R-131 with the March 2020 expiration date. If the new form is not used on or after this date, any new ABN executed on the old form will be considered invalid and would result in provider liability if Medicare denies the claim.

Providers may begin using the new ABN Form CMS-R-131 immediately. For more information, please visit the Fee For Service Advance Beneficiary Notice of Noncoverage webpage on the CMS website. Guidelines for mandatory and voluntary use of the ABN are published in the Internet Only Manual (IOM), Medicare Claims Processing Manual, Chapter 30, Section 50.

**Authenticating with the Interactive Voice Response (IVR)**

Noridian’s IVR offers providers quick and easy access to Medicare information. Information on the IVR includes; Medicare claim information, patient eligibility, check history and status, deductible status and more. Providers may navigate the IVR by either speaking the required information or entering it by using the keypad on the telephone.

We also encourage providers to authenticate even when calling to speak to a Customer Service Representative (CSR). The authentication information will appear for the CSR when a valid National Provider Identifier (NPI), Provider Transaction Access Number (PTAN) and last 5 digits of the TIN (Tax Identification Number) are entered through the IVR. This will make the call go quicker with the CSR, as you will already be authenticated. Please begin authentication through the IVR when calling Noridian.

Note: If unable to authenticate on the IVR, please ensure you are selecting the correct line of business when asking for General Inquiries. If Medicare is billed using the UB-04 form or electronic equivalent, select Part A. If you submit claims via the CMS-1500 or electronic equivalent, select Part B.

For more information, visit the IVR page of our website

**You Spoke. We Listened.**

Thank you for your continued feedback received through our website satisfaction survey. These comments and suggestions are read and evaluated each day. We continue to make improvements to our website and portal and the following departments based on the comments and suggestions provided to us. Stay up-to-date on all changes that are being made on the Noridian website by going to the “You Spoke. We Listened.” page.
Screening for Lung Cancer with LDCT – Second Revision

MLN Matters® Number: MM9246 Revised
Related Change Request (CR) #: 9246
Related CR Release Date: October 15, 2015
Effective Date: February 5, 2015
Related CR Transmittal #: R3374CP and R185NCD
Implementation Date: January 4, 2016

This article was revised on June 12, 2017, to add a paragraph on page 3 to clarify that Independent Diagnostic Testing Facilities (IDTFs) may be eligible facilities. All other information is unchanged.

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) 9246 informs MACs that Medicare covers lung cancer screening with LDCT if all eligibility requirements listed in the National Coverage Determination (NCD) are met. Make sure that your billing staffs are aware of these changes.

Background
Section 1861(ddd)(1) of the Social Security Act (the Act) authorizes the Centers for Medicare & Medicaid Services (CMS) to add coverage of “additional preventive services” through the NCD process. The “additional preventive services” must meet all of the following criteria:

- Be reasonable and necessary for the prevention or early detection of illness or disability;
- Be recommended with a grade of A or B by the United States Preventive Services Task Force (USPSTF); and
- Be appropriate for individuals entitled to benefits under Part A or enrolled under Part B.

CMS reviewed the evidence for lung cancer screening with low dose computed tomography (LDCT) and determined that the criteria listed above were met, enabling CMS to cover this “additional preventive service” under Medicare Part B.

CMS issued NCD 210.14 on August 21, 2015, that provides for Medicare coverage of screening for lung cancer with LDCT. Effective for claims with dates of service on and after February 5, 2015, Medicare beneficiaries must meet all of the following criteria:

- Be 55–77 years of age;
- Be asymptomatic (no signs or symptoms of lung cancer);
- Have a tobacco smoking history of at least 30 pack-years (one pack-year = smoking one pack per day for one year; 1 pack = 20 cigarettes);
- Be a current smoker or one who has quit smoking within the last 15 years; and,
- Receive a written order for lung cancer screening with LDCT that meets the requirements described in the NCD.

Written orders for lung cancer LDCT screenings must be appropriately documented in the beneficiary’s medical record, and must contain the following information:

- Date of birth;
- Actual pack–year smoking history (number);
- Current smoking status, and for former smokers, the number of years since quitting smoking;
- A statement that the beneficiary is asymptomatic (no signs or symptoms of lung cancer); and,
The National Provider Identifier (NPI) of the ordering practitioner.

Counseling and Shared Decision-Making Visit
Before the first lung cancer LDCT screening occurs, the beneficiary must receive a written order for LDCT lung cancer screening during a lung cancer screening counseling and shared decision-making visit that includes the following elements and is appropriately documented in the beneficiary’s medical records:

- Must be furnished by a physician (as defined in section 1861(r)(1) of the Act) or qualified non-physician practitioner (meaning a Physician Assistant (PA), Nurse Practitioner (NP), or Clinical Nurse Specialist (CNS) as defined in section1861(aa)(5) of the Act); and
- Must include all of the following elements:
  - Determination of beneficiary eligibility including age, absence of signs or symptoms of lung cancer, a specific calculation of cigarette smoking pack-years; and if a former smoker, the number of years since quitting;
  - Shared decision-making, including the use of one or more decision aids, to include benefits and harms of screening, follow-up diagnostic testing, over-diagnosis, false positive rate, and total radiation exposure;
  - Counseling on the importance of adherence to annual lung cancer LDCT screening, impact of co-morbidities, and ability or willingness to undergo diagnosis and treatment;
  - Counseling on the importance of maintaining cigarette smoking abstinence if former smoker; or the importance of smoking cessation if current smoker and, if appropriate, furnishing of information about tobacco cessation interventions; and,
- If appropriate, the furnishing of a written order for lung cancer screening with LDCT.

Written orders for subsequent annual LDCT screens may be furnished during any appropriate visit with a physician or qualified non-physician practitioner (PA, NP, or CNS).

As part of the NCD, all criteria listed in the NCD must be met to include requirements for reading radiologists and radiology imaging facilities. In addition to collecting and submitting data to a CMS-approved registry, all facilities that would like to be eligible to perform the lung cancer screening, including Independent Diagnostic Testing Facilities (IDTFs), must meet all criteria stated in the Decision Memo for Lung Cancer Screening with LDCT, which is available at https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=274. Information regarding CMS-approved registries is posted at: http://www.cms.gov/Medicare/Medicare-General-Information/MedicareApprovedFacilities/Lung-Cancer-Screening-Registries.html on the CMS website.

Coinsurance and Deductibles
Medicare coinsurance and Part B deductible are waived for this preventive service.

Health Care Common Procedure Coding System (HCPCS) Codes
Effective for claims with dates of service on and after February 5, 2015, the following HCPCS codes are used for lung cancer screening with LDCT:

- G0296 – Counseling visit to discuss need for lung cancer screening (LDCT) using low dose CT scan (service is for eligibility determination and shared decision making)
- G0297 – Low dose CT scan (LDCT) for lung cancer screening

In addition to the HCPCS code, these services must be billed with ICD-10 diagnosis code Z87.891 (personal history of tobacco use/personal history of nicotine dependence), ICD-9 diagnosis code V15.82.

NOTE: Contractors shall apply contractor-pricing to claims containing HCPCS G0296 and G0297 with dates of service February 5, 2015, through December 31, 2015.

Institutional Billing Requirements
Effective for claims with dates of service on and after February 5, 2015, providers may use the following Types of Bill (TOBs) when submitting claims for lung cancer screening, HCPCS codes G0296 and G0297: 12X, 13X, 22X, 23X, 71X (G0296 only), 77X (G0296 only), and 85X.
Medicare will pay for these services as follows:

- Outpatient hospital departments – TOBs 12X and 13X - based on Outpatient Prospective Payment System (OPPS);
- Skilled nursing facilities (SNFs) – TOBs 22X and 23X – based on the Medicare Physician Fee Schedule (MPFS);
- Critical Access Hospitals (CAHs) - TOB 85X – based on reasonable cost;
- CAH Method II – TOB 85X with revenue code 096X, 097X, or 098X based on the lesser of the actual charge or the MPFS (115% of the lesser of the fee schedule amount and submitted charge) for HCPCS G0296 only;
- Rural Health Clinics (RHCs) - TOB 71X - based on the all-inclusive rate for HCPCS G0296 only; and
- Federally Qualified Health Centers (FQHCs) – TOB 77X - based on the PPS rate for HCPCS G0296 only.

NOTE: For outpatient hospital settings, as in any other setting, services covered under this NCD must be ordered by a primary care provider within the context of a primary care setting and performed by an eligible Medicare provider for these services.

Claim Adjustment Reason Codes (CARCs), Remittance Advice Remark Codes (RARCs), Group Codes

MACs will use the following CARCs, RARCs, and Group Codes when denying payment for LDCT lung cancer screening, HCPCS G0296 and G0297:

Submitted on a TOB other than 12X, 13X, 22X, 23X, 71X, 77X, or 85X:

- CARC 170 - Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- RARC N95 – This provider type/provider specialty may not bill this service.
- Group Code CO (Contractual Obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

NOTE: For modifier GZ, MACs will use CARC 50.

For TOBs 71X and 77X when HCPCS G0296 is billed on the same date of service with another visit (this does not apply to initial preventive physical exams for 71X TOBs):

- CARC 97 - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- RARC M15 - Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.

NOTE: 77X TOBs will be processed through the Integrated Outpatient Code Editor under the current process.
- Group Code CO assigning financial liability to the provider.

Where a previous HCPCS G0297 is paid in history in a 12-month period (at least 11 full months must elapse from the date of the last screening):

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

NOTE: For modifier GZ, MACs will use CARC 50.
Because the beneficiary is not between the ages of 55 and 77 at the time the service was rendered (line-level):

- **CARC 6:** “The procedure/revenue code is inconsistent with the patient’s age. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.”

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

- NOTE: For modifier GZ, MACs will use CARC 50.

Because the claim line was not billed with ICD-10 diagnosis Z87.891:

- **CARC 167** – This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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

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

- NOTE: For modifier GZ, MACs will use CARC 50.

**Additional Information**

The official instruction, CR9246, consists of two transmittals:

- **Transmittal R3374CP,** which updates the “Medicare Claims Processing Manual;” and

- **Transmittal R185NCD,** which updates the “Medicare NCD Manual.”

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**HCV Screening in Adults Billing for Reporting of TOB 014x – Revised**

**MLN Matters® Number:** MM9360 Revised

**Related Change Request (CR) #:** CR 9360

**Related CR Release Date:** November 5, 2015

**Effective Date:** June 2, 2014

**Related CR Transmittal #:** R3393CP

**Implementation Date:** April 4, 2016

This article was revised on May 2, 2017, to correct the TOBs for the screening of HCV other than non-patient laboratory specimen. All other information is the same.

**Provider Types Affected**

This MLN Matters® Article is intended for providers submitting claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries related to screening of Hepatitis C Virus (HCV) in adults.

**Provider Action Needed**

This article is based on Change Request (CR) 9360, which adds Type of Bill (TOB) 014x (Hospital Other Part B) as an applicable TOB for the screening of HCV when submitted for non-patient laboratory specimen (HCPCS Code G0472). Transmittal 3215, CR 8871, titled, “Screening for Hepatitis C Virus (HCV) in Adults,” omitted TOB 014x from the list of applicable TOBs for HCV screening. Payment for these services submitted on TOB 014x will be based on the laboratory fee schedule. Make sure your billing personnel are aware of this change.
Background
Appropriate TOBs for the screening of HCV other than non-patient laboratory specimen remain the same:
- 013x
- 085x

Providers report TOB 014x when submitting claims for screening for HCV when provided to non-patient laboratory specimens.

In addition, MACs will apply the same logic for G0472 on TOB 14x as described in MLN Matters articles MM8871 and MM9200.

Note that MACs will not search for claims with G0472, submitted under TOB 014x with dates of service on or after June 2, 2014, but received before April 4, 2016, but the MACs may adjust claims that are brought to their attention.

Additional Information

Update FISS Editing to Include All Three Patient Reason for Visit Code Fields – Revised
MLN Matters® Number: MM9672 Revised
Related Change Request (CR) #: CR 9672
Related CR Release Date: May 17, 2017
Effective Date: Claims received on or after October 1, 2017
Related CR Transmittal #: R1852OTN
Implementation Date: October 2, 2017

This article was revised on May 18, 2017, to reflect the revised CR9672 issued on May 17. The article was revised to change the effective and implementation dates, the CR release date, transmittal number, and the Web address for accessing the CR. All other information remains the same.

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

What You Need to Know
Change Request (CR) 9672 informs MACs about changes that update logic in the Fiscal Intermediary Standard System (FISS) (Medicare’s system for processing institutional claims) to allow editing of the expanded Patient Reason for Visit (PRV) fields. CR9672 requires updating of FISS to ensure that all of the National Coverage Determination (NCD) edits within Reason Code ranges 3xxxx and 59xxx that are tied to the diagnosis code fields include all three PRV fields for outpatient hospital claims on Types of Bills (TOB) 013x and 085x. CR9672 makes no policy changes.

Additional Information
Admitting Diagnosis Code Field Included in FISS Editing
MLN Matters® Number: MM9753
Related Change Request (CR) #: CR 9753
Related CR Release Date: April 28, 2017
Effective Date: October 1, 2017
Related CR Transmittal #: R1832OTN
Implementation Date: October 2, 2017

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

Provider Action Needed
Change Request (CR) 9753 informs MACs about changes to system edits by the maintainer of Medicare’s Fiscal Intermediary Shared System (FISS). Make sure that your billing staffs are aware of these changes.

Background
In prior system updates, Medicare required FISS to review diagnosis fields. CR9753 updates various system edits to look at the admitting diagnosis field. FISS editing is now being updated to ensure that all of the National Coverage Determination (NCD) edits within Reason Code ranges 3xxxx and 59xxx that are tied to the diagnosis code fields (other than the primary diagnosis field) include the admitting diagnosis field for Inpatient claims on Types of Bill (TOB) 011x, 012x, 018x, 021x, and 022x.

Additional Information

Instructions to Process Services Not Authorized by the VA in a Non-VA Facility Reported with Value Code 42 – Second Revision
MLN Matters® Number: MM9818 Revised
Related Change Request (CR) #: CR 9818
Related CR Release Date: May 24, 2017
Effective Date: October 1, 2013
Related CR Transmittal #: R3779CP
Implementation Date: April 3, 2017

This article was revised on May 25, 2017, due to an updated Change Request (CR) that clarified language, which is stated in this article (in bold) on page 2. The transmittal number, CR release date and link to the CR also changed. 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
CR 9818 corrects a misinterpretation of the changes made with CR8198 - Updating the Shared Systems and Common Working File (CW) 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.

When a Medicare beneficiary is also eligible for veterans health benefits and elects to obtain his/her health care at a VA facility, law entitles the VA to collect from the beneficiary’s supplemental insurer the coinsurance and deductibles that would have been payable had the beneficiary instead received services from a Medicare provider (law, however, prohibits Medicare from paying for these claims).

Currently, through an interagency agreement between CMS and the VA, CMS systems adjudicate the VA claims on a no-pay basis to determine the amounts Medicare would have paid for equivalent services rendered by Medicare providers along with the coinsurance and deductible amounts applicable.

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


HBV Infection Screening – Second Revision
MLN Matters® Number: MM9859 Revised
Related Change Request (CR) #: CR 9859
Related CR Release Date: April 28, 2017
Effective Date: September 28, 2016
Related CR Transmittal #: R3761CP and R195NCD
Implementation Date: January 1, 2018

This article was changed on May 17, 2017, to clarify language on page 3, under the “Professional Billing Requirements.” It now reads, only when services are ordered by the following provider specialties found on the provider’s enrollment record… All other information is unchanged.

Provider Types Affected
This MLN Matters® Article is intended for physicians and other providers submitting claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries.
Provider Action Needed
Change Request (CR) 9859 provides that the Centers for Medicare & Medicaid Services (CMS) has determined that, effective September 28, 2016, Medicare will cover screening for Hepatitis B Virus (HBV) infection when performed with the appropriate U.S. Food and Drug Administration (FDA) approved/cleared laboratory tests, used consistent with FDA-approved labeling and in compliance with the Clinical Laboratory Improvement Act (CLIA) regulations. Medicare coinsurance and the Part B deductible are waived for this additional preventive service. You should ensure that your billing staffs are aware of this coverage change.

Background
Pursuant to Section 1861(ddd) of the Social Security Act (the Act), CMS may add coverage of “additional preventive services” through the National Coverage Determination (NCD) process. The preventive services must meet all of the following criteria:

- Reasonable and necessary for the prevention or early detection of illness or disability.
- Recommended with a grade of A or B by the United States Preventive Services Task Force (USPSTF).
- Appropriate for individuals entitled to benefits under Part A or enrolled under Part B.

The USPSTF has updated its recommendations for HBV screening, and CMS has reviewed these recommendations and supporting evidence; and has determined that the evidence is adequate to conclude that screening for HBV infection is reasonable and necessary for individuals entitled to benefits under Part A or enrolled under Part B, as described below.

Effective for services performed on or after September 28, 2016, Medicare will cover screening for HBV infection, when ordered by the beneficiary’s primary care physician or practitioner within the context of a primary care setting, and performed by an eligible Medicare provider for these services, within the context of a primary care setting with the appropriate U.S. Food and Drug Administration (FDA) approved/cleared laboratory tests, used consistent with FDA-approved labeling and in compliance with the Clinical Laboratory Improvement Act (CLIA) regulations, for beneficiaries who meet either of the following conditions:

- Asymptomatic, non-pregnant adolescents and adults at high risk for HBV infection. “High risk” is defined as persons born in countries and regions with a high prevalence of HBV infection (that is, ≥ 2%), US-born persons not vaccinated as infants whose parents were born in regions with a very high prevalence of HBV infection (≥ 8%), HIV positive persons, men who have sex with men, injection drug users, household contacts or sexual partners of persons with HBV infection. In addition, CMS has determined that repeated screening would be appropriate annually for beneficiaries with continued high risk persons. Testing is covered annually only for persons who have continued high risk (men who have sex with men, injection drug users, household contacts or sexual partners of persons with HBV infection) who have not received hepatitis B vaccination.

- A screening test at the first prenatal visit is covered for pregnant women and then rescreening at time of delivery for those with new or continuing risk factors. In addition, CMS has determined that screening during the first prenatal visit would be appropriate for each pregnancy, regardless of previous hepatitis B vaccination or previous negative hepatitis B surface antigen (HBsAg) test results.

For the purposes of CR9859:

- The determination of “high risk for HBV” is identified by the primary care physician or practitioner who assesses the patient’s history, which is part of any complete medical history, typically part of an annual wellness visit and considered in the development of a comprehensive prevention plan. The medical record should be a reflection of the service provided.
- A primary care setting is defined by the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Emergency departments, inpatient hospital settings, ambulatory surgical centers, skilled nursing facilities, inpatient rehabilitation facilities, clinics providing a limited focus of health care services, and hospice are examples of settings not considered primary care settings under this definition.
Key Points of CR9859
Applicable Healthcare Common Procedure Coding System (HCPCS) Code
Effective for claims with dates of service on or after September 28, 2016, the claims processing instructions for payment of screening for hepatitis B virus will apply to the following HCPCS and CPT codes:

- HBV screening for asymptomatic, non-pregnant adolescents and adults at high risk - code G0499
- HBV screening for pregnant women - CPT codes 86704, 86706, 87340, and 87341

Types of Bills (TOB) for Institutional Claims
Effective for claims with dates of service on or after September 28, 2016, you should use the following TOBs when submitting claims with G0499, 87340, 87341, 86704, or 86706 for HBV screening:

- Outpatient hospitals - TOB 13X (payment based on Outpatient Prospective Payment System)
- Non-patient laboratory specimen - TOB 14X (payment based on laboratory fee schedule)
- Critical Access Hospitals (CAHs) - TOB 85X, (payment based on reasonable cost when the revenue code is not 096X, 097X, and 098X)
- End Stage Renal Disease (ESRD) - TOB 72X (payment based on ESRD Prospective Payment System when submitting code G0499 with diagnosis code N18.6. HBV is not separately payable for ESRD TOB 72X.)

Professional Billing Requirements
For claims with dates of service on or after September 28, 2016, CMS will allow coverage for HBV screening only when services are ordered by the following provider specialties found on the provider’s enrollment record:

- 01 - General Practice
- 08 - Family Practice
- 11 - Internal Medicine
- 16 - Obstetrics/Gynecology
- 37 - Pediatric Medicine
- 38 - Geriatric Medicine
- 42 - Certified Nurse Midwife
- 50 - Nurse Practitioner
- 89 - Certified Clinical Nurse Specialist
- 97 - Physician Assistant

Claims submitted by providers other than the specialty types noted above will be denied.

Additionally, for claims with dates of service on or after September 28, 2016, CMS will allow coverage for HBV screening only when submitted with one of the following Place of Service (POS) codes:

- 11 - Physician’s Office
- 19 - Off Campus Outpatient Hospital
- 22 - On Campus Outpatient Hospital
- 49 - Independent Clinic
- 71 - State or Local Public Health Clinic
- 81 - Independent Laboratory

Claims submitted without one of the POS codes noted above will be denied.
**Diagnosis Code Reporting Requirements**

For claims with dates of service on or after September 28, 2016, CMS will allow coverage for G0499 for HBV screening only when services are reported with both of the following diagnosis codes denoting high risk:

- Z11.59 - Encounter for screening for other viral disease
- Z72.89 - Other Problems related to lifestyle.

For claims with dates of service on or after September 28, 2016, CMS will allow coverage for G0499 for subsequent visits, only when services are reported with the following diagnosis codes:

- Z11.59 and one of the high risk codes below
  - F11.10-F11.99
  - F13.10-F13.99
  - F14.10-F14.99
  - F15.10-F15.99
  - Z20.2
  - Z20.5
  - Z72.52
  - Z72.53

For claims with dates of service on or after September 28, 2016, CMS will allow coverage for HBV screening (CPT codes 86704, 86706, 87340 and 87341) in pregnant women only when services are reported with one of the following diagnosis codes:

- Z11.59 - Encounter for screening for other viral diseases, and one of the following
  - Z34.00 - Encounter for supervision of normal first pregnancy, unspecified trimester
  - Z34.80 - Encounter for supervision of other normal pregnancy, unspecified trimester
  - Z34.90 - Encounter for supervision of normal pregnancy, unspecified, unspecified trimester
- O09.90 - Supervision of high risk pregnancy, unspecified, unspecified trimester

For claims with dates of service on or after September 28, 2016, CMS will allow coverage for HBV screening (CPT codes 86704, 86706, 87340, and 87341) in pregnant women at high risk only when services are reported with one of the following diagnosis codes:

- Z11.59 - Encounter for screening for other viral diseases; and
- Z72.89 - Other Problems related to lifestyle, and also one of the following:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z34.00</td>
<td>Encounter for supervision of normal first pregnancy, unspecified trimester</td>
</tr>
<tr>
<td>Z34.01</td>
<td>Encounter for supervision of normal first pregnancy, first trimester</td>
</tr>
<tr>
<td>Z34.02</td>
<td>Encounter for supervision of normal first pregnancy, second trimester</td>
</tr>
<tr>
<td>Z34.03</td>
<td>Encounter for supervision of normal first pregnancy, third trimester</td>
</tr>
<tr>
<td>Z34.80</td>
<td>Encounter for supervision of other normal pregnancy, unspecified trimester</td>
</tr>
<tr>
<td>Z34.81</td>
<td>Encounter for supervision of other normal pregnancy, first trimester</td>
</tr>
<tr>
<td>Z34.82</td>
<td>Encounter for supervision of other normal pregnancy, second trimester</td>
</tr>
<tr>
<td>Z34.83</td>
<td>Encounter for supervision of other normal pregnancy, third trimester</td>
</tr>
<tr>
<td>Z34.90</td>
<td>Encounter for supervision of normal pregnancy, unspecified, unspecified trimester</td>
</tr>
<tr>
<td>Z34.91</td>
<td>Encounter for supervision of normal pregnancy, unspecified, first trimester</td>
</tr>
<tr>
<td>Z34.92</td>
<td>Encounter for supervision of normal pregnancy, unspecified, second trimester</td>
</tr>
</tbody>
</table>
### FYI

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z34.93</td>
<td>Encounter for supervision of normal pregnancy, unspecified, third trimester</td>
</tr>
<tr>
<td>O09.90</td>
<td>Supervision of high risk pregnancy, unspecified, unspecified trimester</td>
</tr>
<tr>
<td>O09.91</td>
<td>Supervision of high risk pregnancy, unspecified, first trimester</td>
</tr>
<tr>
<td>O09.92</td>
<td>Supervision of high risk pregnancy, unspecified, second trimester</td>
</tr>
<tr>
<td>O09.93</td>
<td>Supervision of high risk pregnancy, unspecified, third trimester</td>
</tr>
</tbody>
</table>

### Claim/Service Denial

When denying payment for HBV screening use, your MAC will use the appropriate Claim Adjustment Reason Codes (CARCs), Remittance Advice Remark Codes (RARCs), or group codes. When denying services submitted on a TOB other than 13X, 14X, or 85X, they will use:

- **CARC 170** - Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- **RARC N95** - This provider type/provider specialty may not bill this service.
- **Group Code CO (Contractual Obligation)** - Assigning financial liability to the provider.

When denying services when HCPCS G0499 is paid in history for claims with dates of service on and after September 28, 2016, or if the beneficiary’s claim history shows claim lines containing CPT codes 86704, 86706, 87340, and 87341 submitted in the previous 11 full months they will use the following messages:

- **CARC 119** - “Benefit maximum for this time period or occurrence has been reached.”
- **RARC N386** - “This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at [www.cms.gov/mcd/search.asp](http://www.cms.gov/mcd/search.asp). If you do not have web access, you may contact the contractor to request a copy of the NCD.”
- **Group Code PR (Patient Responsibility)** - Assigning financial responsibility to the beneficiary (if a claim is received with occurrence code 32 with or without GA modifier or a claim line is received with a GA modifier indicating a signed ABN is on file).)
- **Group Code CO (Contractual Obligation)** - Assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

When denying services for G0499, when ICD-10 diagnosis code Z72.89 and Z11.59 are not present on the claim, MACs will use:

- **CARC 167** - “This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.”
- **RARC N386** - This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at [www.cms.gov/mcd/search.asp](http://www.cms.gov/mcd/search.asp). If you do not have web access, you may contact the contractor to request a copy of the NCD.
- **Group Code CO**

Denying services for HBV screening, HCPCS G0499, when ICD-10 diagnosis code Z34.00, Z34.01, Z34.02, Z34.03, Z34.80, Z34.81, Z34.82, Z34.83, Z34.90, Z34.91, Z34.92, Z34.93, O09.90, O09.91, O09.92, or O09.93 is present on the claim:

- **CARC 167** – “This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.”
- **RARC N386** - This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at [www.cms.gov/mcd/search.asp](http://www.cms.gov/mcd/search.asp). If you do not have web access, you may contact the contractor to request a copy of the NCD.
- **Group Code: CO (Contractual Obligation)**
When denying services for G0499 for subsequent visits, when ICD-10 diagnosis code Z11.59 and one of the following high risk diagnosis codes: F11.10- F11.19, F13.10 - F13.99, F14.10 - F14.99, F15.10 - F15.99, Z20.2, Z20.5, Z72.52, or Z72.53 are not present on the claim, MACs will use:

- CARC 167 - “This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.”
- RARC N386 - This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at [www.cms.gov/mcd/search.asp](http://www.cms.gov/mcd/search.asp). If you do not have web access, you may contact the contractor to request a copy of the NCD.

Group Code CO

When denying claim lines for G0499 without the appropriate POS code, MACs will use:

- CARC 171 - Payment is denied when performed by this type of provider on this type of facility. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- RARC N428 - Not covered when performed in certain settings.
- Group Code CO

When denying claim lines for G0499 that are not submitted from the appropriate provider specialties, MACs will use:

- CARC 184 - The prescribing/ordering provider is not eligible to prescribe/order the service billed. NOTE: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- RARC N386 - “This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at [http://www.cms.gov/mcd/search.asp](http://www.cms.gov/mcd/search.asp). If you do not have web access, you may contact the contractor to request a copy of the NCD.”
- Group Code PR (Patient Responsibility) - Assigning financial responsibility to the beneficiary (if a claim is received with a GA modifier indicating a signed ABN is on file).
- Group Code CO (Contractual Obligation) - Assigning financial liability to the provider (if a claim line-item is received with a GZ modifier indicating no signed ABN is on file).

When denying services where previous HBV screening, HCPCS 86704, 86706, 87340, or 87341, is paid during the same pregnancy period or more than two screenings are paid to women that are at high risk, they will use:

- CARC 119 - “Benefit maximum for this time period or occurrence has been reached.”
- RARC N362 - “The number of days or units of service exceeds our acceptable maximum.”
- RARC N386 - “This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at [www.cms.gov/mcd/search.asp](http://www.cms.gov/mcd/search.asp). If you do not have web access, you may contact the contractor to request a copy of the NCD.”
- Group Code PR (Patient Responsibility) - Assigning financial responsibility to the beneficiary (if a claim is received with a GA modifier indicating a signed ABN is on file).
- Group Code CO (Contractual Obligation) - Assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

When denying claim lines for HBV screening, HCPCS G0499 for a subsequent HBV screening test for non-pregnant, high risk beneficiary when a claim line for an initial HBV screening has not yet been posted in history, use the following messages:

- CARC B15 - This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.
• Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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

• Group Code - CO (Contractual Obligation).

When denying services for HBV screening, HCPCS 86704, 86706, 87340, and 87341 that are billed without the appropriate diagnosis code MACs will use:

• CARC 50 - These are non-covered services because this is not deemed a “medical necessity” by the payer. Note: Refer to the 835 Healthcare Policy identification Segment (loop 2110 Service Payment information REF), if present.

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

• Group Code PR (Patient Responsibility) - Assigning financial responsibility to the beneficiary (if a claim is received with a GA modifier indicating a signed ABN is on file).

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

Additional Notes

• HCPCS code G0499 will appear in the January 1, 2018, Clinical Laboratory Fee Schedule (CLFS), in the January 1, 2017, Integrated Outpatient Code Editor (IOCE), and in the January 1, 2017, Medicare Physician Fee Schedule (MPFS) with indicator ‘X’. HCPCS code G0499 will be effective retroactive to September 28, 2016, in the IOCE.

• Your MAC will not search for claims containing HCPCS G0499 with dates of service on or after September 28, 2016, but may adjust claims that you bring to their attention.

• You should be aware that the revision to the “Medicare National Coverage Determinations Manual” is a National Coverage Determination (NCD). NCDs are binding on all carriers, fiscal intermediaries, contractors with the Federal government that review and/or adjudicate claims, determinations, and/or decisions, quality improvement organizations, qualified independent contractors, the Medicare appeals council, and Administrative Law Judges (ALJs) (see 42 CFR Section 405.1060(a)(4) (2005)). An NCD that expands coverage is also binding on a Medicare advantage organization. In addition, an ALJ may not review an NCD. (See Section 1869(f)(1)(i)(A)(i) of the Social Security Act.)

• MACs will apply contractor pricing to claim lines with G0499 with dates of service September 28, 2016, through December 31, 2017.

• Deductible and coinsurance do not apply to G0499.

Additional Information

Implementation of New Influenza Virus Vaccine Code – Revised

MLN Matters® Number: MM9876 Revised
Related Change Request (CR) #: CR 9876
Related CR Release Date: April 21, 2017
Effective Date: July 1, 2017
Related CR Transmittal #: R3754CP
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:

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 1m 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

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

MLN Matters® Number: MM9893 Revised
Related Change Request (CR) #: CR 9893
Related CR Release Date: June 8, 2017
Effective Date: October 1, 2017
Related CR Transmittal #: R1857OTN
Implementation Date: October 2, 2017

This article was revised on June 9, 2017, due to the release of an updated Change Request (CR). The CR date, transmittal number and the link to the transmittal changed. All other information remains the same.

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

What You Need to Know
This article is based on 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


Screening for the HIV Infection

MLN Matters® Number: MM9980
Related Change Request (CR) #: CR 9980
Related CR Release Date: May 24, 2017
Effective Date: April 13, 2015
Related CR Transmittal #: R3778CP
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 provided to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 9980 informs MACs that they shall recognize the specified HCPCS codes for services related to the Screening for the Human Immunodeficiency Virus (HIV) Infection. Make sure that your billing staffs are aware of these codes.

Background

The Centers for Medicare & Medicaid Services (CMS) issued CR9403 (transmittal 3461), effective April 13, 2015, for screening for HIV infection. The guidelines are based on strong recommendations by the U.S. Preventive Services Task Force published in April 2013. The recommendations provide guidelines for screening various age groups based on risk of infection as well as for pregnant women.
Effective for claims with dates of service on or after April 13, 2015, MACs will recognize the following Healthcare Common Procedure Coding System (HCPCS) codes for claims processed on or after October 2, 2017: G0432, G0433, and G0435. Testing frequency and other functions for these codes is the same as for those listed in CR9403. A related MLN Matters article is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9403.pdf.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0432</td>
<td>Infectious agent antibody detection by enzyme Immune assay (EIA) technique, qualitative or Semi-quantitative, multiple-step method, HIV-1 or HIV-2, screening</td>
</tr>
<tr>
<td>G0433</td>
<td>Infectious agent antibody detection by enzyme-linked immunosorbent assay (ELISA) technique, antibody, HIV-1 or HIV-2, screening.</td>
</tr>
<tr>
<td>G0435</td>
<td>Infectious agent antibody detection by rapid antibody test of oral mucosa transudate, HIV-1 or HIV-2, screening.</td>
</tr>
</tbody>
</table>

**Billing Requirements**

Your MAC will calculate the next eligible date for HIV Screening to include HCPCS codes G0432, G0433, and G0435 to be included with G0475 and based on effective date of April 13, 2015.

The next eligible date will be displayed on all of Medicare’s Common Working File (CWF) provider query screens (HUQA, HIQA, HIQH, ELGA, ELGH, and PRVN). This includes MBD and NGD extract records.

When there is no next eligible date, the CWF provider query screens will display this information in the date field to indicate why there is not a next eligible date.

When the incoming HUOP or HUBC claim line having the HIV screening HCPCS code G0475, G0432, G0433, or G0435 is submitted without the required HIV Primary Diagnosis Codes of Z11.4, OR

When the incoming HUOP or HUBC claim line having the HIV screening HCPCS 80081 is submitted with one of the following secondary diagnosis codes denoting pregnancy, but the required HIV primary diagnosis code of Z11.4 is not present:

- Z34.00, Z34.01, Z34.02, Z34.03, Z34.80, Z34.81, Z34.82, Z34.83, Z34.90, Z34.91, Z34.92, Z34.93, O09.90, O09.91, O09.92, O09.93

The claim line item will be denied. In denying the line, MACs will use either:

- Claim Adjustment Reason Code (CARC) 167 - This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Or
- CARC 11 - This diagnosis is inconsistent with the procedure. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- Remittance Advice Remarks Code (RARC) N386 - This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at http://www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.
- Group Code CO (Contractual Obligation)

Medicare will create a new consistency edit to deny when the incoming HUOP or HUBC claim line having either the HIV HCPCS codes G0475, G0432, G0433, G0435, or the CPT HCPCS code 80081 is submitted with one of the pregnancy secondary diagnosis codes, but the Sex Code on the claim indicates ‘Male.’ The secondary diagnosis codes indicating pregnancy are:

- Z34.00, Z34.01, Z34.02, Z34.03, Z34.80, Z34.81, Z34.82, Z34.83, Z34.90, Z34.91, Z34.92, Z34.93, O09.90, O09.91, O09.92, O09.93

In denying a line for this reason, MACs will use:

- CARC 7 - The procedure/revenue code is inconsistent with the patient’s gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- Group Code CO
Medicare systems will create a consistency edit to not allow Place of Service (POS) other than 11 (Office) or 81 (Independent Lab for the HIV screenings HCPCS G0475, G0432, G0433, and ‘G0435’ effective with dates of service on or after April 13, 2015. If a POS other than 11 or 81 is on the claim, the MAC will deny the line item, using:

- CARC 171 - Payment is denied when performed/billed by this type of provider in this type of facility. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- RARC N428 - Not covered when performed in this place of service.
- Group Code CO

Medicare systems will create a consistency edit to not allow Type of Bill (TOB) other than 12X, 13X, 14X, 22X, 23X, and 85x for the HIV screening HCPCS G0475, G0432, G0433, and G0435.

Additional Information

DMEPOS Fee Schedule - April 2017 Update – Revised
MLN Matters® Number: MM 9988 Revised
Related Change Request (CR) #: CR9988
Related CR Release Date: May 5, 2017
Effective Date: April 1, 2017
Related CR Transmittal #: R3768CP
Implementation Date: April 3, 2017

This article was revised on May 5, 2017, to reflect a revised CR9988 issued that day. The CR was revised to delete an example that was in the original CR. That example has been removed from the article. Also, the CR release date, transmittal number, and the Web address of CR9988 are revised in the article. All other information remains the same.

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))
FYI

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.

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 E1392) or the portable oxygen add-on amount (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

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**Payment for Moderate Sedation Services**

**MLN Matters® Number:** MM 10001  
**Related Change Request (CR) #:** CR 10001  
**Related CR Release Date:** April 14, 2017  
**Effective Date:** January 1, 2017  
**Related CR Transmittal #:** R3747CP  
**Implementation Date:** May 15, 2017

**Provider Types Affected**

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

**What You Need to Know**

Change Request (CR) 10001 revises existing Medicare Claims Processing Manual language to bring the manual in line with current payment policy for moderate sedation and anesthesia services. Providers should refer to the revised *Medicare Claims Processing Manual*, Chapter 12 (Physicians/Nonphysician Practitioners), Sections 50 and 140 for information regarding the reporting of moderate sedation and anesthesia services. The revision is attached to CR10001. Make sure your billing staff is aware of these revisions.

**Key Manual Changes**

**General Payment Rule**

The fee schedule amount for physician anesthesia services furnished is, with the exceptions noted, based on allowable base and time units multiplied by an anesthesia conversion factor specific to that locality. The base unit for each anesthesia procedure is communicated to the MACs by means of the Healthcare Common Procedure Coding System (HCPCS) file released annually. The Centers for Medicare & Medicaid Services (CMS) releases the conversion factor annually. The base units and conversion factor are available at https://www.cms.gov/Center/Provider-Type/Anesthesiologists-Center.html.

**Moderate Sedation Services Furnished in Conjunction with and in Support of Procedural Services**

Anesthesia services range in complexity. The continuum of anesthesia services, from least intense to most intense in complexity is as follows: local or topical anesthesia, moderate (conscious) sedation, regional anesthesia and general anesthesia. Moderate sedation is a drug induced depression of consciousness during which the patient responds purposefully to verbal commands, either alone or accompanied by light tactile stimulation. Moderate sedation does not include minimal sedation, deep sedation or monitored anesthesia care.
Practitioners will report the appropriate CPT and/or HCPCS code that accurately describes the moderate sedation services performed during a patient encounter, which are performed in conjunction with and in support of a procedural service, consistent with CPT guidance.

**Other Manual Revisions to Sections 50 and 140**
There are other minor revisions to these manual sections and those revised manual sections are attached to CR10001.

**Additional Information**
Your MAC will not search their files to either retract payment for claims already paid or to retroactively pay claims. They will adjust impacted claims that you bring to their attention.


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**CWF Blood Editing on MA Enrollees’ Inpatient Claims for IME Payment Update**

**MLN Matters® Number:** MM10012  
**Related Change Request (CR) #:** CR 10012  
**Related CR Release Date:** April 7, 2017  
**Effective Date:** October 1, 2017  
**Related CR Transmittal #:** R1819OTN  
**Implementation Date:** October 2, 2017  

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

**What You Need to Know**
Change Request (CR) 10012 informs MACs about the changes to the Common Working File (CWF) to bypass blood services editing on claims submitted by approved teaching hospitals for Medicare Advantage (MA) enrollees for Indirect Medicare Education (IME) payment (Type of Bill (TOB) 11x, Prospective Payment System (PPS) indicator Y, condition code 04 and condition code 69). CR10012 contains no new policy. It improves the implementation of existing Medicare payment policies. Make sure that your billing staffs are aware of these changes.

**Background**
Approved teaching hospitals submit inpatient claims for MA beneficiaries to their MAC to receive an IME payment and so Original Medicare Part A can include the inpatient days in the Medicare/Supplemental Security Income fraction. Original Medicare Part A does not track utilization of benefits for beneficiaries enrolled in an MA plan. Therefore utilization edits should not apply to an IME only inpatient claim. The Centers for Medicare & Medicaid Services was notified that when an inpatient claim from a teaching hospital for an MA beneficiary is submitted with blood revenue codes, the CWF is setting blood related edits. CR10012 corrects this problem.

**Additional Information**
DMEPOS Fee Schedule – July 2017 Update

MLN Matters Number: MM10071
Related Change Request (CR) # 10071
Related CR Release Date: April 28, 2017
Effective Date: July 1, 2017
Related CR Transmittal Number: R3760CP
Implementation Date: July 3, 2017

Provider Type 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.

Provider Action Needed
Change Request (CR) 10071 provides the July 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, Chapter 23, Section 60 at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf.


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 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 (CBAs), 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 July 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 https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched.
KU Modifier for Complex Rehabilitative Power Wheelchair Accessories & Seat and Back Cushions

Effective July 1, 2017, the fee schedule amounts for wheelchair accessories and seat and back cushions denoted with the HCPCS modifier ‘KU’ are deleted from the DMEPOS fee schedule file. These unadjusted fee schedule amounts have applied to wheelchair accessories and seat and back cushions furnished in connection with Group 3 complex rehabilitative power wheelchairs (codes K0848 through K0864). The fee schedule amounts associated with the KU modifier were mandated by Section 2 of Patient Access and Medicare Protection Act (PAMPA) effective for dates of service January 1, 2016 through December 31, 2016. Additionally, section 16005 of the 21st Century Cures Act extended the effective date through June 30, 2017. The list of HCPCS codes to which this statutory section applied is available in Transmittal 3535, CR 9520 dated June 7, 2016.

Therapeutic Continuous Glucose Monitor (CGM)

As part of this update, the fee schedule amounts for the following therapeutic CGM HCPCS codes are added to the DMEPOS fee schedule file effective for dates of service on or after July 1, 2017:

- K0553 - Supply allowance for therapeutic continuous glucose monitor (CGM), includes all supplies and accessories, 1 unit of service = 1 month’s supply
- K0554 - Receiver (monitor), dedicated, for use with therapeutic continuous glucose monitor system


Additional Information


Payment for Moderate Sedation Services Furnished with Colorectal Cancer Screening Tests

MLN Matters Number: MM10075
Related Change Request (CR) Number: 10075
Related CR Release Date: April 28, 2017
Effective Date: January 1, 2017
Related CR Transmittal Number: R3763CP
Implementation Date: October 2, 2017

Provider Type Affected

This MLN Matters article is intended for physicians and other providers submitting claims to Part A and B Medicare Administrative Contractors (MACs) for sedation services furnished with colorectal cancer screening tests.

Provider Action Needed

Change Request (CR) 10075 ensures accurate program payment for moderate sedation services furnished in conjunction with screening colonoscopy services for which the beneficiary should not be charged the coinsurance or deductible. The coinsurance and deductible for these services are waived, but due to coding changes and additions to the Medicare Physician Fee Schedule (MPFS) Database the payments for Calendar Year (CY) 2017 would not be accurate without this CR. Please make your billing staff aware of these changes.

Background

Section 4104 of the Affordable Care Act defined the term “preventive services” to include “colorectal cancer screening tests” and, as a result, it waives any coinsurance that would otherwise apply under Section 1833(a)(1) of the Social Security Act for screening colonoscopies. In addition, the ACA amended...
Section 1833(b)(1) of the Act to waive the Part B deductible for screening colonoscopies, which includes moderate sedation services as an inherent part of the screening colonoscopy procedural service. These provisions are effective for services furnished on or after January 1, 2011.

In the CY 2017 PFS Final Rule, the Centers for Medicare & Medicaid Services (CMS) modified coding and reporting of procedural services that include moderate sedation as an inherent part of the service, including for screening colonoscopies. CR 10075 operationalizes the existing waiver of deductible and coinsurance for moderate sedation services furnished in conjunction with and in support of colorectal cancer screening tests. Effective January 1, 2017, beneficiary coinsurance and deductible continues to not apply to the following moderate sedation claim lines when furnished in conjunction with screening colonoscopy services and when billed with Modifier 33 or Modifier PT:

- **HCPCS code G0500**: Moderate sedation services provided by the same physician or other qualified health care professional performing a gastrointestinal endoscopic service that sedation supports, requiring the presence of an independent, trained observer to assist in the monitoring of the patient’s level of consciousness and physiological status; patient age 5 years or older (additional time may be reported with 99153, as appropriate).

- **CPT code 99153**: Moderate sedation services provided by the same physician or other qualified healthcare professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent, trained observer to assist in the monitoring of the patient’s level of consciousness and physiological status; each additional 15 minutes of intra-service time (List separately in addition to code for primary service).

MACS will not search their files to either retract payment for claim lines already paid or to retroactively pay claim lines with HCPCS code G0500 or CPT code 99153. However, MACs will adjust such claims that you bring to their attention.

**Additional Information**

**ICD-10 Coding Revisions to NCDs**

MLN Matters Number: MM10086  
Related Change Request (CR) Number: 10086  
Related CR Release Date: May 26, 2017  
Effective Date: October 1, 2017  
Related CR Transmittal Number: R1854OTN  
Implementation Date: October 2, 2017, shared system edits, July 14, 2017, local edits

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

**Provider Action Needed**
Change Request (CR) 10086 constitutes a maintenance update of International Classification of Diseases, Tenth Revision (ICD-10) conversions and other coding updates specific to National Coverage Determinations (NCDs). These NCD coding changes are the result of newly available codes, coding revisions to NCDs released separately, or coding feedback received. Please make sure your billing staffs are aware of these changes.

**Background**
The translations from International Classification of Diseases, Ninth Revision (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. For these reasons, there may be certain ICD-9 codes that were once considered appropriate prior to ICD-10 implementation that are no longer considered acceptable.

Previous NCD coding changes appear in ICD-10 quarterly updates that can be found at https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html, along with other CRs implementing new policy NCDs. Edits to ICD-10 and other coding updates specific to NCDs will be included in subsequent, quarterly releases and individual CRs as appropriate. No policy related changes are included with the ICD-10 quarterly updates. Any policy related changes to NCDs continue to be implemented via the current, long-standing NCD process.

CR10086 makes coding and clarifying adjustments to the following NCDs:

- NCD20.29 - Hyperbaric Oxygen (HBO)
- NCD40.7 - Outpatient Intravenous Insulin Therapy
- NCD80.2 - Photodynamic Therapy
- NCD80.2.1 - Ocular Photodynamic Therapy
- NCD80.3 - Photosensitive Drugs
- NCD80.3.1 - Verteporfin
- NCD80.11 - Vitrectomy
- NCD100.1 - Bariatric Surgery
- NCD110.4 - Extracorporeal Photopheresis
- NCD110.23 - Stem Cell Transplantation
- NCD190.3 - Cytogenetic Studies
- NCD190.11 - Home Prothrombin Time/International Normalized Ratio (PT/INR)
- NCD210.13 - Screening for Hepatitis C Virus
- NCD220.4 - Mammograms
- NCD220.6.17 - PET for Solid Tumors
- NCD270.1 - Electrical Stimulation Electromagnetic Therapy for Treatment of Wounds
- NCD20.31, 20.31.1, 20.31.2, 20.31.3 - Intensive Cardiac Rehabilitation


Additional Information

**Percutaneous Image-Guided Lumbar Decompression for LSS**

MLN Matters Number: MM10089
Related Change Request (CR) Number: 10089
Related CR Release Date: May 26, 2017
Effective Date: December 7, 2016
Related CR Transmittal Number: R3787CP and R196NCD
Implementation Date: June 27, 2017

Provider Type Affected
This MLN Matters Article is intended for providers and other physicians billing Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.
Provider Action Needed
Change Request (CR) 10089 announces that effective for dates of service on or after December 7, 2016, Medicare will cover Percutaneous Image-guided Lumbar Decompression (PILD) under Coverage with Evidence Development (CED) for beneficiaries with Lumbar Spinal Stenosis (LSS) who are enrolled in a Centers for Medicare & Medicaid Services (CMS)-approved prospective longitudinal study. PILD procedures using an FDA-approved/cleared device that completed a CMS-approved prospective, randomized, controlled clinical trial (RCT) that met the criteria are listed in the January 2014 NCD (CR8757, see related MLN Matters article at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8757.pdf).

Background
CMS currently covers PILD under the CED paradigm. PILD is a posterior decompression of the lumbar spine performed under indirect image guidance without any direct visualization of the surgical area. This is a procedure proposed as a treatment for symptomatic LSS unresponsive to conservative therapy. This procedure is generally described as a non-invasive procedure using specially designed instruments to percutaneously remove a portion of the lamina and debulk the ligamentum flavum. The procedure is performed under x-ray guidance (for example, fluoroscopic, CT) with the assistance of contrast media to identify and monitor the compressed area via epiduragram.

Section 1862(a)(1)(E) of the Social Security Act (the Act) authorizes coverage for PILD for beneficiaries with LSS under CED. On January 9, 2014, CMS posted its first NCD (150.13) covering PILD for beneficiaries with LSS when provided in a RCT meeting certain conditions under CED. Clinical studies must be designed using current validated and reliable measurement instruments and clinically appropriate comparator treatments for patients randomized to the non-PILD group.

On April 13, 2016, CMS accepted a complete formal request for a reconsideration of the NCD that limited coverage of PILD for LSS to a CMS-approved prospective RCT. After considering the related published literature and public comments as required by Section 1862(l) of the Act, CMS will expand the January 2014 NCD to cover PILD for LSS under CED through a prospective longitudinal study that meets certain criteria listed in Chapter 1, Section 150.13 of the NCD manual (Pub. 100-03). You should refer to Chapter 1, Section 310 of the NCD Manual, as well as Chapter 32, Sections 69 and 330, of the “Medicare Claims Processing Manual” (Pub. 100-04) for more information.

NOTE: As mentioned in MM8954, there are 2 distinct procedure codes that are to be used: G0276 only for clinical trials that are blinded, randomized, and controlled, and contain a placebo procedure control arm (use CR 8954 for claims processing instructions), and 0275T for all other approved clinical trials (use CR 8757 for claims processing instructions).

CR 10089 does not replace but rather is in addition to CR 8757 and CR 8954.

Additional Information
You can review the list of approved clinical studies related to PILD for LSS at http://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/PILD.html on the CMS website.


MPFSDB – July 2017 Quarterly Update

MLN Matters Number: MM10104
Related Change Request (CR) Number: 10104
Related CR Release Date: May 12, 2017
Effective Date: January 1, 2017
Related CR Transmittal Number: R3772CP
Implementation Date: July 3, 2017

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

Provider Action Needed
Change Request (CR) 10104 informs MACs about the release of payment files based upon the calendar year (CY) 2017 Medicare Physician Fee Schedule (MPFS) Final Rule. 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. Section 1848(c)(4) of the Social Security Act authorizes the Secretary to establish ancillary policies necessary to implement relative values for physicians’ services.

Following is a summary of the changes for the July update to the 2017 MPFSDB.

Effective for dates of service (DOS) on and after January 1, 2017, except as noted otherwise.

<table>
<thead>
<tr>
<th>CPT/HCPCS</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>20245</td>
<td>Global Days = 000</td>
</tr>
<tr>
<td>52441</td>
<td>Endo Base = 52000</td>
</tr>
<tr>
<td>64897</td>
<td>Co-Surgery = 1</td>
</tr>
<tr>
<td>64902</td>
<td>Co-Surgery = 1</td>
</tr>
<tr>
<td>J1725</td>
<td>Status = I, effective for DOS on or after July 1, 2017</td>
</tr>
<tr>
<td>P9072</td>
<td>Status = I, effective for DOS on or after July 1, 2017</td>
</tr>
</tbody>
</table>

The following new codes have been added to the HCPCS file effective May 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>0004U</td>
<td>Nfct ds dna 27 resist genes</td>
<td>Infectious disease (bacterial), DNA, 27 resistance genes, PCR amplification and probe hybridization in microarray format (molecular detection and identification of AmpC, carbapenemase and ESBL coding genes), bacterial culture colonies, report of genes detected or not detected, per isolate</td>
</tr>
<tr>
<td>0005U</td>
<td>Onco prst8 3 gene ur alg</td>
<td>Oncology (prostate) gene expression profile by real-time RT-PCR of 3 genes (ERG, PCA3, and SPDEF), urine, algorithm reported as risk score</td>
</tr>
</tbody>
</table>

The following new codes from CR 10107 have also been added to the MPFSDB effective July 1, 2017 (see MLN Matters article MM10107 (when it is available) for code descriptions and additional information):
The following new HCPCS and CPT Category III codes have been added effective July 1, 2017.

<table>
<thead>
<tr>
<th>Code</th>
<th>Modifier</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>MPFSDB Indicator Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q9987</td>
<td></td>
<td>Pathogen test for platelets</td>
<td>Pathogen(s) test for platelets</td>
<td>Procedure Status X; there are no RVUs, payment policy indicators do not apply.</td>
</tr>
<tr>
<td>0469T</td>
<td></td>
<td>Rta polarize scan oc scr bi</td>
<td>Retinal polarization scan, ocular screening with on-site automated results, bilateral</td>
<td>Procedure Status N; there are no RVUs, payment policy indicators do not apply.</td>
</tr>
<tr>
<td>0470T</td>
<td>TC, 26</td>
<td>Oct skn img acquisj i&amp;r 1st</td>
<td>Optical coherence tomography (OCT) for microstructural and morphological imaging of skin, image acquisition, interpretation, and report; first lesion</td>
<td>Procedure Status C; PC/TC indicator 1; there are no RVUs, no other payment policy indicators apply.</td>
</tr>
<tr>
<td>0471T</td>
<td>TC, 26</td>
<td>Oct skn img acquisj i&amp;r addl</td>
<td>Optical coherence tomography (OCT) for microstructural and morphological imaging of skin, image acquisition, interpretation, and report; each additional lesion (List separately in addition to code for primary procedure)</td>
<td>Procedure Status C; PC/TC indicator 1; there are no RVUs, no other payment policy indicators apply.</td>
</tr>
<tr>
<td>0472T</td>
<td></td>
<td>Prgrmg io rta eltrd ra</td>
<td>Device evaluation, interrogation, and initial programming of intra-ocular retinal electrode array (eg, retinal prosthesis), in person, with iterative adjustment of the implantable device to test functionality, select optimal permanent programmed values with analysis, including visual training, with review and report by a qualified health care professional</td>
<td>Procedure Status C; there are no RVUs, payment policy indicators do not apply.</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Detailed Description</td>
<td>Payment Status</td>
<td></td>
</tr>
<tr>
<td>-------</td>
<td>-----------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------</td>
<td>----------------</td>
<td></td>
</tr>
<tr>
<td>0473T</td>
<td>Repgrmg io rta eltrd ra</td>
<td>Device evaluation and interrogation of intra-ocular retinal electrode array (eg, retinal prosthesis), in person, including reprogramming and visual training, when performed, with review and report by a qualified health care professional</td>
<td>Procedure Status C; there are no RVUs, payment policy indicators do not apply.</td>
<td></td>
</tr>
<tr>
<td>0474T</td>
<td>Insj aqueous drg dev io rsvr</td>
<td>Insertion of anterior segment aqueous drainage device, with creation of intraocular reservoir, internal approach, into the supraciliary space</td>
<td>Procedure Status C; there are no RVUs, payment policy indicators do not apply.</td>
<td></td>
</tr>
<tr>
<td>0475T</td>
<td>Rec ftl car sgl 3 ch i&amp;r</td>
<td>Recording of fetal magnetic cardiac signal using at least 3 channels; patient recording and storage, data scanning with signal extraction, technical analysis and result, as well as supervision, review, and interpretation of report by a physician or other qualified health care professional</td>
<td>Procedure Status C; there are no RVUs, payment policy indicators do not apply.</td>
<td></td>
</tr>
<tr>
<td>0476T</td>
<td>Rec ftl car sgl elec tr data</td>
<td>Recording of fetal magnetic cardiac signal using at least 3 channels; patient recording, data scanning, with raw electronic signal transfer of data and storage</td>
<td>Procedure Status C; there are no RVUs, payment policy indicators do not apply.</td>
<td></td>
</tr>
<tr>
<td>0477T</td>
<td>Rec ftl car sgl xrtj alys</td>
<td>Recording of fetal magnetic cardiac signal using at least 3 channels; signal extraction, technical analysis, and result</td>
<td>Procedure Status C; there are no RVUs, payment policy indicators do not apply.</td>
<td></td>
</tr>
<tr>
<td>0478T</td>
<td>Rec ftl car 3 ch rev i&amp;r</td>
<td>Recording of fetal magnetic cardiac signal using at least 3 channels; review, interpretation, report by physician or other qualified health care professional</td>
<td>Procedure Status C; there are no RVUs, payment policy indicators do not apply.</td>
<td></td>
</tr>
</tbody>
</table>

**Additional Information**

HCPCS Drug/Biological Code Changes – July 2017 Update

MLN Matters Number: MM10107
Related Change Request (CR) Number: CR 10107
Related CR Release Date: May 18, 2017
Effective Date: July 1, 2017
Related CR Transmittal Number: R3776CP
Implementation Date: July 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
The HCPCS code set is updated on a quarterly basis. Change Request (CR) 10107 informs MACs of updating specific drug/biological HCPCS codes. Beginning on July 1, 2017, the HCPCS file will include the following new codes:

- Q9984:
  - Short Description: Kyleena
  - Long Description: Levonorgestrel-releasing intrauterine contraceptive system (Kyleena), 19.5 mg
  - Type of Service (TOS) Code 9

- Q9985
  - Short Description: Inj, hydroxyprogesterone, NOS
  - Long Description: Injection, hydroxyprogesterone caproate, not otherwise specified, 10 mg
  - TOS Code 1, P

- Q9986
  - Short Description: Inj, Makena
  - Long Description: Injection, hydroxyprogesterone caproate (Makena), 10 mg
  - TOS Code 1, P

- Q9988
  - Short Description: Platelets, pathogen reduced
  - Long Description: Platelets, pathogen reduced, each unit
  - TOS Code 9

- Q9989
  - Short Description: Ustekinumab IV Inj, 1 mg
  - Long Description: Ustekinumab, for Intravenous Injection, 1 mg
  - TOS Code 1, P

Also, beginning on July 1, 2017, HCPCS code J1725 (Injection, hydroxyprogesterone caproate, 1 mg) is no longer payable for Medicare.

Make sure your billing staffs are aware of these changes.

Additional Information
I/OCE Specifications Version 18.2 – July 2017

MLN Matters Number: MM10115
Related Change Request (CR) Number: 10115
Related CR Release Date: May 18, 2017
Effective Date: July 1, 2017
Related CR Transmittal Number: R3777CP
Implementation Date: July 3, 2017

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

PROVIDER ACTION NEEDED
Change Request (CR) 10115 informs providers that the Integrated Outpatient Code Editor (I/OCE) is being updated July 1, 2017. The I/OCE routes all institutional outpatient claims (which includes non-Outpatient Prospective Payment System (OPPS) hospital claims) through a single integrated OCE. Make sure that your billing staffs are aware of these changes.

BACKGROUND
CR10115 provides the Integrated OCE instructions and specifications for the Integrated OCE that will be used under the OPPS and Non-OPPS for hospital outpatient departments, community mental health centers, all non-OPPS providers, and for limited services when provided in a Home Health Agency not under the Home Health Prospective Payment System or to a hospice patient for the treatment of a non-terminal illness. The I/OCE specifications will be posted to the CMS Website at http://www.cms.gov/OutpatientCodeEdit/.

The following table summarizes the modifications of the I/OCE for the July 2017 v18.2 release. Note that some I/OCE modifications may be retroactively added to prior releases. If so, the retroactive date appears in the ‘Effective Date’ column.

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Edits Affected</th>
<th>Modification</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/1/2017</td>
<td></td>
<td>Modify the logic for Community Mental Health Center (CMHC) claims (bill type 76x) eligible for outlier payment limitations related to condition code MY; if present with or without condition code 66, new payment method flag 9 is assigned to OPPS payable lines (see special processing logic and Appendix E of Attachment to CR10115).</td>
</tr>
<tr>
<td>1/1/2016</td>
<td></td>
<td>Assign a payment APC of '00000' for drug HCPCS codes with SI = G or K (see special processing logic and note in Appendix E).</td>
</tr>
</tbody>
</table>
| 7/1/2017       | 95             | Reactivate edit 95 as a line item informational only edit returned when weekly Partial Hospitalization Program (PHP) services do not meet the 20-hour per week service requirement (see special processing logic, tables 4, 5 and 7; note in Appendix C-a flowchart). A new value of 3 returned in the line item denial or rejection flag field is returned indicating the rejection has no impact on payment for the line(s) returning edit 95. Edit description is modified to: Weekly partial hospitalization services require a minimum of 20 hours of service as evidenced in PHP plan of care (LIR)
Edit criteria is modified to: A PHP claim contains weekly PH services that total less than 20 hours per 7-day span. |
<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/1/2016</td>
<td>Add modifiers XE, XP, XS, and XU to the critical care ancillary services logic to process under the current exceptions for modifier 59 (see special processing logic).</td>
<td></td>
</tr>
<tr>
<td>5/1/2017</td>
<td>Implement National Coverage Determination (NCD) mid-quarter effective editing for procedure codes 0004U and 0005U.</td>
<td></td>
</tr>
<tr>
<td>10/7/2016</td>
<td>Implement FDA mid-quarter effective editing for procedure code 90651.</td>
<td></td>
</tr>
<tr>
<td>7/1/2017</td>
<td>Add new line item denial or rejection flag value of 3 (see table 7).</td>
<td></td>
</tr>
<tr>
<td>1/1/2016</td>
<td>Implement the multiple imaging composite Ambulatory Payment Classification (APC) family lists to remove the following codes with Status Indicator (SI) = Q1: 76604, 76775, 76870; add note for code 75635 as an exception to the composite logic in Appendix K.</td>
<td></td>
</tr>
<tr>
<td>7/1/2017</td>
<td>Update the following lists for the release (see quarterly data files):</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Coinsurance/Deductible N/A list</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Device-procedure list (edit 92)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Terminated procedures for device credit</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Comprehensive APC ranking</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Male-only procedure list (edit 8)</td>
<td></td>
</tr>
<tr>
<td>7/1/2017</td>
<td>Make all HCPCS/APC/SI changes as specified by CMS (quarterly data files).</td>
<td></td>
</tr>
<tr>
<td>7/1/2017</td>
<td>Implement version 23.2 of the National Correct Coding Initiative (NCCI) (as modified for applicable outpatient institutional providers).</td>
<td></td>
</tr>
</tbody>
</table>

**Additional Information**


**Laboratory NCD Edit Software – Changes for October 2017**

MLN Matters Number: MM10156
Related Change Request (CR) Number: CR 10156
Related CR Release Date: June 16, 2017
Effective Date: October 1, 2017
Related CR Transmittal Number: R3797CP
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 provided to Medicare beneficiaries.

**What You Need To Know**
Change Request (CR) 10156 informs MACs about the changes that will be included in the October 2017 quarterly release of the edit module for clinical diagnostic laboratory services. Make sure your billing staffs are aware of these changes.

**Background**
CR 10156 announces the changes that will be included in the October 2017 quarterly release of the edit module for clinical diagnostic laboratory services.
CR 10156 revises several laboratory NCD code lists as follows:

- Add ICD-10-CM code E034, effective 10/1/2016, to the list of ICD-10-CM codes that are covered by Medicare for the Lipids Testing (190.23A) NCD.
- Add ICD-10-CM code E034, effective 10/1/2016, to the list of ICD-10-CM codes that are covered by Medicare for the Lipids Testing (190.23B) NCD.
- Add ICD-10-CM codes D4959 and R9349, effective 10/1/2016, to the list of ICD-10-CM codes that are covered by Medicare for the Human Chorionic Gonadotropin (190.27) NCD.
- Delete (unspecified eye) ICD-10-CM codes E083219, E083299, E083319, E083419, E083499, E083519, E083529, E083539, E083549, E083559, E0837X9, E093219, E093299, E093319, E093399, E093419, E093499, E093519, E093529, E093539, E093549, E093559, E093599, E0937X9, E103219, E103299,
  - E103319, E103399, E103419, E103499, E103519, E103529, E103539, E103549, E103559, E103599, E1037X9, E113219, E113299, E113319, E113399, E113419, E113499, E113519, E113529, E113539, E113549, E113559, E113579, E1137X9, E133219, E133299, E133319, E133399, E133419, E133499, E133519, E133529, E133539, E133549, E133559, E133599, and E1337X9 from the list of ICD-10-CM codes that are covered by Medicare for the Glycated Hemoglobin/Glycated Protein (190.21) NCD.
- Delete ICD-10-CM code Z8482 from the list of ICD-10-CM codes that are covered by Medicare for the Glycated Hemoglobin/Glycated Protein (190.21) NCD.

Additional Information

MACs will not search their files to either retract payment for claims already paid or retroactively pay claims, but they will adjust such claims that you bring to their attention.


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

MLN Matters® Number: SE1128 Revised

Release Date of Revised Article: May 12, 2017

This article was revised on May 12, 2017, to modify language pertaining to billing beneficiaries enrolled in the Qualified Medicare Beneficiary (QMB) program. All other information is the same.

Provider Types Affected

This article pertains to all Medicare physicians, providers and suppliers, including those serving beneficiaries enrolled in Original Medicare or a Medicare Advantage (MA) plan.

What You Need to Know

This Special Edition MLN Matters® Article from the Centers for Medicare & Medicaid Services (CMS) reminds all Medicare providers that they may not bill beneficiaries enrolled in the QMB program for Medicare cost-sharing. QMB is a Medicare Savings Program (MSP) that exempts Medicare beneficiaries from Medicare cost-sharing liability.

The QMB program is a State Medicaid benefit that covers Medicare premiums and deductibles, coinsurance, and copayments, subject to State payment limits. (States may limit their liability to providers for Medicare deductibles, coinsurance, and copayments under certain circumstances.) Medicare providers may not bill QMB individuals for Medicare cost-sharing, regardless of whether the State reimburses providers for the full Medicare cost-sharing amounts. Further, all original Medicare and MA providers—not only those that accept Medicaid—must refrain from charging QMB individuals for Medicare cost-sharing. Providers who inappropriately bill QMB individuals are subject to sanctions.

Refer to the Background and Additional Information Sections of this article for further details and resources about this guidance. Please ensure that you and your staff are aware of the Federal billing law and policies regarding QMB individuals. Contact the Medicaid Agency in the States in which you practice to learn about...
ways to identify QMB patients in your State and procedures applicable to Medicaid reimbursement for their Medicare cost-sharing. If you are a MA provider, you may also contact the MA plan for more information. Finally, all Medicare providers should ensure that their billing software and administrative staff exempt QMB individuals from Medicare cost-sharing billing and related collection efforts.

Background
This article provides CMS guidance to Medicare providers to help them avoid inappropriately billing QMBs for Medicare cost-sharing, including deductibles, coinsurance, and copayments.

Billing of QMBs Is Prohibited by Federal Law
Federal law bars Medicare providers from billing a QMB beneficiary under any circumstances. See Section 1902(n)(3)(B) of the Social Security Act (the Act), as modified by Section 4714 of the Balanced Budget Act of 1997. QMB is a Medicaid program for Medicare beneficiaries that exempts them from liability for Medicare cost-sharing. 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. See the chart at the end of this article for more information about the QMB benefit.

Medicare providers must accept the Medicare payment and Medicaid payment (if any) as payment in full for services rendered to a QMB beneficiary. Medicare providers who do not follow these billing prohibitions are violating their Medicare Provider Agreement and may be subject to sanctions. (See Sections 1902(n)(3)(C), 1905(p)(3), 1866(a)(1)(A), and 1848(g)(3)(A) of the Act.)

Inappropriate Billing of QMB Individuals Persists
Despite Federal law, improper billing of QMB individuals persists. Many beneficiaries are unaware of the billing restrictions (or concerned about undermining provider relationships) and simply pay the cost-sharing amounts. Others may experience undue distress when unpaid bills are referred to collection agencies. For more information, refer to Access to Care Issues Among Qualified Medicare Beneficiaries (QMB), Centers for Medicare & Medicaid Services July 2015.

Important Clarifications Concerning the QMB Billing Law
Be aware of the following policy clarifications to ensure compliance with QMB billing requirements.

• All original Medicare and MA providers—not only those that accept Medicaid—must abide by the billing prohibitions.
• QMB individuals retain their protection from billing when they cross State lines to receive care. Providers cannot charge QMB individuals even if the patient’s QMB benefit is provided by a different State than the State in which care is rendered.
• Note that QMBs cannot choose to “waive” their QMB status and pay Medicare cost-sharing. The Federal statute referenced above supersedes Section 3490.14 of the State Medicaid Manual, which is no longer in effect.

Ways to Improve Processes Related to QMBs
Proactive steps to identify QMB individuals you serve and to communicate with State Medicaid Agencies (and MA plans if applicable), can promote compliance with QMB billing prohibitions.

1. Determine effective means to identify QMB individuals among your patients, such as finding out the cards that are issued to QMB individuals, so you can in turn ask all your patients if they have them. Learn if you can query State systems to verify QMB enrollment among your patients. MA providers should contact the plan to determine how to identify the plan’s QMB enrollees. Beginning October 1, 2017, you will be able to readily identify the QMB status of your patients with new Medicare Fee-For-Services improvements. Refer to Qualified Medicare Beneficiary Indicator in the Medicare Fee-For-Service Claims Processing System for more information about these improvements.

2. Determine the billing processes that apply to seeking reimbursement for Medicare cost-sharing from the States in which you operate. Different processes may apply to Original Medicare and MA services provided to QMB beneficiaries. For Original Medicare claims, nearly all States have electronic crossover processes through the Medicare Benefits Coordination & Recovery Center (BCRC) to automatically receive Medicare-adjudicated claims.
• If a claim is automatically crossed over to another payer, such as Medicaid, it is customarily noted on the Medicare Remittance Advice.

• Understand the processes you need to follow to request reimbursement for Medicare cost-sharing amounts if they are owed by your State. You may need to complete a State Provider Registration Process and be entered into the State payment system to bill the State.

3. Ensure that your billing software and administrative staff exempt QMB individuals from Medicare cost-sharing billing and related collection efforts.

### QMB Eligibility and Benefits

<table>
<thead>
<tr>
<th>Program</th>
<th>Income Criteria*</th>
<th>Resources Criteria*</th>
<th>Medicare Part A and Part B Enrollment</th>
<th>Other Criteria</th>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>QMB Only</td>
<td>≤100% of Federal Poverty Line (FPL)</td>
<td>≤3 times SSI resource limit, adjusted annually in accordance with increases in Consumer Price Index</td>
<td>Part A***</td>
<td>Not Applicable</td>
<td>Medicaid pays for Part A (if any) and Part B premiums, and may pay for deductibles, coinsurance, and copayments for Medicare services furnished by Medicare providers to the extent consistent with the Medicaid State Plan (even if payment is not available under the State plan for these charges, QMBs are not liable for them)</td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>Program</td>
<td>Income Criteria*</td>
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<td>Other Criteria</td>
<td>Benefits</td>
</tr>
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</tr>
<tr>
<td>QMB Plus</td>
<td>≤100% of FPL</td>
<td>Determined by State</td>
<td>Part A***</td>
<td>Meets financial and other criteria for full Medicaid benefits</td>
<td>Full Medicaid coverage Medicaid pays for Part A (if any) and Part B premiums, and may pay for deductibles, coinsurance, and copayments to the extent consistent with the Medicaid State Plan (even if payment is not available under the State plan for these charges, QMBs are not liable for them)</td>
</tr>
</tbody>
</table>
* States can effectively raise these Federal income and resources criteria under Section 1902(r)(2) of the Act.

*** To qualify as a QMB or a QMB plus, individuals must be enrolled in Part A (or if uninsured for Part A, have filed for premium-Part A on a “conditional basis”). For more information on this process, refer to Section HI 00801.140 of the Social Security Administration Program Operations Manual System.

Additional Information

Office of Inspector General Report: Stem Cell Transplantation - Revised
MLN Matters® Number: SE1624 Revised
Article Release Date: May 1, 2017
This article was revised on May 1, 2017, to make a number of clarifications and to delete the table that had been in the article.

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

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

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

Types of Stem Cell Transplants that are covered:
Medicare covers allogeneic and autologous transplants. Allogeneic and autologous stem cell transplants are covered under Medicare for specific diagnoses.

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

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

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

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

- According to an independent medical review contractor contracted by OIG for this report, stem cell transplants are routinely performed in the outpatient setting.
- Hospitals may have incorrectly thought that stem cell transplantation was on CMS’s list of inpatient-only procedures.

The Two-Midnight Rule

To assist providers in determining whether inpatient admission is appropriate for payment under Medicare Part A, CMS adopted the Two-Midnight rule for admissions beginning on or after October 1, 2013. This rule established Medicare payment policy regarding the benchmark criteria to use when determining whether an inpatient admission is reasonable and necessary for purposes of payment under Medicare Part A.

In general, the Two-Midnight rule states that:

- Inpatient admissions will generally be payable under Part A if the admitting practitioner expects the patient to require a hospital stay that crosses two midnights and the medical record supports that reasonable expectation.
- Medicare Part A payment is generally not appropriate for hospital stays not expected to span at least two midnights.

The Two-Midnight rule also specifies that all treatment decisions for beneficiaries are based on the medical judgment of physicians and other qualified practitioners. The Two-Midnight rule does not prevent the physician or other qualified practitioner from providing any service at any hospital, regardless of the expected duration of the service.

As of CY 2016, for stays for which the physician or other qualified practitioner expects the patient to need less than two midnights of hospital care (and the procedure is not on the inpatient-only list or otherwise listed as a national exception), an inpatient admission may be payable under Medicare Part A on a case-by-case basis based on the judgment of the admitting physician or other qualified practitioner. The documentation in the medical record must support that an inpatient admission is necessary, and is subject to medical review.

Additional Information


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


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

**Next Generation Accountable Care Organization - All Inclusive Population Based Payment Implementation**

MLN Matters Number: SE17011  
Article Release Date: April 20, 2017  
Effective Date: January 1, 2017  
Implementation Date: January 3, 2017

**Provider Types Affected**  
This MLN Matters Article is intended for physicians, hospitals, and other providers who are participating in Next Generation Accountable Care Organization (NGACOs) Model and submitting claims to Medicare Administrative Contractors (MACs) under the All-Inclusive Population Based Payment (AIPBP) alternate payment mechanism for certain services for Medicare beneficiaries.

**Provider Action Needed**  
Special Edition (SE) article SE17011 reminds providers of the implementation of the AIPBP payment mechanism for participating ACOs.

**Background**  
The NGACO Model offers ACOs the option to participate in a payment mechanism called AIPBP under which the ACO takes on responsibility for entering into payment arrangements with its providers and paying claims, in place of claims being paid by Medicare’s Fee-For-Service (FFS) systems. The goal of AIPBP is to establish a monthly cash flow for AIPBP-participating ACOs and a mechanism for ACOs to enter payment arrangements with Next Generation Participants and Preferred Providers. Conceptually, AIPBP builds on population-based payments (PBP) in the Pioneer ACO Model and available in the NGACO Model, but enables even greater flexibility in establishing payment relationships between the ACO and its providers.

Under AIPBP, participating ACOs will receive a monthly lump-sum payment outside of the FFS system and be responsible for paying Next Generation Participants and Preferred Providers with whom they have entered into written AIPBP Payment Arrangement agreements. The monthly payment will be based on an estimation of the care that will be provided to aligned beneficiaries in the performance year by AIPBP-participating providers.

Reconciliation will occur following the performance year to true up the monthly payments (based on estimation) versus what AIPBP-participating providers would have been paid under FFS.

All participating providers will continue to submit FFS claims to CMS, which will fully adjudicate the claims, but will not make payment to providers who have agreed to participate in AIPBP except for add-on payments for inpatient hospitals (specifically operating outlier payments, operating disproportionate share hospital [DSH] payments, operating indirect medical education [IME] payments, Medicare new technology payments, and Islet isolation cell transplantation payments).

ACOs had an annual election to participate in AIPBP from among three alternate payment mechanisms in 2017; the ACO’s Providers/Suppliers and Preferred Providers will agree to participate on a provider-by-provider basis (that is, not all Providers/Suppliers, or Preferred Providers will have claims reduced up to 100 percent). All AIPBP-participating providers will receive a 100-percent reduction to their claims if they see an aligned beneficiary, unless that aligned beneficiary has opted out of medical claims data sharing with the ACO or if the claim is for substance abuse-related services. If an AIPBP-participating provider sees a beneficiary not aligned to an ACO, they would not receive the reduction.

Providers who do not have an AIPBP Payment Arrangement with an ACO, whether in the ACO or not, will continue to receive normal FFS reimbursements for all the beneficiaries they treat, including aligned beneficiaries. Medicare systems will continue to view providers and beneficiaries as being FFS.
As mentioned, providers continue to submit all FFS claims to CMS, which will make coverage and liability determinations and assess beneficiary liability. Beneficiary liabilities will be calculated based on what Medicare would have paid in absence of AIPBP, and Medicare Summary Notices (MSNs) should reflect the amount that would have been paid (as is currently done for PBP). Similarly, Medicare will continue to send remittance notices to AIPBP-participating providers (just as they would receive remittance notices if not participating in AIPBP).

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

Guidance to Providers that Submit Outpatient Facility Claims and Enter Claims Data via DDE to Reduce Incidence of Claims Not Crossing Over

MLN Matters Number: SE17015
Related Change Request (CR) Number: 10103
Article Release Date: June 6, 2017
Effective Date: August 7, 2017
Implementation Date: August 7, 2017

Provider Type Affected
This MLN Matters Special Edition (SE) Article is intended for two types of institutional provider billers: those who submit HIPAA Accredited Standards Committee (ASC) 837 X12N institutional claims for outpatient hospital facility services to Medicare, and those who submit claims to Medicare via Direct Data Entry (DDE).

Provider Action Needed
This article instructs provider billing offices to correctly submit HIPAA ASC X12N 837 institutional claims to Medicare to reduce the incidence of receiving Return-to-Provider (RTP) edits on incoming 837 outpatient hospital facility claims as well as DDE claims due to edits that will be enforced as of August 7, 2017.

Background
Currently, provider billing offices include Present on Admission (POA) information on incoming HIPAA ASC X12N 837 institutional claims for services that are exclusively incurred in the outpatient hospital facility setting. This action is not in compliance with HIPAA 837 Institutional Claim Technical Report-3 (TR-3) Guide, which indicates that POA information is only to be entered on claims to indicate whether a condition was present prior to admission into a hospital or acquired once admitted. Also, the Centers for Medicare & Medicaid Services (CMS) has determined that when provider billing offices enter hospital day counts (that is, number of covered days, non-covered days, co-insurance days, and Life Time Reserve (LTR) days)) as part of DDE claims entry, this action results in a duplication of day counts on outbound HIPAA ASC X12N 837 institutional Coordination of Benefits (COB)/crossover claims. To remedy these two issues, CMS wrote Transmittal 1770, Change Request (CR) 9681. CR9681 required the Fiscal Intermediary Shared System (FISS) maintainer to develop two (2) new RTP edits to: 1) address incorrect inclusion of POA indicators on claims whose Type of Bill (TOB) designation was other than 11x, 18x, 21x, and 41x; and 2) prevent entry of day counts via the DDE claims submission screen. The two RTP edits developed were 34961, which activates when a POA indicator is included on a TOB other than 11x, 18x, 21x, and 41x; and 36190, which activates when a provider billing office enters day counts when billing claim to Medicare via the DDE process.

Initially, both RTP edits applied to “original” claims and to “all adjustment” claims, including mass adjustments generated through Medicare Administrative Contractor (MAC) action. Through subsequent MAC testing, Medicare has determined that the volume of RTP rejections would be much higher than intended if the edits were applied to original claims and to “all” adjustment claims. Therefore, during April 2017, CMS issued direction to its MACs to request that they temporarily turn off FISS RTP edits 34961 and 36190 until further notice.
Latest Information:
Through the issuance of Transmittal 1844, CR10103, CMS has indicated that it intends for the RTP edits 34961 and 36190 to apply to “original” claims and only to “provider-initiated” adjustment claims. **Important: Providers should note that the revised RTP edits will begin to apply to incoming claims on August 7, 2017.** This means:

Effective August 7, 2017, providers will encounter returned claims with RTP edit 34961 if they:

- Submit original or provider-initiated adjustment outpatient hospital facility claims (TOB other than 11x, 18x, 21x, and 41x) with a POA indicator.

Effective August 7, 2017, providers will encounter returned claims with RTP edit 36190 if they:

- Submit original or provider-initiated adjustment claims via DDE and include a day count (that is, number of covered days, non-covered days, co-insurance days, and LTR days).
Ambulance Locality and ALS Assessment – “Medicare Benefit Policy Manual” – Chapter 10

MLN Matters Number: MM10110
Related Change Request (CR) Number: 10110
Related CR Release Date: June 16, 2017
Effective Date: September 18, 2017
Related CR Transmittal Number: R236BP
Implementation Date: September 18, 2017

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

What You Need To Know
Change Request (CR) 10110 which revises the “Medicare Benefit Policy Manual” (Chapter 10, Sections 10.3.5 and 30.1.1) to clarify the definitions for locality and ground ambulance services for Advanced Life Support (ALS) assessment. The term “locality” with respect to ambulance service means the service area surrounding the institution to which individuals normally travel or are expected to travel to receive hospital or skilled nursing services. Your MACs have the discretion to define “locality” in their service areas.

Background
CR10110 provides clarifications of the definitions for locality and ground ambulance services for Advanced Life Support (ALS) assessment, and it revises the “Medicare Benefit Policy Manual” to clarify that:

- MACs have the discretion to define “locality” in their service areas.
- If an ALS assessment is performed, the services will be covered at the ALS emergency level if medically necessary and all other coverage requirements are met.

The Centers for Medicare & Medicaid Services (CMS) defines the term “locality” (with respect to ambulance service) as the service area surrounding the institution to which individuals normally travel (or are expected to travel) to receive hospital or skilled nursing services.

EXAMPLE: Mr. A becomes ill at home and requires ambulance service to the hospital. The small community in which he lives has a 35-bed hospital. Two large metropolitan hospitals are located some distance from Mr. A’s community and both regularly provide hospital services to the community’s residents. The community is within the “locality” of both metropolitan hospitals and direct ambulance service to either of these (as well as to the local community hospital) is covered.

ALS assessment is defined in 42 CFR 414.605 as an assessment performed by an ALS crew as part of an emergency response that was necessary because the patient’s reported condition at the time of dispatch was such that only an ALS crew was qualified to perform the assessment.

Note that an ALS assessment does not necessarily result in a determination that the patient requires an ALS level of service.

In the “Medicare Benefit Policy Manual” (Chapter 10, Section 30.1.1), CMS states that in the case of an appropriately dispatched ALS Emergency service, if the ALS crew completes an ALS Assessment, then the services provided by the ambulance transportation service provider or supplier may be covered at the ALS emergency level. This is regardless of whether the patient required ALS intervention services during the transport, provided that ambulance transportation itself was medically reasonable and necessary.

Additional Information
Redetermination Requests Now Accepting Electronic, Digital and/or Digitized Signatures

CMS has instructed Medicare Administrative Contractors (MACs) to begin accepting electronic, digital and/or digitized signatures on requests for an appeal. Previously, MACs were only allowed to accept handwritten or electronic signatures. This new direction means that providers may now use typed and scanned signatures on the Redetermination Form. Valid signatures must still be legible, contain at least the entire first name and may not be reduced to initials.

As required by CMS, all redetermination requests received without the appellant’s signature are dismissed as incomplete requests. Noridian continues to receive numerous redetermination requests without the proper signature of the requesting party. Providers are encouraged to submit requests for redetermination via the Noridian Medicare Portal (NMP). Step-by-step instructions are available on our website. NMP is free, includes the capability to upload supporting documentation, and can speed up the appeal process.

For further information refer to the Internet Only Manual Publication 100-04, Medicare Claims Processing Manual, Chapter 29, Appeals of Claims Decisions, Section 310.1.B.3, Requirements for a Valid Signature on an Appeal Request.
Documentation Guidelines for Amended Medical Records

Noridian Healthcare Solutions closely monitors Comprehensive Error Rate Testing (CERT) review findings to identify problem areas and to provide education to stop these errors from occurring. We have noted that CERT is finding improperly amended records during their review. How does this affect providers? This can result in providers not being paid for the services rendered. Accurately amending the medical record when needed is essential to maintaining an accurate record of the care that was provided to the beneficiary. It is important for providers to protect themselves financially as well as legally. Medicare expects that providers appropriately amend records using the following information.

Elements of a Complete Medical Record

When records are requested, it is important that providers send all associated documentation that supports the services billed within the timeframe designated in the written request. Sometimes that information may come from a visit or test performed earlier than the claim in question. Elements of a complete medical record may include:

• Physician orders and/or certifications of medical necessity
• Patient questionnaires associated with physician services
• Progress notes of another provider that are referenced in your own note
• Treatment logs
• Related professional consultation reports
• Procedure, lab, x-ray and diagnostic reports
• Billing provider notes for billed date of service

Amended Medical Records: Late entries, addendums or corrections to a medical record are legitimate occurrences in documentation of clinical services. A late entry, an addendum or a correction to the medical record, bears the current date of that entry and is signed by the person making the addition or change.

Late Entry: A late entry supplies additional information that was omitted from the original entry. The late entry bears the current date, is added as soon as possible, is written only if the person documenting has total recall of the omitted information and signs the late entry.

Example: A late entry following treatment of multiple trauma might add: “The left foot was noted to be abraded laterally. John Doe MD 06/15/09”

Addendum: An addendum is used to provide information that was not available at the time of the original entry. The addendum should also be timely and bear the current date and reason for the addition or clarification of information being added to the medical record and be signed by the person making the addendum.

Example: An addendum could note: “The chest x-ray report was reviewed and showed an enlarged cardiac silhouette. John Doe MD 06/15/09”

Correction: When making a correction to the medical record, never write over, or otherwise obliterate the passage when an entry to a medical record is made in error. Draw a single line through the erroneous information, keeping the original entry legible. Sign or initial and date the deletion, stating the reason for correction above or in the margin. Document the correct information on the next line or space with the current date and time, making reference back to the original entry.

Correction of electronic records should follow the same principles of tracking both the original entry and the correction with the current date, time, reason for the change and initials of person making the correction. When a hard copy is generated from an electronic record, both records must show the correction. Any corrected record submitted must make clear the specific change made, the date of the change and the identity of the person making that entry.

Falsified Documentation: Providers are reminded that deliberate falsification of medical records is a felony offense and is viewed seriously when encountered. Examples of falsifying records include:

• Creation of new records when records are requested
• Back-dating entries
Claims Review

- Post-dating entries
- Pre-dating entries
- Writing over, or
- Adding to existing documentation (except as described in late entries, addendums and corrections)

Corrections to the medical record legally amended prior to claims submission and/or medical review will be considered in determining the validity of services billed. If these changes appear in the record following payment determination based on medical review, only the original record will be reviewed in determining payment of services billed to Medicare.

Appeal of claims denied based on an incomplete record, may result in a reversal of the original denial if the information supplied includes pages or components that were part of the original medical record, but were not submitted on the initial review.

Sources
- Section 1833(e) Title XVIII of the Social Security Act (No Documentation)
- Section 1842(a)(1)(c) of the Social Security Act (Carrier Audits)
- Section 1862(a)(1)(A) of Title XVIII of the Social Security Act (Medical Necessity)
- IOM Publication 100-08 Medicare Program Integrity Manual Chapter 3.3.2.5

Medical Review of Hospital Claims for Part A Payment

MLN Matters Number: MM10080
Related Change Request (CR) # 10080
Related CR Release Date: May 12, 2017
Effective Date: June 13, 2017
Related CR Transmittal Number: R716PI
Implementation Date: June 13, 2017

Provider Types Affected
This MLN Matters® Article is intended for providers that submit institutional claims to Medicare Administrative Contractors (MACs) for inpatient hospital services provided to Medicare beneficiaries.

Provider Action Needed
Change Request (CR) 10080 clarifies the medical review requirements for Part A payment of short stay hospital claims (more commonly referred to as the “Two-Midnight” Rule) for MACs, Supplemental Medical Review Contractors (SMRC), Recovery Audit Contractors and the Comprehensive Error Rate Testing (CERT) contractors. (Note, such reviews are currently, mainly overseen by Quality Improvement Organizations). Make sure that your staffs are aware of these policies.

Background
CR 10080 updates the Medicare Program Integrity Manual (PIM), Chapter 6, Section 6.5.2, to ensure consistency with recent regulations, as published by the Centers for Medicare & Medicaid Services (CMS). It clarifies the medical review requirements for Part A payment of short stay hospital claims (more commonly referred to as the “Two-Midnight” Rule) status.

For purposes of determining the appropriateness of Medicare Part A payment, Medicare contractors will conduct reviews of medical records for inpatient acute Hospital Inpatient Prospective Payment System (PPS) hospital, Critical Access Hospital (CAH), Inpatient Psychiatric Facility (IPF) and Long Term Care Hospital (LTCH) claims, as appropriate and as permitted by CMS, based on data analysis and their prioritized medical review strategies. Review of the medical record must indicate that hospital care was medically necessary, reasonable, and appropriate for the diagnosis and condition of the beneficiary at any time during the stay, and that the stay was appropriate for Medicare Part A payment.
These updates apply to MACs, as well as Medicare’s SMRC, Recovery Audit Contractors, and the CERT contractor. The following describes the updates:

A. Determining the Appropriateness of Part A Payment
The term “patient status review” refers to reviews conducted by Medicare contractors to determine a hospital’s compliance with Medicare requirements to bill for Medicare Part A payment. “Patient status reviews” may result in determinations that claims are not properly payable under Medicare Part A. “Patient status reviews” do not involve changing a beneficiary’s status from inpatient to outpatient.

Medicare contractors will conduct such reviews in accordance with two distinct, but related medical review policies:

1. A Two-Midnight presumption which helps guide contractor selection of claims for medical review
Per the Two-Midnight presumption, Medicare contractors will presume hospital stays spanning two or more midnights after the beneficiary is formally admitted as an inpatient are reasonable and necessary for Part A payment. Generally, Medicare contractors will not focus their medical review efforts on stays spanning 2 or more midnights after formal inpatient admission absent evidence of systematic gaming, abuse, or delays in the provision of care in an attempt to qualify for the Two-Midnight presumption. (Due to its function, the CERT contractor would not exclude such claims from its review and calculation of the improper payment rate).

2. A Two-Midnight benchmark which helps guide contractor reviews of short stay hospital claims for Part A payment
Per the Two-Midnight benchmark, hospital stays are generally payable under Part A if the admitting practitioner expects the beneficiary to require medically necessary hospital care spanning two or more midnights and such reasonable expectation is supported by the medical record documentation. Medicare Part A payment is generally not appropriate for hospital stays expected to span less than two midnights.

If a stay is not reasonably expected to span two or more midnights, Medicare contractors will assess the claim to determine if an exception exists that would nonetheless make Part A payment appropriate, including:

- If the procedure is on the Secretary’s list of “inpatient only” procedures (identified through annual regulation)
- If the procedure is a CMS-identified, national exception to the Two-Midnight benchmark
- If the admission otherwise qualifies for a case-by-case exception to the Two-Midnight benchmark because the medical record documentation supports the admitting physician/practitioner’s judgment that the beneficiary required hospital care on an inpatient basis despite the lack of a Two-Midnight expectation. Medicare contractors will note CMS’ expectation that stays under 24 hours would rarely qualify for an exception to the Two-Midnight benchmark.

Hospital treatment decisions for beneficiaries are based on the medical judgment of physicians and other qualified practitioners. The Two-Midnight rule does not prevent such practitioners from providing any service at any hospital, regardless of the expected duration of the service. Rather, it provides a benchmark to help guide consistent Part A payment decisions.

Reviewing Hospital Claims for Patient Status: The Two-Midnight benchmark determines if the stay involved an “Inpatient Only” procedure
When conducting patient status reviews, assuming all other coverage requirements are met, the Medicare review contractor will determine Medicare Part A payment to be appropriate if a medically necessary procedure classified by the Secretary as an “inpatient only” procedure is performed. “Inpatient only” procedures are so designated per 42 C.F.R. Section 419.22(n), and are detailed in the annual Outpatient Prospective Payment System (OPPS) regulation.

MACs will review the medical documentation and make an initial determination of whether a medically necessary inpatient only procedure is documented within the medical record. If so, and if the other requisite elements for payment are present, then the Medicare review contractor will deem Medicare Part A payment to be appropriate, without regard to the expected or actual length of stay.
If the Medicare review contractor does not identify an inpatient only procedure during the initial review, the claim should be assessed in accordance with the Two-Midnight benchmark.

Calculating Time Relative to the Two-Midnight Benchmark

Per the Two-Midnight benchmark, Medicare contractors will assess short stay (that is, less than 2 midnights after formal inpatient admission) hospital claims for their appropriateness for Part A payment. Generally, hospital claims are payable under Part A if the contractor identifies information in the medical record supporting a reasonable expectation on the part of the admitting practitioner at the time of admission that the beneficiary would require a hospital stay that crossed at least 2 midnights.

Medicare review contractor reviews will assess the information available at the time of the original physician/practitioners’ decision as follows:

1. The expectation for sufficient documentation is well rooted in good medical practice. Physician/practitioners need not include a separate attestation of the expected length of stay; rather, this information may be inferred from the physician/practitioner’s standard medical documentation, such as his/her plan of care, treatment orders, and progress notes.

2. Medicare contractors will consider the complex medical factors that support both the decision to keep the beneficiary at the hospital and the expected length of the stay. These complex medical factors may include, but are not limited to, the beneficiary’s medical history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk (probability) of an adverse event occurring during the time period for which hospitalization is considered.

3. For purposes of determining whether the admitting practitioner had a reasonable expectation of hospital care spanning 2 or more midnights at the time of admission, the Medicare contractors will take into account the time the beneficiary spent receiving contiguous outpatient services within the hospital prior to inpatient admission.

   • This pre-admission time may include services such as observation services, treatments in the emergency department (ED), and procedures provided in the operating room or other treatment area.

   • If the beneficiary was transferred from one hospital to another, then for the purpose of determining whether the beneficiary satisfies the Two-Midnight benchmark at the recipient hospital, the Medicare contractors will take into account the time and treatment provided to the beneficiary at the initial hospital. In the event that a beneficiary was transferred from one hospital to another, the Medicare review contractor may request documentation that was authored by the transferring hospital to support the medical necessity of the services provided and to verify when the beneficiary began receiving hospital care. Medicare contractors will generally expect this information to be provided by the recipient hospital seeking Part A payment.

   • Medicare contractors will continue to follow CMS’ longstanding instruction that Medicare Part A payment is prohibited for care rendered for social purposes or reasons of convenience that are not medically necessary. Therefore, Medicare contractors will exclude extensive delays in the provision of medically necessary care from the Two-Midnight benchmark calculation. Factors that may result in an inconvenience to a beneficiary, family, physician or facility do not, by themselves, support Part A payment for an inpatient admission. When such factors affect the beneficiary’s health, Medicare contractors will consider them in determining whether Part A payment is appropriate for an inpatient admission.

NOTE: While, as discussed above, the time a beneficiary spent as an outpatient before being admitted as an inpatient is considered during the medical review process for purposes of determining the appropriateness of Part A payment, such time does not qualify as inpatient time. (See the Medicare Benefit Policy Manual, Chapter 1, Section 10 for additional information regarding the formal order for inpatient admission.)

Unforeseen Circumstances Interrupting Reasonable Expectation

The Two-Midnight benchmark is based on the expectation at the time of admission that medically necessary hospital care will span 2 or more midnights. Medicare contractors will, during the course of their review, assess the reasonableness of such expectations. In the event that a stay does not span 2 or more midnights, Medicare contractors will look to see if there was an intervening event that nonetheless supports the reasonableness of the physician/practitioner’s original judgment.
An event that interrupts an otherwise reasonable expectation that a beneficiary’s stay will span two or more midnights is commonly referred to by CMS and its contractors as an unforeseen circumstance. Such events must be documented in the medical record, and may include, but are not limited to, unexpected death, transfer to another hospital, departure against medical advice, clinical improvement, and election of hospice in lieu of continued treatment in the hospital.

**Stays Expected to Span Less than 2 Midnights**

When a beneficiary enters a hospital for a surgical procedure not specified by Medicare as inpatient only under 42 C.F.R. Section 419.22(n), a diagnostic test, or any other treatment, and the physician expects to keep the beneficiary in the hospital for less than two midnights, the services are generally inappropriate for inpatient payment under Medicare Part A, regardless of the hour that the patient came to the hospital or whether the beneficiary used a bed.

The Medicare review contractor will assess such claims to see if they qualify for a general or case-by-case exception to this generalized instruction, which would make the claim appropriate for Medicare Part A payment, assuming all other requirements are met.

**Exceptions to the Two-Midnight Rule:**

1. Medicare’s Inpatient-Only List

   Inpatient admissions where a medically necessary Inpatient-Only procedure is performed are generally appropriate for part A payment regardless of expected or actual length of stay.

2. Nationally-Identified Rare & Unusual Exceptions to the Two-Midnight Rule

   If a general exception to the Two-Midnight benchmark, as identified by CMS, is present within the medical record, the Medicare review contractor will consider the inpatient admission to be appropriate for Part A payment so long as other requirements for Part A payment are met. CMS has identified the following national or general exception to the Two-Midnight rule:
   
   a. **Mechanical Ventilation Initiated During Present Visit:** CMS believes newly initiated mechanical ventilation to be rarely provided in hospital stays less than two midnights, and to embody the same characteristics as those procedures included in Medicare’s inpatient–only list. While CMS believes a physician will generally expect beneficiaries with newly initiated mechanical ventilation to require two or more midnights of hospital care, if the physician expects that the beneficiary will only require one midnight of hospital care, but still orders inpatient admission, Part A payment is nonetheless generally appropriate.

3. Physician-Identified Case-by-Case Exceptions to the Two-Midnight Rule

   For hospital stays that are expected to span less than 2 midnights, an inpatient admission may be payable under Medicare Part A on a case-by-case or individualized basis if the medical record supports the admitting physician/practitioner’s judgment that the beneficiary required hospital care on an inpatient basis despite the lack of a 2-midnight expectation. Medicare contractors will consider, when assessing the physician’s decision, complex medical factors including but not limited to:
   
   - The beneficiary history and comorbidities
   - The severity of signs and symptoms
   - Current medical needs
   - The risk of an adverse event

   Medicare contractors will note CMS’ expectation that stays under 24 hours would rarely qualify for an exception to the Two-Midnight benchmark and as such, may be prioritized for medical review.

**Additional Information**

Recovery Auditor Region 4 Website and New Issues

CMS awarded HMS Federal Solutions the Region 4 Recovery Auditor contract on October 31, 2016. HMS Federal Solutions has launched the new Region 4 Recovery Auditor website located at https://racinfo.hms.com/home.aspx. Providers can locate the following information on the new Region 4 Recovery Auditor website:

- Additional Documentation Request Letter Example
- Automated Review Information Letter Example
- RAC Discussion Period Process
- Region 4 Contact Information
- Region 4 New Issues
- Region 4 Provider Information
- Region 4 Provider Portal

Noridian encourages providers to review the New Issues section of the website in detail. The New Issues page lists the name, description, provider type, review type, approved date, dates of service affected by the review, and additional resources on each review topic. Providers may use this information to prepare for potential requests for information if selected as part of any of the new issue reviews.
QMB Indicator in the Medicare Fee-For-Service Claims Processing System – Revised

MLN Matters® Number: MM9911 Revised
Related Change Request (CR) #: CR 9911
Related CR Release Date: April 28, 2017
Effective Date: For claims processed on or after October 2, 2017
Related CR Transmittal #: R3764CP
Implementation Date: October 2, 2017

The article was revised on May 1, 2017, to reflect a revised CR9911 issued on April 28, 2017. In the article, the CR release date, transmittal number, and the Web address of CR9911 are revised. All other information remains the same.

Provider Types Affected
This MLN Matters® Article is intended for physicians, providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs), 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(k)(3); 1866(a)(1)(A); 1848(g)(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.

ASP Medicare Part B Drug Pricing Files and Revision to Prior Quarterly Pricing Files – July 2017

MLN Matters Number: MM10016
Related Change Request (CR) Number: 10016
Related CR Release Date: April 7, 2017
Effective Date: July 1, 2017
Related CR Transmittal Number: R3746CP
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.

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

**Background**

The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply contractors with the ASP and Not Otherwise Classified (NOC) drug-pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the OPPS are incorporated into the Outpatient Code Editor (OCE) through separate instructions.

The following files are related to this most recent update:

- July 2017 ASP and ASP NOC – Effective Dates of Service: July 1, 2017, through September 30, 2017
- April 2017 ASP and ASP NOC – Effective Dates of Service: April 1, 2017, through June 30, 2017
- January 2017 ASP and ASP NOC – Effective Dates of Service: January 1, 2017, through March 31, 2017
- October 2016 ASP and ASP NOC – Effective Dates of Services: October 1, 2016, through December 31, 2016
- July 2016 ASP and ASP NOC – Effective Dates of Service: July 1, 2016, through September 30, 2016

For any drug or biological not listed in the ASP or NOC drug-pricing files, MACs will determine the payment allowance limits in accordance with the policy described in 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](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c17.pdf).

For any drug or biological not listed in the ASP or NOC drug-pricing files that is billed with the KD modifier, contractors shall determine the payment allowance limits in accordance with instructions for pricing and payment changes for infusion drugs furnished through an item of Durable Medical Equipment (DME) on or after January 1, 2017, associated with the passage of the 21st Century Cures Act.

**Additional Information**

**New Physician Specialty Code for Advanced Heart Failure and Transplant Cardiology, Medical Toxicology, and Hematopoietic Cell Transplantation and Cellular Therapy**

MLN Matters® Number: MM9957  
Related Change Request (CR) #: CR 9957  
Related CR Release Date: April 28, 2017  
Effective Date: October 1, 2017  
Related CR Transmittal #: R283F and R3762CP  
Implementation Date: October 2, 2017

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

**Provider Action Needed**
Change Request (CR) 9957 establishes new physician specialty codes for Advanced Heart Failure and Transplant Cardiology (C7), Medical Toxicology (C8), and Hematopoietic Cell Transplantation and Cellular Therapy (C9). The new codes are effective on October 1, 2017. Make sure that your billing staffs are aware of these new specialty codes.

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

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

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

**Additional Information**


**Modifier CG for Type of Bill 72x Implementation**

MLN Matters® Number: MM9989  
Related Change Request (CR) #: CR 9989  
Related CR Release Date: May 12, 2017  
Effective Date: October 1, 2017  
Related CR Transmittal #: R1849OTN  
Implementation Date: October 2, 2017  
Provider Types Affected
This MLN Matters® Article is intended for physicians, other providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs) for dialysis services provided to Medicare beneficiaries.

Provider Action Needed
Change Request (CR) 9989 informs MACs about the implementation of modifier CG for dialysis claim lines that do not meet the MAC’s medical justification requirements for dialysis treatments. Make sure that your billing staffs are aware of these changes.

Background
When the End Stage Renal Disease (ESRD) Prospective Payment System (PPS) was implemented in 2011, the Centers for Medicare & Medicaid Services (CMS) adopted a per treatment unit of payment. This per treatment unit of payment is the same base rate that is paid for all dialysis treatment modalities furnished by an ESRD facility (hemodialysis (HD) and the various forms of peritoneal dialysis (PD)). Consistent with CMS policy since implementation of the composite rate payment system in the 1980s, CMS also adopted the 3-times weekly payment limit for HD under the ESRD PPS. When a beneficiary’s plan of care requires more than three weekly dialysis treatments, whether HD or daily PD, CMS applies payment edits to ensure that Medicare payment on the monthly claim is consistent with the 3-times weekly dialysis treatment payment limit. Thus, for a 30-day month, payment is limited to 13 treatments, and for a 31-day month payment it is limited to 14 treatments, with exceptions made for medical justification.

In order to accurately capture all treatments provided to a beneficiary, CMS is implementing a new modifier (CG – Policy Criteria Applies) for the 72x type of bill (TOB) with Revenue Codes 0821 or 0881 and HCPCS 90999 when used in the billing of dialysis treatments for patients with ESRD in excess of the 13 or 14 monthly allowable treatments.

Note: This does not apply to training treatments (condition code 73 or 87). These services should be paid when modifier CG is present and they are within the current limitations.

Modifier CG (Policy Criteria Applies) is used to identify dialysis treatments (CPT 90999) in excess of 13 or 14 per month that do not meet medical justification requirements as defined by the MACs. This modifier shall be appended to the claim line for the date of service associated with the excess treatment. This modifier indicates that the facility attests the additional treatment does not meet medical justification requirements and should not be paid separately.

MACs will continue to use existing processes to determine medical justification for claim lines in excess of 13/14 per month that do not include the new modifier. When a claim line includes modifier CG and medical justification, the claim line should not be separately payable.

Medicare will deny claim lines on TOB 72x with Revenue Codes 0821 or 0881, HCPCS code 90999 and Modifier CG using Group Code CO and Claims Adjustment Reason Code 96 (Non-covered charge(s)). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT). Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

Additional Information
Abbreviated Daytime Sleep Study

The Abbreviated Daytime Sleep Study (e.g. PAP-NAP) coverage article has been created and published for notice under contract numbers: 02101 (AK), 02201 (ID), 02301(OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601 (WY) in the CMS Medicare Coverage Database (MCD) and on our (Noridian) website.

Article Summary: The article addresses the use of abbreviated daytime sleep study.

Effective Date: June 5, 2017

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

Billing Medicare for the SphenoCath Device

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

Article Summary: This article explains how to code and bill for the SphenoCath® Device

Effective Date: January 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

Bladder Tumor Markers FISH Billing and Coding Guidelines – R1

The Bladder Tumor Markers FISH Billing and Coding Guidelines coverage article has been revised and 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: Local Coverage article A55029 has been revised to add billing instructions for Part A and to clarify them for Part B.

Effective Date: May 16, 2017
Coverage

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

Chemotherapy Administration – R7

The Chemotherapy Administration coverage article has been revised and 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.

Effective Date: July 1, 2017

Summary of Changes: Local Coverage article A52991 has been revised with the following information added:

• Editorial updates to add “unless otherwise specified” for effective date in the very first sentence of the article and to correct the spelling of Stelara in the Intramuscular and subcutaneous injection section.

• Added billing information to avoid inappropriate claim rejections when billing the wrong administration code effective July 31, 2017 in both the Intramuscular and subcutaneous injection and Infusions Non-Chemotherapy sections.

• Added J2505-pegfilgrasrin (Neulasta®) to the Intramuscular and subcutaneous injections section and clarified the need to use 96372 instead of 96377 when billing for Neulasta® Onpro Kit.

• In the Intramuscular and subcutaneous injections section, we corrected J3262- tocilizumab (Actemra®) injection, 1mg to J3590. Per the manufacturer, J3262 is for IV tocilizumab.

• Added the following HCPCS codes to the Infusions Non-Chemotherapy section.
  • C9483 - -atezolizumab effective 10/01/2016 in the OPPS setting.
  • J3590 - unclassified biological and for OPPS C93699 effective 10/21/16 through 12/31/2016 and C9490 effective 01/01/2017 for bezlotoxumab (Zipla™ )
  • J3590 - unclassified biological and for OPPS C9399 with dates of service (DOS) prior to 04/01/2017, C9487 effective 04/01/2017 through 06/30/2017 and C9487 effective 7/01/2017 for IV ustekinumab (Stelara®). This version of the drug is only FDA for Crohn’s Disease.

• Added the following HCPCS codes to the Infusions Chemotherapy section
  • J3590 - unclassified biological and for OPPS C93699 effective 03/23/17 for avelumab (Bavencio®).
  • C9485 – olaratumab (Lartruvo™) effective 04/01/2017.
  • J3590 - unclassified biological and for OPPS C93699 effective 03/28/17 for crelizumab (Ocrevus™).

• Added the following drugs to be billed with G0498 - Chemotherapy administration, intravenous infusion technique; initiation of infusion in the office/other outpatient setting using office/other outpatient setting pump/supplies, with continuation of the infusion in the community setting (e.g., home, domiciliary, rest home or assisted living) using a portable pump provided by the office/other outpatient setting, includes follow up office/other outpatient visit at the conclusion of the infusion.
• 9000 Injection, doxorubicin hydrochloride, 10 mg (Adrimycin, Doxil, Caelyx, Myocet and others)
• J9181 Injection, etoposide, 10 mg (Toposar, Etopophos)
• J9190 Injection, fluorouracil, 500 mg (Efudex, Carac, Fluotoplex, Adrucil)
• J9352 Injection, trabectedinYondelis®, effective DOS on or after DOS 01/01/2017 (use J3490 (OPPS: C9480) for DOS prior to 01/01/2017).
• J9371 Injection, vincristine sulfate liposome, 1mg (Oncovin, Vincasar PFS).

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

Hydration Services - R3

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

Summary of Changes: Updated to clarify intravenous hydration services must be ordered by a physician or non-physician practitioner and must meet the reasonable and necessary criteria for intravenous hydration services. JF Part B (JFB) Local Coverage article A54636 was combined into the updated JF Part A (JFA) article A52732 effective January 20, 2017. Both JFA and JFB contract numbers now have the same final MCD article number A54635.

Effective Date: January 20, 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 column (This link will redirect you to the CMS website.)
  • Once in the CMS MCD, select corresponding article title
**COVERAGE**

**NMP22 Bladder Check Test for Monitoring Bladder Cancer Article Retirement – Effective May 15, 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: A52721

**Article Title:** NMP22 Bladder Check® Test for Monitoring Bladder Cancer

**Effective Date:** May 15, 2017

**Summary:** This article is being retired due to the Notice period for Bladder/Urothelial Bladder Tumor Markers LCD L36680 and Local Coverage Article (LCA) A55029 - Bladder Tumor Marker FISH Billing and Coding Guidelines for Jurisdiction JF Part A (JFA) and Jurisdiction JF Part B (JFB) ending. This new LCD and LCA is effective May 16, 2017.

To access the Noridian Retired coverage articles 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 “Medicare Coverage Articles” page, select the state of interest in the table under “Retired Articles.”
    - This link will redirect you to the CMS website.
    - Select Retired Articles on the CMS webpage.
  - Locate the above-listed CMS Medicare Coverage Database (MCD) number and article title and select the title of interest.

**Ocular Photodynamic Therapy (OPT) with Verteporfin - R3**

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

Medicare Coverage Database (MCD) Number: A52769

**Effective Date:** October 1, 2016

**Article Summary of Changes:** This Article has been updated to add central serous chorioretinopathy to the Group 2 Paragraph as part of Noridian’s expanded coverage for OPT and ICD-10 codes:

- **H35.3231** - Exudative age-related macular degeneration, bilateral, with active choroidal neovascularization to Group 1
- **H35.711** - Central serous chorioretinopathy, right eye to List I in Group 2; effective 10/01/2015
- **H35.712** - Central serous chorioretinopathy, left eye to List I in Group 2; effective 10/01/2015
- **H35.713** - Central serous chorioretinopathy, bilateral to List I in Group 2; effective 10/01/2015

Go to the Noridian [National Coverage Determination (NCD) webpage](https://med.noridianmedicare.com/web/jfa/policies/coverage-articles) to:

- View the locally hosted Noridian Active Medicare Coverage Articles
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
Self-Administered Drug Exclusion List – R12

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: August 7, 2017

Summary of Changes: Two new drugs added and four drugs removed from the Self-Administered Drug Exclusion List.

New drugs added effective August 7, 2017:

- C9399 – Unclassified drugs or biologicals, Dupilumab (Dupixent)
- J3590 – Unclassified Biologics, Dupilumab (Dupixent)
- C9399 – Unclassified drugs or biologicals, Brodalumab (Siliq)
- J3590 – Unclassified Biologics, Brodalumab (Siliq)

Drugs removed effective July 14, 2017

- J0275 – Alprostadil urethral suppository (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self-administered)
- J1562 – Injection, immune globulin (vivaglobin), 100 mg
- J2760 – Injection, phentolamine mesylate, up to 5 mg
- J3590 – Unclassified Biologics, Efalizumab (Raptiva®), variable

The miscellaneous drug Methylnaltrexone bromide billed under J3490 is removed as a duplicate drug. This is the same drug as J2212, Injection, Methylnaltrexone, 0.1 mg also listed in the SAD article.

View the complete Noridian Self-Administered Drug Exclusion List.

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

Go to the Noridian Medicare Coverage Articles webpage to:

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

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

Article Summary: The article addresses and clarifies the credentialing of sleep labs.

Effective Date: June 5, 2017

Go to the Noridian Medicare Coverage Articles webpage to:

• View complete list of Noridian coverage articles
  • The End User Agreement for Providers will appear if you have not recently visited the website. Select "Accept" (if necessary).

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

• Once in the CMS MCD, select corresponding article title
Do Not Forward Initiative Reminder

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

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

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

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

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

Policy

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

Implementation Process

- “Return service requested” envelopes are used for all hardcopy remittance advices starting October 1, 2002. These envelopes will be used for all providers.
- “Return service requested” envelopes will not be used for beneficiary correspondence, such as Medicare Summary Notices (MSNs) or for overpayment demand letters.
- When the post office returns a remittance advice due to an incorrect address, A/B MACs/carriers will follow the same procedures as followed for returned checks, that is:
  - Flag the provider’s file DNF.
  - A/B MAC/carrier staff will notify provider enrollment team.
  - A/B MAC/carriers will cease generating any further payments or remittance advice to that provider or supplier until furnished with a new, verified address.
- When the provider establishes a new, verified address, A/B MACs/carriers will remove the DNF flag and pay the provider any funds which are still being held due to a DNF flag. A/B MAC/carriers must also reissue any remittance advices, which have been held.
- Previously, CMS only required corrections to the “pay to” address. However, with the implementation of this initiative, CMS requires corrections to all addresses before the contractor can remove the DNF flag and begin paying the provider or supplier again. Therefore, A/B MAC/carriers cannot release any payments to DNF providers until the provider enrollment department has verified and updated all addresses for that provider’s location.
IRS-1099 Reporting

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

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

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

FISS Updates to Accommodate Section 603 Bipartisan Budget Act of 2015 – Implementing Phase 2

MLN Matters® Number: MM9907
Related Change Request (CR) #: CR 9907
Related CR Release Date: February 2, 2017
Effective Date: January 1, 2017
Related CR Transmittal #: R1783OTN
Implementation Date: July 3, 2017

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

Provider Action Needed
Change Request (CR) 9907 announces that, starting on January 1, 2017, off-campus outpatient department(s) of a provider services that fall under the Bipartisan Budget Act of 2015 (§603) are required to be correctly identified. If a hospital claim is submitted with a service facility location that was not included on the CMS 855A enrollment form, the claim will be Returned to the Provider (RTP) until the CMS 855A enrollment form and claims processing system are updated.

Make sure your billings staffs are aware of these changes.

Background
The Social Security Act (Section 1833 (t)) as amended by the Bipartisan Budget Act of 2015 (Section 603), authorizes the Centers for Medicare & Medicaid Services (CMS) to implement amended policies related to treatment of off-campus outpatient department(s) of a provider services.

Hospital providers are required to include all practice locations on the CMS 855A enrollment form, and CMS has performed a re-validation process (March 25, 2011 – March 23, 2015) where in the last 4 years all hospital providers have completed an 855A enrollment form to either:

- Initially enroll in Medicare,
- Add a new practice location, or
- Revalidate its enrollment information.

Starting on January 1, 2017, off-campus outpatient department(s) of provider services that fall under the Bipartisan Budget Act of 2015 (§603) are required to be correctly identified.

If a hospital claim is submitted with a service facility location that was not included on the CMS 855A enrollment form, it will be Returned to the Provider (RTP) until the hospital updates its CMS 855A enrollment form and Medicare’s claims processing system are updated accordingly.
ENROLLMENT

CR9907 also requires that either modifier PO or PN be present on all service lines with HCPCS codes when the service facility address is present. For more details on these modifiers please review MLN Matters article MM9930.

Collection and retention of CMS 855 enrollment data has been cleared through a Paperwork Reduction Act Notice in the Federal Register. The authority for the various types of data to be collected is found in:

- The Social Security Act (Sections 1816, 1819, 1833, 1834, 1842, 1861, 1866, and 1891), and

Additional Information


Provider Enrollment Revalidation – Cycle 2- Second Revision

MLN Matters® Number: SEI605 Revised

This article was revised on June 15, 2017, to change the effective date of deactivations due to non-billings from 5 days from the date of the deactivation letter to 10 days. (See page 6.) 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

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.

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.

1. Check http://go.cms.gov/MedicareRevalidation for the provider/suppliers due for revalidation;
2. 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 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 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 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 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 certifying 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. 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 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-Network-MLN/MLNProducts/Downloads/MedEnroll_PECOS_PhysNonPhys_FactSheet_ICN903764.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.
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.

**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 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.

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 prior to due date</td>
<td>March 30, 2017</td>
</tr>
<tr>
<td>Issue large group notifications</td>
<td>Approximately 6 months prior to due date</td>
<td>March 30, 2017</td>
</tr>
<tr>
<td>MAC sends email/letter notification</td>
<td>75 – 90 days prior to due date</td>
<td>July 2 - 17, 2017</td>
</tr>
<tr>
<td>MAC sends letter for undeliverable emails</td>
<td>75 – 90 days prior to due date</td>
<td>July 2 - 17, 2017</td>
</tr>
<tr>
<td>Revalidation due date</td>
<td></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 10 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, you 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.

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.
EFT Payments and Change of Ownership Updated Guidelines

MLN Matters Number: SE17012
Related Change Request (CR) Number: 9953
Article Release Date: May 16, 2017
Effective Date: May 15, 2017
Related CR Transmittal Number: R715PI
Implementation Date: May 15, 2017

Provider Types Affected
This MLN Matters Article is intended for providers involved in a Change of Ownership (CHOW) submitting claims to Part A & B Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed
Special Edition article SE17012 clarifies language in Chapter 15, Section 15.7.7.1.5 of the “Medicare Program Integrity Manual” related to Electronic Funds Transfer (EFT) Payments and Changes of Ownership (CHOWs). Please make sure your staffs are aware of this update.

Background
The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 9953 (effective May 15, 2017), for the purpose of making revisions to Chapter 15, Section 15.7.7.1.5 (Electric Funds Transfer (EFT) Payments and CHOWs) of the “Medicare Program Integrity Manual.” The revisions explain that after a Change of Ownership (CHOW) has been processed, only the Buyer is permitted to submit claims. Change of Ownership (CHOW) is defined in 42 CFR 489.18 (a) and generally means, in the case of a partnership, the removal, addition, or substitution of a partner, unless the partners expressly agree otherwise, as permitted by applicable State law. In the case of a corporation, the term generally means the merger of the provider corporation into another corporation, or the consolidation of two or more corporations, resulting in the creation of a new corporation. The transfer of corporate stock or the merger of another corporation into the provider corporation does not constitute change of ownership.

The most common example of a CHOW occurs when a provider’s CMS Certification Number (CCN) and provider agreement are transferred to another entity as a result of the latter’s purchase of the provider. To illustrate, suppose Entity A is enrolled in Medicare, but Entity B is not. B acquires A. Assuming all regulatory requirements are met, A’s provider agreement and CCN number will transfer to B.

Upon accepting the provider agreement, the new owner accepts the terms and conditions under which it was originally issued. Once the CHOW processes and the MAC: 1) receives the tie-in notice from the CMS Regional Office; and 2) updates the Provider Enrollment Chain and Ownership System (PECOS), claims will only be paid under the new owner’s tax identification number, National Provider Identifier and CCN, or provider transaction number.

MACs will no longer have the ability to update the crosswalk in order for the Seller to complete their billing. Therefore, the old and new owners are responsible for working together on payment arrangements for claims for services furnished during and before the CHOW is processed.

The updated manual language follows:

PIM Language Update
In a CHOW, the existing provider agreement is automatically assigned to the Buyer/Transferee. If the Buyer/Transferee does not explicitly reject automatic assignment before the transfer date, the provider agreement is automatically assigned, along with the CCN, effective on the transfer date. The assigned agreement is subject to all applicable statutes and regulations and to the terms and conditions under which it was originally issued. Among other things, this means that the contractor will continue to adjust payments to the provider to account for prior overpayments and underpayments, even if they relate to services provided before the sale/transfer. If the Buyer rejects assignment of the provider agreement, the Buyer must file an initial application to participate in the Medicare program. In this situation, Medicare will never pay the
applicant for services the prospective provides before the date on which the provider qualifies for Medicare participation as an initial applicant.

Depending on the terms of the sale, the Buyer/Transferee may obtain a new NPI or maintain the existing NPI. After CHOW processing is complete, the Seller/Transferor will no longer be allowed to bill for services (i.e., services furnished after CHOW processing is complete) and only the Buyer is permitted to submit claims using the existing CCN. It is ultimately the responsibility of the old and new owners to work out between themselves any payment arrangements for claims for services furnished during the CHOW processing period.

Additional Information

Modernized National Plan and Provider Enumeration System

MLN Matters Number: SE17016
Article Release Date: June 27, 2017

Provider Types Affected
This MLN Matters® Article is intended for all health care providers -- users of the National Plan and Provider Enumeration System (NPPES) to obtain, or update a National Provider Identifier (NPI) and to maintain their NPI account. This includes all physicians, providers and suppliers—it is not limited or restricted to Medicare.

Provider Action Needed
The Centers for Medicare & Medicaid Services has modernized the NPPES (NPPES 3.0) that now has unified login for type 1 and type 2 providers which increases security, provides new surrogacy functionality, has a more responsive User Interface (UI) and a streamlined NPI application process. All NPPES users who obtain and manage NPI account information should be aware of these new and improved features/processes, especially those who support Type 2 providers. NPPES has implemented a more efficient way of accessing type 2 NPI accounts so providers no longer need separate credentials for type 2 accounts and are no longer inclined to share these credentials.

Background
The NPI is the standard for a unique identifier for health care providers for use in the health care system. NPPES is the application that health care providers must use to be awarded an NPI number. Within the NPPES, there are two types of providers:

- Type 1 Providers – Health care providers who are individuals, including physicians, dentists, and all sole proprietors (An individual is eligible for only one NPI.)
- Type 2 providers – Health care providers who are organizations, including physician groups, hospitals, nursing homes, and the corporation formed when an individual incorporates him/herself.


New NPPES Impact on Type 1 Providers
Type 1 providers who already have an account in the Identity & Access (I&A) Management System may login to NPPES without incident. Type 1 providers who do not have an I&A account will need to create an account by visiting https://nppes.cms.hhs.gov/IAWeb/login.do.

Under the modernized NPPES, surrogates of Type 1 providers will have access to their Type 1 provider’s NPI records.


New NPPES Impact on Type 2 Providers
In the past, the sharing of login credentials between Type 2 providers and surrogates posed great security risks including fraud and provider identity theft. The new unified login and surrogacy helps lessen these risks and increase account security. Type 2 provider users will need I&A authentication credentials to access the modernized NPPES. Users may obtain these in the I&A system by going to https://nppes.cms.hhs.gov/IAWeb/login.do. The Authorized Officials (AO) and Delegated Officials (DO) in I&A of Type 2 providers will be able to access all NPIs under the Employer Identification Number (EIN) on the type 2 provider with an organization EIN. Users can claim NPIs using their legacy Type 2 usernames and passwords after they login with an I&A account. As an additional convenience, large organizations can contact the enumerator to get access to their NPIs. More information on the types of possible user roles is available at https://nppes.cms.hhs.gov/IAWebContent/Quick_Reference_Guide.pdf.

Key Features of the Modernized NPPES

Some of the key features of the modernized and more responsive UI include:

- If users have an I&A user ID and password, they now can use those credentials to login to NPPES and they can access all NPIs from one unified account.
- Users can save applications that are not fully complete and may continue where they left off when they return to the NPPES.
- NPPES will have smart filters that only display entries containing the data entered by users to filter away unnecessary information.
- Users may add more than one practice location to their NPI application.
- All taxonomy information may be completed on one page due to the smart filter technology of NPPES 3.0.
- Surrogacy allows administrative users the ability to update records in NPPES on behalf of a provider.
- NPPES 3.0 provides a help option to give assistance to the user based on the screen on which they are working.
- Increased security because NPPES now uses surrogacy functionality for Type 2 NPIs to prevent sharing of Type 2 login credentials.

Electronic File Interchange (EFI) Features

NPPES 3.0 will continue to allow providers and surrogates to submit multiple NPI applications at one time using Comma Separated Values (CSV) files. To use the EFI feature, the users will need to apply for EFI access. This can be done by logging into NPPES and clicking the ‘Manage EFI’ button on the bottom of the NPPES homepage. The EFI access application is pre-populated with some of the user’s information pre-filled when it is generated. For more information on EFI functionality please visit https://nppes.cms.hhs.gov/webhelp/nppeshelp/EFI%20HELP%20PAGE.html.

Data Dissemination File (DDS) Enhancements

NPPES will generate weekly and monthly Org Other Name, Practice Location Addresses, and Endpoint Information Files. The weekly files will have updates of the information that changes from week to week, while the monthly files will generate regardless of updated information. DDS files with PII will continue to be delivered to stakeholders, while DDS files without PII will continue to be delivered to http://download.cms.gov/nppes/NPI_Files.html.

New Optional Fields in NPPES 3.0

The following new fields will allow the user to give more information about the provider and the practice location:

- Primary languages
- Secondary languages
- Race and ethnicity
- Accessibility of the location to users with mobility disabilities
- Provider’s office hours of operation
• Provider’s direct email address

**Frequently Asked Questions**
Feel free to visit the NPPES web help guide to see solutions to frequently asked questions. That guide is available at [https://nppes.cms.hhs.gov/webhelp/nppeshelp/NPPES%20FAQS.html](https://nppes.cms.hhs.gov/webhelp/nppeshelp/NPPES%20FAQS.html).

**Additional Information**
Additional Information on NPPES is available at the following links:
- [https://www.youtube.com/watch?v=BOJCAj1P2u8&feature=youtu.be](https://www.youtube.com/watch?v=BOJCAj1P2u8&feature=youtu.be)
- [https://nppes.cms.hhs.gov/webhelp/nppeshelp/NPPES%20FAQS.html#How-can-I-gain-access-to-my-Type-2-NPI](https://nppes.cms.hhs.gov/webhelp/nppeshelp/NPPES%20FAQS.html#How-can-I-gain-access-to-my-Type-2-NPI)

If you have any questions, please contact the NPI enumerator by phone at 1-800-465-3203 (NPI Toll-Free) or 1-800-692-2326 (NPI TTY), by email at customerservice@npienumerator.com or by regular mail at:

NPI Enumerator
PO Box 6059
Fargo, ND 58108-6059
ESRD Claims Processing Affected by Dates

The Social Security Administration (SSA) Office that services the claim will receive the completed Form CMS-2728-U3 “End Stage Renal Disease (ESRD) Medical Evidence Report – Medicare Entitlement and/or Patient Registration.” Facilities also submit copies of and are responsible for verifying the information on the form and resolving any questionable items before sending the information to the ESRD Networks who transmit the information to CMS.

Facilities must submit the Medical Evidence Report within 45 days after either a transplant or the start of a regular course of dialysis (whichever occurs first). A copy of the completed form is maintained with the patients’ medical records to support billing.

Noridian will use the dates sent from CMS to process renal dialysis claims. The Form CMS-2728 contains important data elements; date of dialysis, date of transplant and restart dates which impact reimbursement and quality improvement measures. Facilities should review the patient Medicare claims, the form and chart information for internal audits or quality measures.

Primary Cause of Renal Failure

• Item 15 – to be completed by the attending physician. Enter the ICD-10-CM to indicate the primary cause of end stage renal disease. If there are several, choose one as primary.

ESRD Patients in Dialysis Treatment - Initial Date

• Item 24 – Enter the date of the first regular course of dialysis treatment after the physician’s order. The first date of treatment may be in the inpatient of a hospital, outpatient dialysis center or home setting.

Note: If re-entering the Medicare program, enter beginning date of the current ESRD episode. Note in Remarks, Item 53, that patient is restarting dialysis. This section may be used for any necessary comment by either the physician, patient, ESRD Network or the SSA.

• Item 25 – Enter the date the patient started chronic dialysis at the current facility. In cases where the patient transferred to the current dialysis facility, this date will be after the date in Item 24.

Kidney Transplant Patients

• Item 28 – Enter the date(s) of the patient’s kidney transplant(s). If reentering the Medicare program, enter current transplant date.

• Item 31 – Enter the date patient was admitted as an inpatient to a hospital in preparation for, or anticipation of, a kidney transplant prior to the date of actual transplantation. This includes hospitalization for transplant workup to place the patient on a transplant waiting list.

Self-dialysis Training Patients

• Item 40 – Enter the date self-dialysis training began.

• Item 43 – Enter date patient completed or is expected to complete self-dialysis training.

• Items 38-43 – These items must be completed if the patient is applying for a Medicare waiver of the 3-month qualifying period for dialysis benefits based on participation in a self-care dialysis training program.
ESRD Facility Claim (Type of Bill 72X) to Accommodate Dialysis
Furnished to Beneficiaries with AKI – Revised

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

This article was revised on June 19, 2017, to refer to code G0491 as a HCPCS code rather than a CPT code. In addition, a clarification was made on page 3 in the paragraphs relating to the ESRD Conditions of Coverage and the Low Volume Payment Adjustment. Information regarding home or self-dialysis, billing for physician services, payment for erythropoietin stimulating agents, telehealth, and modifiers, value codes, condition codes, and occurrence codes is also added starting on page 4. A link to CR9807 was added. All other information is unchanged.

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

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

Background
On June 29, 2015, The Trade Preferences Extension Act of 2015 was enacted in which Section 808 amended Section 1861(s)(2)(F) of the Social Security Act (42 U.S.C. 1395x(s)(2)(F)) by extending renal dialysis services paid under Section 1881(b)(14) to beneficiaries with AKI effective January 1, 2017. Beginning January 1, 2017, ESRD facilities will be able to furnish dialysis to AKI patients. The AKI provision was signed into law on June 29, 2015. (See Sec. 808 Public Law 114-27.)

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

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

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

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

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

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

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

Applicability of Other ESRD and CMS Adjustments

**ESRD Network Fee**

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

**ESRD Quality Incentive Program (QIP)**

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

**Sequestration Adjustments**

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

**ESRD Conditions for Coverage (CfCs)**

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

**Low Volume Payment Adjustment (LVPA)**

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

**Home or Self-Dialysis Training Add-On Payment Adjustment**

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

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

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

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

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

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

ESAs are included in the bundled payment amount for treatments administered to patients with AKI. The Non-ESRD HCPCS codes should be used (J0881, J0885, J0887). This policy will be implemented with CR 9987 on October 2, 2017.

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

Telehealth

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

Modifier, Value Code, Condition Code, and Occurrence Codes

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

Additional Information


42 CFR 413.171 is available at http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=3233ff9c843c3f74275cab5dcbcf088c&mc=true&n=pt42.2.413&r=PART&ty=HTML#se42.2.413_1171.
42 CFR 494 is available at http://www.ecfr.gov/cgi-bin/text-idx?SID=0cf1f211399c42665d1bfb2ed9b6783a&mc=true&tpl=/ecfrbrowse/Title42/42cfr494_main_02.tpl.


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


Allergy 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: DL37342
LCD Title: Allergy Testing
Comment period: June 1, 2017–August 14, 2017

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

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

• policya.drafts@noridian.com

Botulinum Toxin Types A and B LCD - R9

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

Medicare Coverage Database (MCD) Number: L35172
LCD Title: Botulinum Toxin Types A and B
Effective Date: February 3, 2017

Summary of Changes: Effective for dates of service June 1, 2016 - code 92265 is removed from the LCD. Please see the Nerve Conduction Studies and Electromyography LCD for coverage criteria. Typographical errors in Group 1 Paragraph - corrected CPT codes in the ICD-10 Section: 95875 was changed to 95873 and 92265 removed.

View the locally hosted Noridian Active LCD PDF.

Cardiovascular Stress Testing, Including Exercise and/or Pharmacological Stress and Stress Echocardiography Final LCD - Effective July 17, 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: L36889
LCD Title: Cardiovascular Stress Testing, Including Exercise and/or Pharmacological Stress and Stress Echocardiography
Effective Date: July 17, 2017
Summary of LCD: Finalization of Draft LCD DL36889 with addition of the following ICD-10 Codes:

- E78.00: Pure hypercholesterolemia, unspecified
- E78.2: Mixed hyperlipidemia
- I25.119: Atherosclerotic heart disease of native coronary artery with unspecified angina pectoris
- I42.9: Cardiomyopathy, unspecified
- I44.7: Left bundle-branch block, unspecified
- I47.1: Supraventricular tachycardia
- I48.91: Atrial fibrillation unspecified
- I48.92: Unspecified atrial flutter
- I49.3: Ventricular premature depolarization (Already included in LCD)
- R00.0: Tachycardia, unspecified
- R00.1: Bradycardia, unspecified
- R00.2: Palpitations
- R06.00: Dyspnea
- R07.9: Chest pain, unspecified
- E10-13.9: Diabetes
- M79.602: Pain in left arm
- M79.601: Pain in right arm
- R68.84: Jaw Pain

Aspects of the LCD that relate to coverage of nuclear imaging and its interpretation and reporting has been expanded in the policy and the addition of Appropriate Use Criteria for Cardiac Radionuclide Imaging has been added as a reference.

To access the Noridian Future Effective 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 “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.
**Chiropractic Services 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:** DL34009  
**LCD Title:** Chiropractic Services  
**Comment period:** June 1 – August 14, 2017

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

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

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

**Diagnostic and Therapeutic Colonoscopy Final LCD – Effective July 17, 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:** L36868  
**LCD Title:** Diagnostic and Therapeutic Colonoscopy  
**Effective Date:** July 17, 2017

**Summary of LCD:** This policy has been updated from the Draft version with the following changes:

- Updated the indications for **diagnostic** and **therapeutic** colonoscopies and when a diagnostic colonoscopy evaluation is not covered in the Coverage Indications, Limitations and/or Medical Necessity section.
- Added the following 2017 ICD-10-CM codes
  - C49.A4 - Gastrointestinal stromal tumor of large intestine  
  - C49.A9 - Gastrointestinal stromal tumor of other sites  
  - K52.21 - Food protein-induced enterocolitis syndrome  
  - K52.22 - Food protein-induced enteropathy  
  - K52.29 - Other allergic and dietetic gastroenteritis and colitis  
  - K52.3 - Indeterminate colitis  
  - K52.831 - Collagenous colitis  
  - K52.832 - Lymphocytic colitis  
  - K52.838 - Other microscopic colitis  
  - K55.031 - Focal (segmental) acute (reversible) ischemia of large intestine  
  - K55.032 - Diffuse acute (reversible) ischemia of large intestine  
  - K55.039 - Acute (reversible) ischemia of large intestine, extent unspecified
K55.041 - Focal (segmental) acute infarction of large intestine
Deleted the following ICD-10-CM codes effective 10/01/2016
K52.2 - Allergic and dietetic gastroenteritis and colitis
K55.0 - Acute vascular disorders of intestine
K59.3 - Megacolon, 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.

**Draft LCDs Published for Review and Comments**

The following draft Local Coverage Determinations (LCDs) will be published for review and comment 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), on the Noridian website and CMS Medicare Coverage Database (MCD) for Open Public Meetings occurring on June 1, 2017. Individual notice articles for each LCD will also be published once the LCDs are publicly viewable.

Individuals wishing to make presentations at the Open Public Meeting must request to do so by May 18th and will find additional information regarding this process at https://med.noridianmedicare.com/web/jfa/policies/lcds/open.

LCDs viewable in the MCD effective May 11, 2017

| DL37342 | Allergy Testing |
| DL34009 | Chiropractic Services |
| DL37283 | Electrocardiograms |
| DL37281 | Lumbar MRI |
| DL34100 | Monitored Anesthesia Care (MAC) |
| DL35175 | MRI and CT Scans of the Head and Neck |
| DL37344 | Noninvasive Extracranial Arterial Studies |
| DL37346 | Transcranial Doppler Studies |
| DL37336 | Noninvasive Physiologic Studies of Upper and Lower Extremity Arteries |
### LCDs viewable in the MCD effective May 18, 2017 (likely sooner under Palmetto Government Services’ contract numbers)

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<td>DL37368</td>
<td>MolDX: Foodborne Gastrointestinal Panels Identified by Multiplex Nucleic Acid Amplification Tests (NAATs)</td>
</tr>
</tbody>
</table>
Duplex Scan of Lower Extremity Arteries 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: DL37340

LCD Title: Duplex Scan of Lower Extremity Arteries

Comment period: June 1, 2017 - August 14, 2017

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

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

- policya.drafts@noridian.com

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

Electrocardiograms 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: DL37283

LCD Title: Electrocardiograms

Comment period: June 1, 2017 – August 14, 2017

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

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

- policya.drafts@noridian.com

Noridian Medicare JF Part A
Attention: Draft LCD Comments
PO Box 6781
Fargo, ND 58103-6781
GlycoMark Testing for Glycemic Control Final LCD - Effective August 1, 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: L36866

LCD Title: GlycoMark Testing for Glycemic Control

Effective Date: August 1, 2017

Summary of LCD: This is a non-coverage policy for the GlycoMark® assay (aka 1,5-anhydroglucitol [1,5-AG]; developed by Nippon Kayaku, Co., Ltd).

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.

Injections - Tendon, Ligament, Ganglion Cyst, Tunnel Syndromes and Morton’s Neuroma Final LCD – Effective May 22, 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: L34076

LCD Title: Injections - Tendon, Ligament, Ganglion Cyst, Tunnel Syndromes and Morton’s Neuroma

Effective Date: May 22, 2017

Summary of LCD: This policy addresses the injection of chemical substances, such as local anesthetics, steroids, sclerosing agents and/or neurolytic agents into ganglion cysts, tendon sheaths, tendon origins/insertions, ligaments or near nerves of the feet (e.g., Morton’s neuroma) to affect therapy for a pathological condition.

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.
Lumbar MRI 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: DL37281

LCD Title: Lumbar MRI

Comment period: June 1, 2017 - August 14, 2017

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

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

- policya.drafts@noridian.com

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

MolDX: AlloSure Donor-Derived Cell-Free DNA Test Draft LCD Published for Review and Comments

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

Medicare Coverage Database Number: DL37358

LCD Title: MolDX: AlloSure Donor-Derived Cell-Free DNA Test

Comment period: June 1, 2017 – August 14, 2017

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

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

- policya.drafts@noridian.com

Noridian Medicare JF Part A
Attention: Draft LCD Comments
PO Box 6781
Fargo, ND 58103-6781
**MolDX – CDD: ProMark Risk Score Final LCD – Effective June 1, 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:** L36706

**LCD Title:** MolDX – CDD: ProMark Risk Score

**Effective Date:** June 01, 2017

**Summary of LCD:** This LCD provides limited coverage for the ProMark (Metamark Genetics) Test to help determine which patients with early stage, needle biopsy proven prostate cancer can be conservatively managed rather than treated with definitive surgery or radiation therapy.

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

Go to [https://med.noridianmedicare.com/web/jfa/policies/lcd/future](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: EndoPredict Breast Cancer Gene Expression Test Draft LCD Published for Review and Comments**

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

**Medicare Coverage Database Number:** DL37311

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

**Comment period:** June 1, 2017 – August 14, 2017

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

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

- policya.drafts@noridian.com

Noridian Medicare JF Part A
Attention: Draft LCD Comments
PO Box 6781
Fargo, ND 58103-6781
Medicare A News Noridian Medicare A Jurisdiction F Issue 2132 July 2017

MolDX: MolDX: Foodborne Gastrointestinal Panels Identified by Multiplex Nucleic Acid Amplification Tests (NAATs) 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: DL37368

LCD Title: MolDX: Foodborne Gastrointestinal Panels Identified by Multiplex Nucleic Acid Amplification Tests (NAATs)

Comment period: June 1, 2017 – August 14, 2017

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

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

- policydraft@noridian.com

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

MolDX: Multiplex Nucleic Acid Amplified Tests for Respiratory Viral Panels 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: DL37315

LCD Title: MolDX: Multiplex Nucleic Acid Amplified Tests for Respiratory Viral Panels

Comment period: June 1, 2017 – August 14, 2017

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

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

- policya.drafts@noridian.com

Noridian Medicare JF Part A
Attention: Draft LCD Comments
PO Box 6781
Fargo, ND 58103-6781
MolDX: Oncotype DX Genomic Prostate Score for Men with Favorable Intermediate Risk Prostate 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: DL37321

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

Comment period: June 1, 2017 – August 14, 2017

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

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

- policya.drafts@noridian.com

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

MolDX: Prometheus IBD sgi Diagnostic Policy 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: DL37313

LCD Title: MolDX: Prometheus IBD sgi Diagnostic Policy

Comment period: June 1, 2017 – August 14, 2017

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

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

- policya.drafts@noridian.com

Noridian Medicare JF Part A
Attention: Draft LCD Comments
PO Box 6781
Fargo, ND 58103-6781
Monitored Anesthesia Care (MAC) 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: DL34100
LCD Title: Monitored Anesthesia Care (MAC)
Comment period: June 1, 2017 – August 14, 2017

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

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

- policya.drafts@noridian.com

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

MRI and CR Scans of the Head, Neck and Brain LCD – R5

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

Medicare Coverage Database (MCD) Number: L35175
LCD Title: MRI and CR Scans of the Head, Neck and Brain
Effective Date: October 1, 2015
Summary of Changes: LCD revised to add the A and D 7th characters to the following ICD-10-CM codes:

- T20.211-Burn of second degree of right ear [any part, except ear drum]
- T20.212-Burn of second degree of left ear [any part, except ear drum]
- T20.22X-Burn of second degree of lip(s)
- T20.23X-Burn of second degree of chin
- T20.24X-Burn of second degree of nose (septum)
- T20.25X-Burn of second degree of scalp [any part]
- T20.26X-Burn of second degree of forehead & cheek
- T20.27X-Burn of second degree of neck
- T20.29X-Burn of second degree of multiple sites of head, face, and neck
- T20.311-Burn of third degree of right ear [any part, except ear drum]
- T20.312-Burn of third degree of left ear [any part, except ear drum]
- T20.32X-Burn of third degree of right ear [any part, except ear drum]
- T20.33X-Burn of third degree of lip(s)
- T20.34X-Burn of third degree of nose (septum)
- T20.35X-Burn of third degree of scalp [any part]
T20.36X- Burn of third degree of forehead & cheek
T20.37X- Burn of third degree of neck
T20.39X- Burn of third degree of multiple sites of head, face, and neck
T20.511- Corrosion of first degree of right ear [any part, except ear drum]
T20.512- Corrosion of first degree of left ear [any part, except ear drum]
T20.52X- Corrosion of first degree of lip(s)
T20.53X- Corrosion of first degree of chin
T20.54X- Corrosion of first degree of nose (septum)
T20.55X- Corrosion of first degree of scalp [any part]
T20.56X- Corrosion of first degree of forehead and cheek
T20.57X- Corrosion of first degree of neck
T20.59X- Corrosion of first degree of multiple sites of head, face, and neck
T20.611- Corrosion of second degree of right ear [any part, except ear drum]
T20.612- Corrosion of second degree of left ear [any part, except ear drum]
T20.62X- Corrosion of second degree of lip(s)
T20.63X- Corrosion of second degree of chin
T20.64X- Corrosion of second degree of nose (septum)
T20.65X- Corrosion of second degree of scalp [any part]
T20.66X- Corrosion of second degree of forehead and cheek
T20.67X- Corrosion of second degree of neck
T20.69X- Corrosion of second degree of multiple sites of head, face, and neck
T20.711- Corrosion of third degree of right ear [any part, except ear drum]
T20.712- Corrosion of third degree of left ear [any part, except ear drum]
T20.72X- Corrosion of third degree of lip(s)
T20.73X- Corrosion of third degree of chin
T20.74X- Corrosion of third degree of nose (septum)
T20.75X- Corrosion of third degree of scalp [any part]
T20.76X- Corrosion of third degree of forehead and cheek
T20.77X- Corrosion of third degree of neck,
T20.79X- Corrosion of third degree of multiple sites of head, face, and neck

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


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

On the “Active LCDs” page, locate the above listed LCD title.

This link will direct you to the locally hosted copy of the Active LCD. You may also view the LCD on the CMS MCD by selecting the appropriate state link at the left of the page and locating the LCD title.
MRI and CT Scans of the Head and Neck 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: DL35175

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

Comment period: June 1, 2017 – August 14, 2017

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

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

- policya.drafts@noridian.com

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

Non-Covered Services LCD – R20

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

Medicare Coverage Database (MCD) Number: L35008

LCD Title: Non-Covered Services

Effective Date: January 18, 2017

Summary of Changes: The following Category III CPT® codes have been removed from the Non-Covered Services LCD, effective January 18, 2017:

0387T – Transcatheter insertion or replacement of permanent leadless pacemaker, ventricular

0388T – Transcatheter removal of permanent leadless pacemaker, ventricular

0389T – Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report, leadless pacemaker system

0390T – Peri-procedural device evaluation (in person) and programming of device system parameters before or after a surgery, procedure or test with analysis, review and report, leadless pacemaker system

0391T – Interrogation device evaluation (in person) with analysis, review and report, includes connection, recording and disconnection per patient encounter, leadless pacemaker system.

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

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

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

On the “Active LCDs” page, locate the above listed LCD title.

This link will direct you to the locally hosted copy of the Active LCD. You may also view the LCD on the CMS MCD by selecting the appropriate state link at the top of the page and locating the LCD title.
Noninvasive Extracranial Arterial Studies 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: DL37344
LCD Title: Noninvasive Extracranial Arterial Studies
Comment period: June 1, 2017 - August 14, 2017

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

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

• policya.drafts@noridian.com

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

Noninvasive Peripheral Venous Studies 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: DL37291
LCD Title: Noninvasive Peripheral Venous Studies
Comment period: June 1, 2017 - August 14, 2017

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

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

• policya.drafts@noridian.com

Noridian Medicare JF Part A
Attention: Draft LCD Comments
PO Box 6781
Fargo, ND 58103-6781
Noninvasive Physiologic Studies of Upper or Lower Extremity Arteries
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: DL37336

LCD Title: Noninvasive Physiologic Studies of Upper or Lower Extremity Arteries

Comment period: June 1, 2017 - August 14, 2017

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

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

- policya.drafts@noridian.com

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

Peripheral Nerve Stimulation 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: DL34360

LCD Title: Peripheral Nerve Stimulation

Comment period: June 1, 2017 – August 14, 2017

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

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

- policya.drafts@noridian.com

Noridian Medicare JF Part A
Attention: Draft LCD Comments
PO Box 6781
Fargo, ND 58103-6781
Polysomnography and Other Sleep Studies Final LCD
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: L34040

LCD Title: Polysomnography and Other Sleep Studies

Effective Date: June 5, 2017

Summary of LCD: Finalization of Draft LCD DL34040 with addition of the following ICD-10 Codes:
F51.3: Sleepwalking (somnambulism)
F51.4: Sleep terrors (night terrors)

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.

Pulmonary Function 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: DL37289

LCD Title: Pulmonary Function Testing

Comment period: June 1, 2017 – August 14, 2017

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

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

Noridian Medicare JF Part A
Attention: Draft LCD Comments
PO Box 6781
Fargo, ND 58103-6781
Respiratory Care (Respiratory Therapy) 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: DL37293

LCD Title: Respiratory Care (Respiratory Therapy)

Comment period: June 1, 2017 – August 14, 2017

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

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

• policya.drafts@noridian.com

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

Transcranial Doppler Studies 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: DL37346

LCD Title: Transcranial Doppler Studies

Comment period: June 1, 2017 - August 14, 2017

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

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

• policya.drafts@noridian.com

Noridian Medicare JF Part A
Attention: Draft LCD Comments
PO Box 6781
Fargo, ND 58103-6781
MLN Connects – April 6, 2017
MLN Connects® for Thursday, April 6, 2017
View this edition as a PDF

News & Announcements
• Clinical Laboratory Data Reporting: Enforcement Discretion
• Open Payments Program Year 2016 Review and Dispute Period Ends May 15
• MIPS Group Web Interface and CAHPS Reporting: Registration Period Open through June 30
• Home Health and LTCH Quality Reporting Program Review and Correct Reports Available
• 2018 Medicare Shared Savings Program: Notice of Intent to Apply Guidance Document Available
• April Quarterly Provider Update Available
• Help Prevent Alcohol Misuse or Abuse

Provider Compliance
• Lumbar Spinal Fusion CMS Provider Minute Video

Claims, Pricers & Codes
• Home Health Services Pre-Claim Review Demonstration Pause

Upcoming Events
• 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
• Hospice Quality Reporting Program: Public Reporting Webinar — April 27

Medicare Learning Network Publications & Multimedia
• Denial of Home Health Payments When Required Patient Assessment Is Not Received: Additional Information MLN Matters® Article — New
• SNF Value-Based Purchasing Call: Audio Recording and Transcript — New
• Dementia Care Call: Audio Recording and Transcript — New
• Reading an Institutional RA Booklet — Revised
• PECOS for Physicians and Non-Physician Practitioners Booklet — Reminder
MLN Connects – April 13, 2017
MLN Connects® for Thursday, April 13, 2017
View this edition as a PDF

News & Announcements
• Accountable Health Communities Model: CMS Selects 32 Participants
• Mapping Medicare Disparities Tool: Identify Disparities in Chronic Disease
• Questions about Medicare Enrollment Revalidation?
• Administrative Simplification: New Fact Sheet and Infographic
• National Healthcare Decisions Day is April 16

Provider Compliance
• Billing for Ambulance Transports

Claims, Pricers & Codes
• April 2017 OPPS Pricer File

Upcoming Events
• 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
• IRF, LTCH, SNF QRP Review and Correct Reports Provider Training Webcast — May 2

Medicare Learning Network Publications & Multimedia
• April 2017 Catalog Available
• Quality Payment Program in 2017: Pick Your Pace Web-Based Training Course — New
• 2017 Medicare Part C and Part D Reporting Requirements and Data Validation Web-Based Training Course — New
• IMPACT Act Call: Audio Recording and Transcript — New
• Educational Resources to Assist Chiropractors with Medicare Billing MLN Matters Article — Revised
• Home Health Prospective Payment System Booklet — Revised
MLN Connects Special Edition – April 14, 2017

CMS Proposes 2018 Payment and Policy Updates for Medicare Hospital Admissions, Releases a Request for Information

Proposed rule seeks transparency, flexibility, program simplification and innovation to transform the Medicare program

On April 14, CMS issued a proposed rule that would update 2018 Medicare payment and polices when patients are admitted into hospitals. The proposed rule aims to relieve regulatory burdens for providers; supports the patient-doctor relationship in health care; and promotes transparency, flexibility, and innovation in the delivery of care.

“Through this proposed rule we want to reduce burdens for hospitals so they can focus on providing high quality care for patients,” said CMS Administrator Seema Verma. “Medicare is better able to support the work of dedicated hospitals and clinicians who provide the care that people need with these more flexible and simplified approaches.”

CMS is committed to transforming the health care delivery system – and the Medicare program – by putting a strong focus on patient-centered care, so providers can direct their time and resources to patients and improve outcomes. In addition to the payment and policy proposals, CMS is releasing a Request for Information to solicit ideas for regulatory, policy, practice and procedural changes to better achieve transparency, flexibility, program simplification and innovation. This will inform the discussion on future regulatory action related to inpatient and long-term hospitals.

In relieving providers of administrative burdens and encouraging patient choice, CMS is proposing:

- a one year regulatory moratorium on the payment policy threshold for patient admissions in long-term care hospitals while CMS continues to evaluate long-term care hospital policies
- to reduce clinical quality measure reporting requirements for hospitals that have implemented electronic health records

Due to the combination of proposed payment rate increases and other proposed policies and payment adjustments, CMS projects that hospitals would see a total increase in inpatient operating prospective payments of 2.9 percent in fiscal year 2018. CMS also projects that, based on the changes included in the proposed rule, payments to long-term care hospitals would decrease by approximately 3.75 percent in fiscal year 2018.

For More Information:

- Full text of this excerpted CMS press release (issued April 14)
- CMS fact sheet
MLN Connects – April 20, 2017
MLN Connects® for Thursday, April 20, 2017
View this edition as a PDF

News & Announcements
• 2018 Medicare Shared Savings Program: Submit Notice of Intent to Apply May 1 through 31
• IRF/LTCH/SNF QRP Data Due May 15
• Rural Community Hospital Demonstration: Submit Applications by May 17
• New Quality Payment Program Resources Available
• Revised CMS-588: Electronic Funds Transfer Authorization Agreement
• SNF QRP Quick Reference Guide Now Available
• Beneficiary Notice Initiative: New Email Address for Questions
• April is National Minority Health Month

Provider Compliance
• Psychiatry and Psychotherapy CMS Provider Minute Video

Upcoming Events
• Global Surgery: Required Data Reporting for Post-Operative Care Call — April 25
• Emergency Preparedness Requirements Final Rule Training Call — April 27
• IRF, LTCH, SNF QRP Review and Correct Reports Provider Training Webcast — May 2

Medicare Learning Network Publications & Multimedia
• Medicare Shared Savings Program Call: Audio Recording and Transcript — New
• Provider Compliance Products Fact Sheet — Revised
• Provider Compliance Tips for Spinal Orthoses Fact Sheet — Revised
• SNF Billing Reference Booklet — Revised
MLN Connects – April 27, 2017

MLN Connects® for Thursday, April 27, 2017

View this edition as a PDF

News & Announcements
• Clinicians: MIPS Participation Status Letter
• Open Payments Program Year 2016 Review and Dispute Period Ends May 15
• EHR Incentive Programs: Submit Comments on Proposed Changes by June 13
• IMPACT Act Data Elements Public Comments Due June 26
• IRF Quality Reporting Program Review and Correct Reports Available
• Quality Payment Program: New Videos for Small, Rural, and Underserved Practices
• EHR Incentive Programs: Public Health Agency and Clinical Data Registry Reporting
• Updated Advance Beneficiary Notice
• Antipsychotic Drug use in Nursing Homes: Trend Update
• April is STD Awareness Month: Talk, Test, Treat

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

Upcoming Events
• IRF, LTCH, SNF QRP Review and Correct Reports Provider Training Webcast — May 2
• Comparative Billing Report on Transitional Care Management Webinar — June 21

Claims, Pricers & Codes
• Hospitals and SNFs: Claims Hold Related to VA Claims

Medicare Learning Network Publications & Multimedia
• Next Generation ACO – All Inclusive Population Based Payment Implementation MLN Matters Article — New
• Open Payments Call: Audio Recording and Transcript — New
• Medicare Home Health Benefit Web-Based Training Course — Revised
• Diagnosis Coding: Using the ICD-10-CM Web-Based Training Course — Revised
• Guidelines for Teaching Physicians, Interns, and Residents Fact Sheet — Revised
• PECOS FAQs Booklet — Reminder
MLN Connects Special Edition – Friday, April 28, 2017

In This Edition:
1. Skilled Nursing Facilities: Proposed FY 2018 Payment and Policy Changes
2. Inpatient Rehabilitation Facilities: Proposed FY 2018 Payment and Policy Changes
3. Medicare Hospice Benefit: Proposed FY 2018 Updates to the Wage Index and Payment Rates

Skilled Nursing Facilities: Proposed FY 2018 Payment and Policy Changes
CMS issued a proposed rule (CMS-1679-P) outlining proposed FY 2018 Medicare payment rates and quality programs for Skilled Nursing Facilities (SNFs). Additionally, CMS released an Advance Notice of Proposed Rulemaking (CMS-1686-ANPRM), which solicits comment on potential revisions to the SNF payment system, based on research conducted under the SNF Payment Models Research project.

Proposed Rule Details:
• Changes to payment rates under the SNF Prospective Payment System (PPS)
• SNF Quality Reporting Program
• SNF Value-Based Purchasing (VBP) Program
• End-Stage Renal Disease Quality Incentive Program
• Request for Information
• Survey team composition

For More Information:
• Proposed Rule: CMS will accept comments until June 26
• Advanced Notice of Proposed Rulemaking: CMS will accept comments until June 26
• SNF PPS Payment Model Research webpage
• SNF PPS website
• SNF QRP website
• SNF VBP Program website

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

Inpatient Rehabilitation Facilities: Proposed FY 2018 Payment and Policy Changes
CMS issued a proposed rule (CMS-1671-P) outlining proposed FY 2018 Medicare payment policies and rates for the Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) and the IRF Quality Reporting Program (QRP). In addition to the proposed rule, CMS is releasing a Request for Information to welcome continued feedback on the Medicare Program.

Proposed Rule Details:
• Proposed updates to IRF payment rates
• Proposed removal of 25 percent payment penalty for late transmissions of the IRF- Patient Assessment Instrument
• Proposed refinements to the 60 percent rule presumptive methodology
• Solicitation of comments regarding the criteria used to classify facilities for payment under the IRF PPS
• Proposed technical IRF process revisions
• Proposed changes to the IRF QRP

For More Information:
• Proposed Rule: CMS will accept comments until June 26

See the full text of this excerpted CMS Fact Sheet (issued April 27).
Medicare Hospice Benefit: Proposed FY 2018 Updates to the Wage Index and Payment Rates
CMS issued a proposed rule (CMS-1675-P) that would update FY 2018 Medicare payment rates and the wage index for hospices serving Medicare beneficiaries and releases Request for Information within the proposed rule. This proposed rule would update the hospice wage index, payment rates, and cap amount for FY 2018.

Proposed Rule Details:

• Routine annual rate setting changes
• Discussion and solicitation of comments regarding sources of clinical information for certifying terminal illness
• Hospice CAHPS® Experience of Care Survey
• Quality measure concepts under consideration for future years
• New data collection mechanisms under consideration: Hospice Evaluation & Assessment Reporting Tool (HEART)
• Public reporting

For More Information:

• Proposed rule: CMS will accept comments until June 26
• Hospice Center webpage

See the full text of this excerpted CMS Fact Sheet (issued April 27).
MLN Connects – May 4, 2017
MLN Connects® for Thursday, May 4, 2017
View this edition as a PDF

News & Announcements
• DMEPOS Revised Blended Fee Schedule Amounts
• TEP on SNF QRP Development and Maintenance of Quality Measures: Nominations due May 12
• 2018 Medicare Shared Savings Program: Submit Notice of Intent to Apply by May 31
• MIPS: Submit Measures for the Advancing Care Information Performance Category by June 30
• Hospice Item Set V2.00.0 Receives OMB Approval
• EHR Incentive Programs: Review 2017 Program Requirements
• Hand Hygiene Day is May 5

Provider Compliance
• Cochlear Devices Replaced Without Cost: Bill Correctly

Upcoming Events
• MIPS Group Reporting 101 Webinar — May 11

Medicare Learning Network Publications & Multimedia
• Medicare Shared Savings Program Call: Audio Recording and Transcript — New
• Medicare Fraud & Abuse: Prevention, Detection, and Reporting Web-Based Training Course — Revised
• Medicare Ambulance Transports Booklet — Revised
• Looking for the Latest National Medicare Policy Information?

MLN Connects – May 11, 2017
MLN Connects® for Thursday May 11, 2017
View this edition as a PDF

News & Announcements
• Open Payments Program Year 2016 Review and Dispute Period Ends May 15
• 2018 Medicare Shared Savings Program: Submit Notice of Intent to Apply by May 31
• Lookup Tool to Help Determine MIPS Participation Status
• Updated CY 2018 eCQM Specifications Available
• New PEPPERs Available for Hospices, SNFs, IRFs, IPFs, CAHs, LTCHs
• Requesting Appeal Redeterminations
• National Women’s Health Week Kicks off on Mother’s Day

Provider Compliance
• CMS Provider Minute Video: Coudé Tip Catheters

Medicare Learning Network Publications & Multimedia
• Global Surgery Call: Audio Recording and Transcript — New
• Emergency Preparedness Call: Audio Recording and Transcript — New
• Resources for Medicare Beneficiaries Booklet — Revised
• SNF Billing Reference Booklet — Revised
• Dual Eligible Beneficiaries under Medicare and Medicaid Booklet — Revised
MLN Connects – May 18, 2017
MLN Connects® for Thursday, May 18, 2017
View this edition as a PDF

News & Announcements
- Clinical Laboratories: Lab Data Due May 30
- SNF Quality Reporting Program: Submission Deadline Extended to June 1
- National Mental Health Awareness Month 2017

Provider Compliance
- Reporting Changes in Ownership

Claims, Pricers & Codes
- 2018 ICD-10-PCS Files Available

Upcoming Events
- Quality Payment Program Participation Criteria Webinar — May 22
- National Partnership to Improve Dementia Care and QAPI Call — June 15

Medicare Learning Network Publications & Multimedia
- Updated Manual Guidelines for Electronic Funds Transfer Payments and Change of Ownership MLN Matters Article — New
- Prohibition on Billing Dually Eligible Individuals Enrolled in the QMB Program MLN Matters Article — Revised
- Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians Web-Based Training Course — Reminder

MLN Connects – May 25, 2017
MLN Connects® for Thursday, May 25, 2017
View this edition as a PDF

News & Announcements
- Social Security Number Removal Initiative Reminder: Get Your Systems Ready
- 2018 Medicare Shared Savings Program: Submit Notice of Intent to Apply by May 31
- Quality Payment Program: Technical Assistance Resource Guide Available
- SNF QRP Quality Measure User’s Manual
- Administrative Simplification: Get the Basics
- May is National Osteoporosis Month

Provider Compliance
- Advanced Life Support Ambulance Services: Insufficient Documentation

Upcoming Events
- National Partnership to Improve Dementia Care and QAPI Call — June 15
- CLIA Certificate of Provider-performed Microscopy Webcast — June 28
- CBR on Anesthesia Services for Lower Endoscopic Procedures Webinar — July 12

Medicare Learning Network Publications & Multimedia
- ABCs of the Initial Preventive Physical Examination Educational Tool — Revised
MLN Connects – June 1, 2017
MLN Connects® for Thursday, June 1, 2017
View this edition as a PDF

News & Announcements
• New Medicare Cards Offer Greater Protection to More Than 57.7 Million Americans
• EHR Incentive Programs: Submit Comments on Proposed Changes by June 13
• New Quality Payment Program Resources Available
• Review 2017 EHR Incentive Program Requirements
• CY 2017 eCQM Resources and Tools

Provider Compliance
• Automatic External Defibrillators: Inadequate Medical Record Documentation

Claims, Pricers & Codes
• Hospices: Submit Adjustments to Correct Payment Errors

Upcoming Events
• National Partnership to Improve Dementia Care and QAPI Call — June 15
• CLIA Certificate of Provider-performed Microscopy Webcast — June 28
• Improvements to the Medicare Claims Appeal Process and Statistical Sampling Call — June 29

Medicare Learning Network Publications & Multimedia
• Required Workaround for Hospices Submitting RHC and SIA Payments at the End of Life MLN Matters Article — New
• SBIRT Services Booklet — Revised
• Medicare Basics: Parts A and B Claims Overview Video — Reminder
• Medicare Fraud & Abuse: Prevention, Detection, and Reporting Booklet — Reminder

MLN Connects – June 8, 2017
MLN Connects® for Thursday, June 8, 2017
View this edition as a PDF

News & Announcements
• Hospitals and SNFS: Reduce Legionella Risk in Water Systems
• Predictive Qualifying APM Participant Status Announced
• Hospices: Review First Provider Preview Reports by June 30
• IRFs & LTCHs: Review QRP Provider Preview Reports by June 30
• IRF and LTCH Compare Quarterly Refresh
• PEPPER for Short-term Acute Care Hospitals Available
• Quality Payment Program Resources Available
• ONC eMeasurement and Quality Improvement Webinar: Recording Available
• Proposed Revisions to Long-Term Care Facilities’ Arbitration Agreements
• World No Tobacco Day
Provider Compliance
- Duplicate Claims Will Not be Paid

Claims, Pricers & Codes
- July 2017 Average Sales Price Files Available

Upcoming Events
- National Partnership to Improve Dementia Care and QAPI Call — June 15
- CLIA Certificate of Provider-performed Microscopy Webcast — June 28
- Improvements to the Medicare Claims Appeal Process and Statistical Sampling Call — June 29

Medicare Learning Network Publications & Multimedia
- Quality Payment Program Overview Web-Based Training Course — New
- Scheduled End of the Intravenous Immune Globulin Demonstration MLN Matters® Article — New
- Avoiding Medicare Fraud and Abuse: A Roadmap for Physicians Booklet — Reminder
- Medicare Secondary Payer Booklet — Reminder

MLN Connects – June 15, 2017

MLN Connects® for Thursday, June 15, 2017

News & Announcements
- MIPS Group Reporting: Registration Period Ends June 30
- MIPS Performance Categories: Accepting Future Measures and Activities until June 30
- Chronic Care Management Services: New Connected Care Materials
- National Men’s Health Week 2017
- County by County Analysis of Current Projected Insurer Participation in Health Insurance Exchanges

Provider Compliance
- CMS Provider Minute: CT Scans Video

Claims, Pricers & Codes
- 2018 ICD-10-CM Code Files Available

Upcoming Events
- IMPACT Act Special Open Door Forum — June 20
- CLIA Certificate of Provider-performed Microscopy Webcast — June 28
- Diagnosis and Treatment of Parkinson’s Disease Webinar — June 28
- Improvements to the Medicare Claims Appeal Process and Statistical Sampling Call — June 29

Medicare Learning Network Publications & Multimedia
- Guidance to Providers that Submit Outpatient Facility Claims and Those That Enter Claims Data via DDE Screens to Reduce Incidence of Claims Not Crossing Over MLN Matters® Article — New
MLN Connects – June 22, 2017

MLN Connects® for Thursday, June 22, 2017

View this edition as a PDF

News & Announcements

• CMS Proposes Quality Payment Program Updates to Increase Flexibility and Reduce Burdens
• Coming in April 2018: New Medicare Card – New Number
• Quality Payment Program: New Resources Available
• Quality Payment Program: View Recordings of Recent Webinars
• Quality Measure Development Plan Annual Report
• SNF QRP Review and Correct Reports Available
• 2015 Physician and Other Supplier Utilization and Payment Data
• 2015 Referring DMEPOS Utilization and Payment Data
• Hospice QRP: Clarifying Coding Guidance for Hospice Item Set
• IRFs & LTCHs: Reminder to Review QRP Provider Preview Reports by June 30
• Hospices: Reminder to Review Provider Preview Reports by June 30
• Minority Research Grant Program: Apply by July 10

Provider Compliance

• Hospice Election Statements Lack Required Information or Have Other Vulnerabilities

Upcoming Events

• CLIA Certificate of Provider-performed Microscopy Webcast — June 28
• Improvements to the Medicare Claims Appeal Process and Statistical Sampling Call — June 29
• Quality Payment Program Year 2 Proposed Rule Listening Session — July 5
• Creating and Verifying Your National Provider Identifier Call — July 12

Medicare Learning Network Publications & Multimedia

• Provider Enrollment Revalidation – Cycle 2 MLN Matters Article — Revised
• Complying with Medical Record Documentation Requirements — Revised
MLN Connects – June 29, 2017
MLN Connects® for Thursday, June 29, 2017
View this edition as a PDF

News & Announcements
• New Medicare Number: Prepare Your Systems for April 2018
• DMEPOS: Payment for Group 3 Complex Rehabilitative Power Wheelchair Accessories Effective July 1
• Quarterly Provider Update

Provider Compliance
• Evaluation and Management: Correct Coding

Upcoming Events
• Quality Payment Program Year 2 Proposed Rule Listening Session — July 5
• DMEPOS Prior Authorization Special Open Door Forum – July 6
• ESRD QIP: Reviewing Your Facility’s PY 2018 Performance Data — July 10
• Creating and Verifying Your National Provider Identifier Call — July 12

Medicare Learning Network Publications & Multimedia
• Behavioral Health Integration Services Fact Sheet — New
• Evaluation and Management Services Web-Based Training Course — New
• Dementia Care Call: Audio Recording and Transcript — New
• Medical Privacy of Protected Health Information Fact Sheet — Revised
• Medicare Basics: Commonly Used Acronyms Educational Tool — Revised
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 new users each time you log in. 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 is taking a “phased” approach which will ensure all NMP users are in compliance before the September 30, 2017 deadline.

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 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.

When this change will affect you:

New users registering on or after April 1, 2017:
For new users registering for an NMP account on or after April 1, 2017, enrolling in MFA will no longer be an option, but part of the normal registration process. You will be prompted to set up your MFA verifications, and each time you log in you will be sent a one-time passcode to use.

Current NMP users:
If you are a current NMP user, you can continue to log in as per usual. As part of our “phased” approach, you will receive an email one week in advance, informing you of the date you will be required to use MFA with each login. On the date noted in that email, NMP will prompt you to set up your MFA verifications and each time you log in you will be sent a one-time passcode to use.

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
New Process for Providers and Suppliers Submitting Redeterminations and Reopenings via NMP - Effective June 16, 2017

Noridian has added a feature to the Noridian Medicare Portal (NMP). Providers and suppliers who submit their Redetermination and/or Reopening requests through NMP will now receive the Level 1 Medicare Redetermination Notices (MRNs) via NMP.

If a Redetermination or Reopening outcome results in a fully favorable (payable) determination, the Remittance Advice (RA) and Direct Data Entry (DDE) will continue as the method of communication. For all other decisions, in which providers had received an MRN, the determination letter will now be available through the Appeal Status Inquiry feature in NMP only.

This enhancement allows providers and suppliers, who submit such requests through NMP, the ability to print the determination letter and obtain their MRNs quickly and efficiently.

Because MRNs will no longer be mailed, please ensure that the appropriate staff is registered as an NMP user.

Noridian encourages the submission of electronic Reopening and Redetermination requests and all supporting documentation (10MB per file; unlimited file submission per claim) via NMP. This submission method ensures that the requests contain all required information, including the signature on Redetermination requests.
Outlier Limitation on OPPS CMHC Services

MLN Matters® Number: MM9671
Related Change Request (CR) #: CR 9671
Related CR Release Date: August 5, 2016
Effective Date: January 1, 2017
Related CR Transmittal #: R1705OTN
Implementation Date: January 3, 2017

Provider Types Affected
This MLN Matters® Article is intended for Community Mental Health Centers (CMHCs) submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed
Change Request (CR) 9671 instructs Medicare shared systems maintainers and MACs to implement an Outlier Limitation on Outpatient Prospective Payment System (OPPS) CMHC Services. Make sure that your billing staffs are aware of these changes.

Background
In the 2017 OPPS final rule, the Centers for Medicare & Medicaid Services (CMS) finalized a limitation on outlier payments for CMHC services under the OPPS. Under these requirements, Medicare systems accumulate a calendar year-to-date total during claims processing, for each CMHC provider, the overall total payments the CMHC provider has received and the total of outlier payments they have received. The total payment amount includes any outlier payments. These totals are then compared to determine whether a CMHC provider has been paid 8 percent of their total payments for the calendar year-to-date in outliers. Thus, an individual CMHC provider will receive no more than 8 percent of its total CMHC OPPS payments in outlier payments. To make the outlier limitation more transparent to providers, a detail file of outlier payments will be created that each CMHC provider may review for the purpose of monitoring their payments accrued toward the outlier limitation.

MACs will use claim adjustment reason code 273 along with group code CO, rather than code 45, on the remittance advice of CMHC claims with dates of service on or after January 1, 2017, when an outlier amount is calculated but cannot be paid as a result of this rule. Also, MACs will use Remittance Advice Remark Code N523 in addition to Claim Adjustment Reason Code 273 along with group code CO on the remittance advice of CMHC claims with dates of service on or after January 1, 2017, when an outlier amount is calculated but cannot be paid.

Additional Information

Remittance Advice Messaging for the 20 Hour Weekly Minimum for Partial Hospitalization Program Services

MLN Matters® Number: MM9880
Related Change Request (CR) #: CR 9880
Related CR Release Date: April 28, 2017
Effective Date: October 1, 2017
Related CR Transmittal #: R1833OTN
Implementation Date: October 2, 2017

Provider Types Affected
This MLN Matters® Article is intended for Outpatient Prospective Payment System (OPPS) providers submitting Partial Hospitalization Program (PHP) claims to Medicare Administrative Contractors (MACs) for PHP services provided to Medicare beneficiaries.

What You Need to Know
Change Request (CR) 9880 implements informational messaging, effective October 1, 2017, that conveys supplemental and educational information to the provider submitting claims for PHP services where the patient did not receive the minimum 20 hours per week of therapeutic services his plan of care indicates is required, on claims with line item date of service (LIDOS) on or after October 1, 2017. When the minimum 20 hours per week care is not provided, MACs will return Remittance Advice Remarks Code N787 - “Alert: An eligible PHP beneficiary requires a minimum of 20 hours of PHP services per week, as evidenced in the plan of care. PHP services must be furnished in accordance with the plan of care.”

Background
Partial hospitalization services are intensive outpatient services provided in lieu of inpatient hospitalization for mental health conditions. The regulation at 42 CFR 410.43(c)(1) states that PHPs are intended for patients who require a minimum of 20 hours per week of therapeutic services as evidenced in their plan of care. Additionally, the regulation at 42 CFR 410.43(a)(3) requires that PHP services are services that are furnished in accordance with a physician certification and plan of care as specified under 42 CFR 424.24(e).

Additional Information

Hospital OPPS July 2017 Update
MLN Matters Number: MM10122
Related Change Request (CR) Number: 10122
Related CR Release Date: May 30, 2017
Effective Date: July 1, 2017
Related CR Transmittal Number: R3783CP
Implementation Date: July 3, 2017

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

Provider Action Needed
This article is based on Change Request (CR) 10122 which describes changes to the OPPS to be implemented in the July 2017 update. Make sure your billing staffs are aware of these changes.
Background

Key changes to and billing instructions for various payment policies implemented in the July 2017 Outpatient Prospective Payment System (OPPS) updates are as follows:

Category III CPT Codes Effective July 1, 2017
The American Medical Association (AMA) releases Category III Current Procedural Terminology (CPT) codes twice per year: in January, for implementation beginning the following July, and in July, for implementation beginning the following January.

For the July 2017 update, the CMS is implementing 10 Category III CPT codes that the AMA released in January 2017 for implementation on July 1, 2017. The Status Indicators (SI) and APC assignments for these codes are shown below in Table 1. Payment rates for these services are available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html.

Table 1 - Category III CPT Codes Effective July 1, 2017

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Long Descriptor</th>
<th>July 2017 OPPS SI</th>
<th>July 2017 OPPS APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>0469T</td>
<td>Retinal polarization scan, ocular screening with on-site automated results, bilateral</td>
<td>E1</td>
<td>N/A</td>
</tr>
<tr>
<td>0470T</td>
<td>Optical coherence tomography (OCT) for microstructural and morphological imaging of skin, image acquisition, interpretation, and report; first lesion</td>
<td>M</td>
<td>N/A</td>
</tr>
<tr>
<td>0471T</td>
<td>Optical coherence tomography (OCT) for microstructural and morphological imaging of skin, image acquisition, interpretation, and report; each additional lesion (List separately in addition to code for primary procedure)</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>0472T</td>
<td>Device evaluation, interrogation, and initial programming of intra-ocular retinal electrode array (eg, retinal prosthesis), in person, with iterative adjustment of the implantable device to test functionality, select optimal permanent programmed values with analysis, including visual training, with review and report by a qualified health care professional</td>
<td>Q1</td>
<td>5743</td>
</tr>
<tr>
<td>0473T</td>
<td>Device evaluation and interrogation of intra-ocular retinal electrode array (eg, retinal prosthesis), in person, including reprogramming and visual training, when performed, with review and report by a qualified health care professional</td>
<td>Q1</td>
<td>5742</td>
</tr>
<tr>
<td>0474T*</td>
<td>Insertion of anterior segment aqueous drainage device, with creation of intraocular reservoir, internal approach, into the supraciliary space</td>
<td>J1</td>
<td>5492</td>
</tr>
<tr>
<td>0475T</td>
<td>Recording of fetal magnetic cardiac signal using at least 3 channels; patient recording and storage, data scanning with signal extraction, technical analysis and result, as well as supervision, review, and interpretation of report by a physician or other qualified health care professional</td>
<td>M</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Recording of fetal magnetic cardiac signal using at least 3 channels; patient recording, data scanning, with raw electronic signal transfer of data and storage

Recording of fetal magnetic cardiac signal using at least 3 channels; signal extraction, technical analysis, and result

Recording of fetal magnetic cardiac signal using at least 3 channels; review, interpretation, report by physician or other qualified health care professional

*For the device offset amount associated with this CPT code, refer to the discussion on device offset.

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

The AMA CPT Editorial Panel established two additional PLA CPT codes, specifically, CPT codes 0004U and 0005U effective May 1, 2017. The long descriptors for the codes are listed below in Table 2. Because the codes were effective May 1, 2017, they were not included in the April 2017 OPPS Update and are instead being included in the July Update with an effective date of May 1, 2017.

Under the hospital OPPS, CPT code 0004U is assigned to status indicator “A” and CPT code 0005U to status indicator “Q4” (Conditionally packaged laboratory tests). For more information on OPPS SI “A” and “Q4”, refer to OPPS Addendum D1 of the CY 2017 OPPS/ASC final rule for the latest definitions to the OPPS status indicators for CY 2017.

CPT codes 0004U and 0005U have been added to the July 2017 I/OCE with an effective date of May 1, 2017. These codes, along with their short descriptors and status indicators, are in the July 2017 Addendum B at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Long Descriptor</th>
<th>OPPS SI</th>
</tr>
</thead>
<tbody>
<tr>
<td>0004U</td>
<td>Infectious disease (bacterial), DNA, 27 resistance genes, PCR amplification and probe hybridization in microarray format (molecular detection and identification of AmpC, carbapenemase and ESBL coding genes), bacterial culture colonies, report of genes detected or not detected, per isolate</td>
<td>A</td>
</tr>
<tr>
<td>0005U</td>
<td>Oncology (prostate) gene expression profile by real-time RT-PCR of 3 genes (ERG, PCA3, and SPDEF), urine, algorithm reported as risk score</td>
<td>Q4</td>
</tr>
</tbody>
</table>

New Separately Payable Procedure Codes

Effective July 1, 2017, three new HCPCS codes, C9745, C9746, and C9747 have been created as described in the Table 3.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>C9745</td>
<td>Nasal endo balloon dil</td>
<td>Nasal endoscopy, surgical; balloon dilation of eustachian tube</td>
<td>J1</td>
<td>5165</td>
<td>J8</td>
</tr>
<tr>
<td>C9746</td>
<td>Trans imp balloon cont</td>
<td>Transperineal implantation of permanent adjustable balloon continence device, with cystourethroscopy, when performed and/or fluoroscopy, when performed</td>
<td>J1</td>
<td>5377</td>
<td>J8</td>
</tr>
</tbody>
</table>
New Procedures Requiring the Insertion of a Device

As described in the CY 2017 OPPS/ASC final rule with comment period, effective January 1, 2017, all new procedures requiring the insertion of an implantable medical device will generally be assigned a default device offset percentage of 41 percent and assigned device intensive status, until claims data become available. In certain rare instances, CMS may temporarily assign a higher offset percentage if warranted by additional information. In accordance with this policy, the following new code(s) requiring the insertion of a device (listed Table 4) will be assigned device intensive status.

Table 4 - New Device Intensive Procedures Effective July 1, 2017

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
<th>Effective Date</th>
<th>July 2017 OPPS</th>
<th>July 2017 OPPS</th>
<th>CY 2017 OPPS Payment Rate</th>
<th>CY 2017 Device Offset</th>
</tr>
</thead>
<tbody>
<tr>
<td>0474T</td>
<td>Insertion of anterior segment aqueous drainage device, with creation of intraocular reservoir, internal approach, into the supraciliary space</td>
<td>7-01-2017</td>
<td>J1</td>
<td>5492</td>
<td>$3,418.76</td>
<td>$1,401.69</td>
</tr>
<tr>
<td>C9745</td>
<td>Nasal endoscopy, surgical; balloon dilation of eustachian tube</td>
<td>7-01-2017</td>
<td>J1</td>
<td>5165</td>
<td>$4,130.94</td>
<td>$1,693.69</td>
</tr>
<tr>
<td>C9746</td>
<td>Transperineal implantation of permanent adjustable balloon continence device, with cystourethroscopy, when performed and/or fluoroscopy, when performed</td>
<td>7-01-2017</td>
<td>J1</td>
<td>5377</td>
<td>$14,363.61</td>
<td>$5,889.08</td>
</tr>
</tbody>
</table>

New HCPCS Code for Pathogen Testing for Blood Platelets

For the July 2017 update, the HCPCS Workgroup inactivated HCPCS P9072 for Medicare reporting and replaced the code with two new HCPCS codes effective July 1, 2017. Specifically, to report either of the services described by HCPCS P9072 based on the code descriptor in effect for January 1, 2017 – June 30, 2017, providers must instead report either HCPCS code Q9988 (Platelets, pathogen reduced, each unit) or Q9987 (Pathogen(s) test for platelets) effective July 1, 2017. CMS notes that HCPCS code Q9987 should be reported to describe the test used for the detection of bacterial contamination in platelets as well as any other test that may be used to detect pathogen contamination. The coding changes associated with these codes are available at [https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update.html](https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update.html) effective July 2017. The payment rates for HCPCS codes Q9987 and Q9988 are available at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html). Also, see Table 5 below.
Table 5 – Blood Platelet Coding Changes Effective July 1, 2017

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>July 2017 OPPS SI</th>
<th>July 2017 OPPS APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>P9072</td>
<td>Plate path red/rapid bac tes</td>
<td>Platelets, pheresis, pathogen reduced or rapid bacterial tested, each unit</td>
<td>E1</td>
<td>N/A</td>
</tr>
<tr>
<td>Q9987</td>
<td>Pathogen test for platelets</td>
<td>Pathogen(s) test for platelets</td>
<td>S</td>
<td>1493</td>
</tr>
<tr>
<td>Q9988</td>
<td>Platelets, pathogen reduced</td>
<td>Platelets, pathogen reduced, each unit</td>
<td>R</td>
<td>9536</td>
</tr>
</tbody>
</table>

Drugs, Biologicals, and Radiopharmaceuticals

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

For CY 2017, payment for non-pass-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 costs of these pass-through items. Payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. Updated payment rates effective July 1, 2017 are available at http://www.cms.gov/HospitalOutpatientPPS/.

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

Some drugs and biologicals based on ASP methodology will have payment rates that are corrected retroactively. These retroactive corrections typically occur on a quarterly basis. The list of drugs and biologicals with corrected payments rates will be accessible 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.

C. Drugs and Biologicals with OPPS Pass-Through Status Effective July 1, 2017

Two drugs and biologicals have been granted OPPS pass-through status effective July 1, 2017. These items, along with their descriptors and APC assignments, are in Table 6 below.

Table 6 - Drugs and Biologicals with OPPS Pass-Through Status Effective July 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>C9489</td>
<td>Injection, nusinersen, 0.1 mg</td>
<td>9489</td>
<td>G</td>
</tr>
<tr>
<td>C9490</td>
<td>Injection, bezlotoxumab, 10 mg</td>
<td>9490</td>
<td>G</td>
</tr>
</tbody>
</table>

D. New Drug HCPCS Codes Effective July 1, 2017

Effective July 1, 2017, three 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 7.
Table 7 - New Drug HCPCS Codes Effective July 1, 2017

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
<th>Status Indicator</th>
<th>APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q9984</td>
<td>Levonorgestrel-releasing intrauterine contraceptive system (Kyleena), 19.5 mg</td>
<td>E1</td>
<td>N/A</td>
</tr>
<tr>
<td>Q9985</td>
<td>Injection, hydroxyprogesterone caproate, not otherwise specified, 10 mg</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>Q9986</td>
<td>Injection, hydroxyprogesterone caproate (Makena), 10 mg</td>
<td>K</td>
<td>9074</td>
</tr>
</tbody>
</table>

E. Changes to Status Indicator for CPT Code 90682

The influenza vaccine associated with CPT code 90682 (Influenza virus vaccine, quadrivalent (riv4), derived from recombinant DNA, hemagglutinin (ha) protein only, preservative and antibiotic free, for intramuscular use) is approved for use in the 2017-2018 flu season. (This is per CR9876; see related MLN Matters Article MM9876 at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9876.pdf.) CPT code 90682 was added to the January 2017 I/OCE with an effective date of January 1, 2017 and assigned status indicator “L” (Not paid under OPPS. Paid at reasonable cost; not subject to deductible or coinsurance). Because this code is not payable until the start of the 2017 flu season, the status indicator will be retroactively corrected from SI=L to SI=E1 (Not paid by Medicare when submitted on outpatient claims [any outpatient bill type]) effective January 1, 2017, through June 30, 2017. Effective July 1, 2017, CPT code 90682 is assigned SI=L. Table 8, below, describes the status indicator change and effective date.

Table 8 - Changes to Status Indicator for HCPCS Code 90682

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Long Descriptor</th>
<th>Status Indicator</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>90682</td>
<td>(Influenza virus vaccine, quadrivalent (riv4), derived from recombinant dna, hemagglutinin (ha) protein only, preservative and antibiotic free, for intramuscular use)</td>
<td>E1</td>
<td>January 1, 2017 – June 30, 2017</td>
</tr>
<tr>
<td>90682</td>
<td>(Influenza virus vaccine, quadrivalent (riv4), derived from recombinant dna, hemagglutinin (ha) protein only, preservative and antibiotic free, for intramuscular use)</td>
<td>L</td>
<td>July 1, 2017</td>
</tr>
</tbody>
</table>

F. Revised Status Indicator for HCPCS Code J1725

For the July 2017 update, the HCPCS Workgroup inactivated HCPCS code J1725 for Medicare reporting and replaced it with HCPCS code Q9986. Therefore, effective July 1, 2017, the status indicator for HCPCS code J1725 (Injection, hydroxyprogesterone caproate, 1 mg) will change from SI=K (Paid under OPPS; separate APC payment) to SI=E1 (Not paid by Medicare when submitted on outpatient claims [any outpatient bill type]). Table 9, below, describes the status indicator change and effective date for HCPCS code J1725. The payment rates for HCPCS codes Q9986 are available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html.

Table 9 - Revised Status Indicator for HCPCS Code J1725

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Long Descriptor</th>
<th>Status Indicator</th>
<th>Effective Date</th>
<th>Termination Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>J1725</td>
<td>Injection, hydroxyprogesterone caproate, 1 mg</td>
<td>K</td>
<td>01/01/2012</td>
<td>06/30/2017</td>
</tr>
<tr>
<td>J1725</td>
<td>Injection, hydroxyprogesterone caproate, 1 mg</td>
<td>E1</td>
<td>07/01/2017</td>
<td></td>
</tr>
</tbody>
</table>

G. Other Changes to CY 2017 HCPCS Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals

Effective July 1, 2017, HCPCS code Q9989 (Ustekinumab, for Intravenous Injection, 1 mg) will replace
HCPCS code C9487 (Ustekinumab, for Intravenous Injection, 1 mg). The status indicator will remain G, “Pass-Through Drugs and Biologicals”. Table 10 describes the HCPCS code change and effective date.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
<th>Status Indicator</th>
<th>APC</th>
<th>Effective Date</th>
<th>Termination Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9487</td>
<td>Ustekinumab, for Intravenous Injection, 1 mg</td>
<td>G</td>
<td>9487</td>
<td>04/01/2017</td>
<td>06/30/2017</td>
</tr>
<tr>
<td>Q9989</td>
<td>Ustekinumab, for Intravenous Injection, 1 mg</td>
<td>G</td>
<td>9487</td>
<td>07/01/2017</td>
<td></td>
</tr>
</tbody>
</table>

**Application of Co-insurance and Deductible for HCPCS Code G0404**

For CY 2017 HCPCS code G0404 (Electrocardiogram, routine ECG with 12 leads; tracing only, without interpretation and report, performed as a screening for the Initial Preventive Physical Examination (IPPE)) was inadvertently assigned a waiver of coinsurance and deductible. Beginning July 1, 2017, CMS will apply coinsurance and deductible to HCPCS code G0404. This change will be retroactive back to January 1, 2017.

**Changes to OPPS Pricer Logic**

- Effective January 1, 2017, for outliers for Community Mental Health Centers (CMHCs) (bill type 76x), updated logic to cap CMHC claims’ outlier payments at 8% of payments based on the current claim’s OPPS Pricer calculations.
- Effective January 1, 2017, added Payment Method Flag (PMF) ‘9’ to valid list to bypass the outlier cap logic.
- Effective for CY’s 2016 and 2017, changed the location of the device credit selection logic to ensure that providers with a special payment indicator of ‘1’ or ‘2’ in the Outpatient Provider Specific File receive the device credit.
- Effective July 1, 2017, added line item Denial/Rejection (D/R) Flag ‘3’ to valid list for FISS informational use.

**Coverage Determinations**

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

**Additional Information**

RARC, CARC, MREP and PC Print Update

MLN Matters Number: MM10040
Related Change Request (CR) Number: 10040
Related CR Release Date: May 26, 2017
Effective Date: October 1, 2017
Related CR Transmittal Number: R3780CP
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 provided to Medicare beneficiaries.

Provider Action Needed
Change Request (CR) 100040 updates the remittance advice remark code (RARC) and claims adjustment reason code (CARC) lists and also instruct ViPS Medicare System (VMS) and Fiscal Intermediary Shared System (FISS) maintainers to update Medicare Remit Easy Print (MREP) and PC Print. Make sure that your billing staffs are aware of these changes and obtain the updated MREP and PC Print software if they use that software.

Background
The Health Insurance Portability and Accountability Act (HIPAA) of 1996 instructs health plans to be able to conduct standard electronic transactions adopted under HIPAA using valid standard codes. Medicare policy states that CARCs and RARCs, as appropriate, which provide either supplemental explanation for a monetary adjustment or policy information that generally applies to the monetary adjustment, are required in the remittance advice and coordination of benefits transactions.

The Centers for Medicare & Medicaid Services (CMS) instructs MACs to conduct updates based on the code update schedule that results in publication three times per year – around March 1, July 1, and November 1.

CMS provides a CR as a code update notification indicating when updates to CARC and RARC lists are made available on the Washington Publishing Company (WPC) website. Shared System Maintainers (SSMs) have the responsibility to implement code deactivation, making sure that any deactivated code is not used in original business messages and allowing the deactivated code in derivative messages. SSMs must make sure that Medicare does not report any deactivated code on or after the effective date for deactivation as posted on the WPC website. If any new or modified code has an effective date past the implementation date specified in the CR, MACs must implement those updates on the date specified on the WPC website, which is at http://wpc-edi.com/Reference/.

A discrepancy between the dates may arise as the WPC website is only updated three times per year and may not match the CMS release schedule. For CR10040, the MACs and the SSMs must get the complete list for both CARCs and RARCs from the WPC website to obtain the comprehensive lists for both code sets and determine the changes included on the code list since the last code update CR (CR 9878).

Additional Information
Implement Operating Rules – Phase III ERA EFT: Core 360 Uniform Use of Claim CARC, RARC and CAGC Rule – Update from CAQH CORE

MLN Matters Number: MM10041
Related Change Request (CR) Number: 10041
Related CR Release Date: May 26, 2017
Effective Date: October 1, 2017
Related CR Transmittal Number: R3781CP
Implementation Date: October 2, 2017

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

Provider Action Needed
This article is based on Change Request (CR) 10041 which instructs MACs and Medicare’s Shared System Maintainers (SSMs) to update systems based on the CORE 360 Uniform Use of Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC) and Claim Adjustment Group Code (CAGC) Rule publication. These system updates reflect the Committee on Operating Rules for Information Exchange (CORE) Code Combination List for June 2017. Make sure that your billing staff is aware of these changes.

In addition, if you use the PC Print or Medicare Remit Easy Print (MREP) software supplied by your MAC, be sure to obtain the updated version of that software when it is available.

Background
The Department of Health and Human Services (DHHS) adopted the Phase III CAQH CORE, EFT and ERA Operating Rule Set that was implemented on January 1, 2014, under the Patient Protection and Affordable Care Act (ACA) of 2010.

The Health Insurance Portability and Accountability Act (HIPAA) amended the Act by adding Part C—Administrative Simplification—to Title XI of the Social Security Act, requiring the Secretary of DHHS to adopt standards for certain transactions to enable health information to be exchanged more efficiently and to achieve greater uniformity in the transmission of health information.

Through the ACA, Congress sought to promote implementation of electronic transactions and achieve cost reduction and efficiency improvements by creating more uniformity in the implementation of standard transactions. This was done by mandating the adoption of a set of operating rules for each of the HIPAA transactions. The ACA defines operating rules and specifies the role of operating rules in relation to the standards.

Change Request (CR) 10041 deals with the regular update in CAQH CORE defined code combinations per Operating Rule 360 - Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule.

CAQH CORE will publish the next version of the Code Combination List on or about June 10, 2017. This update is based on the CARC and RARC updates as posted at the Washington Publishing Company (WPC) website on or about March 1, 2017. This will also include updates based on Market Based Review (MBR) that CAQH CORE conducts once a year to accommodate code combinations that are currently being used by Health Plans including Medicare as the industry needs them.

You can find CARC and RARC updates at CARC/RARC News and CAQH CORE defined code combination updates at CAQH/CORE News.

Note: Per ACA mandate, all health plans including Medicare must comply with CORE 360 Uniform Use of CARCs and RARCs (835) rule or CORE developed maximum set of CARC/RARC and CAGC combinations for a minimum set of 4 Business Scenarios. Medicare can use any code combination if the business scenario is not one of the 4 CORE defined business scenarios. With the 4 CORE defined business scenarios, Medicare must use the code combinations from the lists published by CAQH CORE.
Claim Status Category and Claim Status Codes Update

MLN Matters Number: MM10043
Related Change Request (CR) # 10043
Related CR Release Date: May 26, 2017
Effective Date: October 1, 2017
Related CR Transmittal Number: R3782CP
Implementation Date: October 2, 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.

Provider Action Needed
Change Request (CR) 10043 informs MACs about system changes to update, as needed, the Claim Status and Claim Status Category Codes used for the Accredited Standards Committee (ASC) X12 276/277 Health Care Claim Status Request and Response and ASC X12 277 Health Care Claim Acknowledgment transactions. Make sure that your billing staffs are aware of these changes.

Background
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires all covered entities to use only Claim Status Category Codes and Claim Status Codes approved by the National Code Maintenance Committee in the ASC X12 276/277 Health Care Claim Status Request and Response transaction standards adopted under HIPAA for electronically submitting health care claims status requests and responses. These codes explain the status of submitted claim(s). Proprietary codes may not be used in the ASC X12 276/277 transactions to report claim status. This Recurring Update Notification (RUN) can be found in Chapter 31, Section 20.7. The National Code Maintenance Committee meets at the beginning of each ASC X12 trimester meeting (January/February, June, and September/October) and makes decisions about additions, modifications, and retirement of existing codes. The Committee has decided to allow the industry 6 months for implementation of newly added or changed codes.


Included in the code lists are specific details, including the date when a code was added, changed, or deleted. All code changes approved during the June 2017 committee meeting will be posted on these sites on or about July 1, 2017. MACs must complete entry of all applicable code text changes and new codes, and terminate use of deactivated codes by the implementation date of CR 10043.

The Centers for Medicare & Medicaid Services (CMS) will issue RUNs regarding the need for future updates to these codes. When instructed, Medicare contractors must update their claims systems to ensure that the current version of these codes is used in their claim status responses. Contractor and shared systems changes will be made as necessary as part of a routine release to reflect applicable changes such as retirement of previously used codes or newly created codes.

These code changes are to be used in editing of all ASC X12 276 transactions processed on or after the date of implementation and to be reflected in the ASC X12 277 transactions issued on and after the date of implementation of this CR 10043.

Additional Information
Rural Health Clinics (RHC) Billing Update

The Fiscal Intermediary Shared System (FISS) system logic was recently updated to process charges of $0.01 or more on all informational line items. This notification corrects a billing instruction given in the RHC Billing Requirements webinar held March 2017.

The CG modifier policy criteria has not changed. RHCs shall report modifier CG on one revenue code 052x and/or 0900 service line per day, which includes all charges subject to coinsurance and deductible for the visit. Each additional service furnished during the visit should be reported with the most appropriate revenue code and charges greater to or equal to $0.01. Refer to SE1611 for more information.
Medicare Part A SNF PPS Pricer Update – FY 2018

MLN Matters Number: MM10118
Related Change Request (CR) Number: CR10118
Related CR Release Date: June 16, 2017
Effective Date: October 1, 2017
Related CR Transmittal Number: R3796CP
Implementation Date: October 2, 2017

Provider Types Affected
This MLN Matters® Article is intended for Skilled Nursing Facilities (SNFs) submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries paid under the Skilled Nursing Facility (SNF) Prospective Payment System (PPS).

Provider Action Needed
Change Request (CR) 10118 informs MACs about the updates to the payment rates under the PPS for SNFs, for FY 2018, as required by statute. Make sure that your billing staffs are aware of these changes.

Background
Annual updates to PPS rates are required by Section1888(e) of the Social Security Act, as amended by the Medicare, Medicaid, and State Children’s Health Insurance Plan (SCHIP) Balanced Budget Refinement Act of 1999 (the BBRA), the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (the BIPA), and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (the MMA), relating to Medicare payments and consolidated billing for SNFs.

Each July, the Centers for Medicare & Medicaid Services (CMS) publishes the SNF payment rates for the upcoming Fiscal Year (FY) (that is, October 1, 2017, through September 30, 2018) in the Federal Register, available online at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/List-of-SNF-Federal-Regulations.html. The update methodology is similar to that used in the previous year, which includes a forecast error adjustment whenever the difference between the forecasted and actual change in the SNF market basket exceeds a 0.5 percentage point. The statute mandates an update to the Federal rates using the latest SNF full market basket adjusted for productivity. However, for FY 2018, the SNF payment increase factor is 1.0 percent, as required by Section 411(a) of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The payment rates will be effective October 1, 2017.

Additional Information