Medicare A News

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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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Contact Noridian

Noridian Part A Customer Service Contact and Hours of Operation

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<th>877-908-8431</th>
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<tr>
<td>• Interactive Voice Response (IVR)</td>
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<tr>
<td>• Provider Contact Center (PCC)</td>
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<td>• Provider Enrollment</td>
<td>8 a.m. – 4 p.m. (in respective time zones)</td>
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<td>• EDISS</td>
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<tr>
<td>• User Security (including Endeavor)</td>
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<td>General IVR inquiries available 24/7.</td>
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<tr>
<td>Claim-specific inquiries Monday – Friday</td>
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<tr>
<td>Text Teletype Calls (TTY)</td>
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<tr>
<td>877-261-4163</td>
<td></td>
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<tr>
<td>Monday – Friday</td>
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<td>8 a.m. – 4 p.m. (in respective time zones)</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](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.


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

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**Unsolicited or Voluntary Refunds Reminder**

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

**Background**

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

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

**Additional Information**


**Effective Date:** January 1, 2005

**Implementation Date:** January 4, 2005

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

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**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.**

<table>
<thead>
<tr>
<th>ACT Type</th>
<th>Link</th>
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<tbody>
<tr>
<td>JF Part B</td>
<td><a href="https://med.noridianmedicare.com/web/jfb/education/act">https://med.noridianmedicare.com/web/jfb/education/act</a></td>
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<tr>
<td>JD DME</td>
<td><a href="https://med.noridianmedicare.com/web/jddme/education/act">https://med.noridianmedicare.com/web/jddme/education/act</a></td>
</tr>
<tr>
<td>JA DME</td>
<td><a href="https://med.noridianmedicare.com/web/jadme/education/act">https://med.noridianmedicare.com/web/jadme/education/act</a></td>
</tr>
</tbody>
</table>

**Credit Balance Reports Reminder**

CMS requires a Credit Balance Report (CMS-838) be submitted within 30 days after the end of each quarter for all providers participating in the Medicare program. The current CMS quarter will end on September 30, 2017. The quarterly CMS-838 report will be due by October 30, 2017. Please take note that each Provider Transition Access Number (PTAN) is required to have their own certification page.

For more information please visit our Credit Balance Reports webpage.

**NGACO Year Three Benefit Enhancements**

MLN Matters Number: MM10044  
Related Change Request (CR) Number: 10044  
Related CR Release Date: August 4, 2017  
Effective Date: January 1, 2018  
Related CR Transmittal Number: R177DEMO  
Implementation Date: January 2, 2018  

**Provider Types Affected**

This MLN Matters® Article is intended for providers who are participating in Next Generation Accountable Care Organizations (NGACOs) and submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

**Provider Action Needed**

Change Request (CR) 10044 provides instruction to MACs to implement two new benefit enhancements for performance year three (calendar year 2018) of the NGACO Model. MACs will process and pay claims for Asynchronous Telehealth and Post-Discharge Home Visit Waiver services when those services meet the appropriate payment requirements as outlined in CR10044. Make sure your billing staff is aware of these changes.
Background
The aim of the NGACO Model is to improve the quality of care, population health outcomes, and patient experience for the beneficiaries who choose traditional Medicare Fee-for-Service (FFS) through greater alignment of financial incentives and greater access to tools that may aid beneficiaries and providers in achieving better health at lower costs.

In order to emphasize high-value services and support the ability of ACOs to manage the care of beneficiaries, the Centers for Medicare & Medicaid Services (CMS) is issuing the authority under Section 1115A of the Social Security Act (the Act) (Section 3021 of the Affordable Care Act) to conditionally waive certain Medicare payment requirements as part of the NGACO Model.

Asynchronous Telehealth
CMS is expanding the current telehealth waiver to include asynchronous (also known as “storeand-forward”) telehealth in the specialties of teledermatology and teleophthalmology. Asynchronous telehealth includes the transmission of recorded health history (for example, retinal scanning and digital images) through a secure electronic communications system to a practitioner, usually a specialist, who uses the information to evaluate the case or render a service outside of a real-time interaction. Asynchronous telecommunications system in single media format does not include telephone calls, images transmitted via facsimile machines, and text messages without visualization of the patient (electronic mail). Photographs must be specific to the patients’ condition and adequate for rendering or confirming a diagnosis or treatment plan.

Payment will be permitted for telemedicine when asynchronous telehealth in single or multimedia formats, is used as a substitute for an interactive telecommunications system for dermatology and ophthalmology services. Distant site practitioners will bill for these new services using new codes, and the distant site practitioner must be an NGACO Participant or Preferred Provider.

Asynchronous Telehealth Based on Intra-Service + 5 Minutes Post-Service Time
- Code 1: G9868 – Receipt and analysis of remote, asynchronous images for dermatologic and/or ophthalmologic evaluation, for use under the Next Generation ACO model, less than 10 minutes.
- Code 2: G9869 – Receipt and analysis of remote, asynchronous images for dermatologic and/or ophthalmologic evaluation, for use under the Next Generation ACO model, 10-20 minutes.
- Code 3: G9870 – Receipt and analysis of remote, asynchronous images for dermatologic and/or ophthalmologic evaluation, for use under the Next Generation ACO model, 20 or more minutes.

Additional Information

DMEPOS Fee Schedule – July 2017 Update – Revised
MLN Matters Number: MM10071 Revised
Related Change Request (CR) # 10071
Related CR Release Date: August 2, 2017
Effective Date: July 1, 2017
Related CR Transmittal Number: R3824CP
Implementation Date: July 3, 2017

This article was revised on August 3, 2017, to reflect an updated Change Request (CR). That CR updated the policy section on complex rehabilitative power wheelchair accessories & seat and back cushions (page 2 of this article). The CR release date, transmittal number and link to the CR was also changed. All other information is the same.
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
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
Suppliers should continue to use the KU modifier when billing for wheelchair accessories and seat and back cushions furnished in connection with Group 3 complex rehabilitative power wheelchairs (codes K0848 through K0864) with dates of service on or after July 1, 2017. The fee schedule amounts associated with the KU modifier were not adjusted using information from the competitive bidding program in accordance with Section 2 of Patient Access and Medicare Protection Act (PAMPA) for dates of service January 1, 2016 through December 31, 2016. Section 16005 of the 21st Century Cures Act then extended the effective date through June 30, 2017. Effective for dates of service on or after July 1, 2017, taking into consideration the exclusion at section 1847(a)(2)(A) of the Social Security Act, the policy for these items is revised. As a result, payment for these items furnished in connection with a Group 3 complex rehabilitative power wheelchair and billed with the KU modifier will be based on the unadjusted fee schedule amounts updated in accordance with section 1834(a)(14) of the Act. The list of HCPCS codes associated with the KU modifier is available in Transmittal 3713, CR 9966, dated February 3, 2017. The updated DMEPOS fee schedule files have been released.
**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**


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

**MLN Matters Number:** MM10089 Revised  
**Related Change Request (CR) Number:** 10089  
**Related CR Release Date:** July 25, 2017  
**Effective Date:** December 7, 2016  
**Related CR Transmittal Number:** R3811CP and R200NCD  
**Implementation Date:** June 27, 2017

This article was revised on July 26, 2017, to reflect the revised CR10089 issued on July 25. In the article, the transmittal numbers, CR release date, implementation date, and the Web addresses for accessing the transmittals are revised. All other information remains the same.

**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](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.


IOM Pub 100-04, Chapter 15 Update

MLN Matters Number: MM10143
Related Change Request (CR) Number: 10143
Related CR Release Date: June 23, 2017
Effective Date: July 25, 2017
Related CR Transmittal Number: R3800CP
Implementation Date: July 25, 2017

PROVIDER TYPE AFFECTED

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

WHAT YOU NEED TO KNOW

Change Request (CR) 10143 corrects errors in Chapter 15, Section 20.1.4 of the Medicare Claims Processing Manual.

BACKGROUND

CR10143 corrects errors in Chapter 15, Section 20.1.4 of the Medicare Claims Processing Manual. These changes are being made to correct minor typographical errors. No policy, processing, or system changes are anticipated. The change specifies that the year that is associated with the Medicare Modernization Act 2003.
ADDITIONAL INFORMATION

ASP Medicare Part B Drug Pricing Files and Revisions – October 2017
MLN Matters Number: MM10187
Related Change Request (CR) Number: 10187
Related CR Release Date: July 21, 2017
Effective Date: October 1, 2017
Related CR Transmittal Number: R3809CP
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) 10187 instructs MACs to download and implement the October 2017 and, if released, the revised July 2017, April 2017, January 2017, and October 2016, ASP drug pricing files for Medicare Part B drugs via the Centers for Medicare & Medicaid Services (CMS) Data Center (CDC). Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after October 1, 2017, with dates of service October 1, 2017, through December 31, 2017. Make sure your billing staffs are aware of these changes.

BACKGROUND
The ASP methodology is based on quarterly data submitted to the 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 Outpatient Prospective Payment System (OPPS) are incorporated into the Outpatient Code Editor (OCE) through separate instructions available in Chapter 4, section 50 of the Medicare Claims Processing Manual, at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c04.pdf.

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

MFPSDB October 2017 Quarterly Update

MLN Matters Number: MM10222
Related Change Request (CR) Number: 10222
Related CR Release Date: August 25, 2017
Effective Date: January 1, 2017
Related CR Transmittal Number: R3838CP
Implementation Date: October 2, 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) 10222 amends payment files that were issued to the MACs based upon the Calendar Year (CY) 2017 Medicare Physician Fee Schedule (MPFS) Final Rule. Please make sure your billing staffs are aware of these changes.

BACKGROUND
Payment files are 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 of the Department of Health & Human Services (HHS) to establish ancillary policies necessary to implement relative values for physicians' services.

This article presents a summary of the changes for the October update to the 2017 MPFSDB. Unless otherwise stated, these changes are effective for dates of service on and after January 1, 2017.

<table>
<thead>
<tr>
<th>CPT/HCPCS &amp; Mod</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>20245</td>
<td>Pre Op = 0, Intra Op = 0, Post Op = 0</td>
</tr>
<tr>
<td>36473</td>
<td>Bilateral Surg = 1</td>
</tr>
<tr>
<td>64897</td>
<td>Post Op = 0.13</td>
</tr>
<tr>
<td>93668</td>
<td>Status Indicator = C for dates of service 1/1/17 or after</td>
</tr>
<tr>
<td>A4575</td>
<td>Status Indicator = X for dates of service 4/3/17 or after</td>
</tr>
</tbody>
</table>

The following new codes have been added to the HCPCS file, effective August 1, 2017. The HCPCS file coverage code is C (carrier judgment) for these new codes. Coverage and payment will be determined by your 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>0006U</td>
<td>RX MNTR 120+ DRUGS &amp; SBSTS</td>
<td>Prescription drug monitoring, 120 or more drugs and substances, definitive tandem mass spectrometry with chromatography, urine, qualitative report of presence (including quantitative levels, when detected) or absence of each drug or substance with description and severity of potential interactions, with identified substances, per date of service</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Details</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>0007U</td>
<td>RX TEST PRSMV UR W/DEF CONF</td>
<td>Drug test(s), presumptive, with definitive confirmation of positive results, any number of drug classes, urine, includes specimen verification including DNA authentication in comparison to buccal DNA, per date of service</td>
</tr>
<tr>
<td>0008U</td>
<td>HPYLORI DETCJ ABX RSTNC DNA</td>
<td>Helicobacter pylori detection and antibiotic resistance, DNA, 16S and 23S rRNA, gyrA, ppb1, rdxA and rpoB, next generation sequencing, formalin-fixed paraffin embedded or fresh tissue, predictive, reported as positive or negative for resistance to clarithromycin, fluoroquinolones, metronidazole, amoxicillin, tetracycline and rifabutin</td>
</tr>
<tr>
<td>0009U</td>
<td>ONC BRST CA ERBB2 AMP/NONAMP</td>
<td>Oncology (breast cancer), ERBB2 (HER2) copy number by FISH, tumor cells from formalin fixed paraffin embedded tissue isolated using image-based dielectrophoresis (DEP) sorting, reported as ERBB2 gene amplified or non-amplified</td>
</tr>
<tr>
<td>0010U</td>
<td>NFCT DS STRN TYP WHL GEN SEQ</td>
<td>Infectious disease (bacterial), strain typing by whole genome sequencing, phylogenetic-based report of strain relatedness, per submitted isolate</td>
</tr>
<tr>
<td>0011U</td>
<td>RX MNTR LC-MS/MS ORAL FLUID</td>
<td>Prescription drug monitoring, evaluation of drugs present by LC-MS/MS, using oral fluid, reported as a comparison to an estimated steady-state range, per date of service including all drug compounds and metabolites</td>
</tr>
<tr>
<td>0012U</td>
<td>GERMLN DO GENE REARGMT DETCJ</td>
<td>Germline disorders, gene rearrangement detection by whole genome next-generation sequencing, DNA, whole blood, report of specific gene rearrangement(s)</td>
</tr>
<tr>
<td>0013U</td>
<td>ONC SLD ORG NEO GENE REARGMT</td>
<td>Oncology (solid organ neoplasia), gene rearrangement detection by whole genome next-generation sequencing, DNA, fresh or frozen tissue or cells, report of specific gene rearrangement(s)</td>
</tr>
<tr>
<td>0014U</td>
<td>HEM HMTLMF NEO GENE REARGMT</td>
<td>Hematology (hematolymphoid neoplasia), gene rearrangement detection by whole genome next-generation sequencing, DNA, whole blood or bone marrow, report of specific gene rearrangement(s)</td>
</tr>
<tr>
<td>0015U</td>
<td>RX METAB ADVRS RX RXN DNA</td>
<td>Drug metabolism (adverse drug reactions), DNA, 22 drug metabolism and transporter genes, real-time PCR, blood or buccal swab, genotype and metabolizer status for therapeutic decision support</td>
</tr>
<tr>
<td>0016U</td>
<td>ONC HMTLMF NEO RNA BCR/ABL1</td>
<td>Oncology (hematolymphoid neoplasia), RNA, BCR/ABL1 major and minor breakpoint fusion transcripts, quantitative PCR amplification, blood or bone marrow, report of fusion not detected or detected with quantitation</td>
</tr>
<tr>
<td>0017U</td>
<td>ONC HMTLMF NEO JAK2 MUT DNA</td>
<td>Oncology (hematolymphoid neoplasia), JAK2 mutation, DNA, PCR amplification of exons 12-14 and sequence analysis, blood or bone marrow, report of JAK2 mutation not detected or detected</td>
</tr>
</tbody>
</table>

The short descriptors for the technical and professional components of the following codes were not displaying properly on the MPFS and did not match the HCPCS file. The global procedure accurately reflects the short descriptor from the HCPCS file. This display issue has been corrected and the short descriptors for the technical and professional components now read as follows on the MPFS:

- 92978 – TC Endoluminal ivus oct c 1st
- 92978 – 26 Endoluminal ivus oct c 1st
- 92979 – TC Endoluminal ivus oct c ea
- 92979 – 26 Endoluminal ivus oct c ea
- G0202 – TC Scr mammo bi incl cad
• G0202 – 26 Scr mammo bi incl cad
• G0204 – TC Dx mammo incl cad bi
• G0204 – 26 Dx mammo incl cad bi
• G0206 – TC Dx mammo incl cad uni
• G0206 – 26 Dx mammo incl cad uni

Providers should be aware that MACs do not need to search their files to either retract payment for claims already paid or to retroactively pay claims. However, MACs will adjust claims that you bring to their attention.

ADDITIONAL INFORMATION

DOCUMENT HISTORY

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>August 29, 2017</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>

Influenza Vaccine Payment Allowances – Annual Update for 2017-2018 Season

MLN Matters Number: MM10224
Related Change Request (CR) Number: CR 10224
Related CR Release Date: August 18, 2018
Effective Date: August 1, 2017
Related CR Transmittal Number: R3837CP
Implementation Date: No later than October 2, 2017

PROVIDER TYPE AFFECTED
This MLN Matters Article is intended for physicians and other providers submitting claims to Medicare Administrative Contractors (MACs) for influenza vaccines provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED
Change Request (CR) 10224 informs MACs about the payment allowances for seasonal influenza virus vaccines, which are updated on August 1 of each year. The Centers for Medicare & Medicaid Services (CMS) will post the payment allowances for influenza vaccines that are approved after the release of CR10224 at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html. Make sure your billing staffs are aware that the payment allowances are being updated.

BACKGROUND
The Medicare Part B payment allowance limits for influenza and pneumococcal vaccines are 95 percent of the Average Wholesale Price (AWP) as reflected in the published compendia except where the vaccine is furnished in a hospital outpatient department, Rural Health Clinic (RHC), or Federally Qualified Health Center (FQHC). Where the vaccine is furnished in the hospital outpatient department, RHC, or FQHC, payment for the vaccine is based on reasonable cost.

The Medicare Part B payment allowances for the following Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes below apply for the effective dates of August 1, 2017 - July 31, 2018:
• CPT 90653 Payment allowance is $50.217.
• CPT 90655 Payment allowance is pending.
• CPT 90656 Payment allowance is $19.247.
• CPT 90657 Payment allowance is pending.
• CPT 90661 Payment allowance is pending.
• CPT 90685 Payment allowance is $21.198.
• CPT 90686 Payment allowance is $19.032.
• CPT 90687 Payment allowance is $9.403.
• CPT 90688 Payment allowance is $17.835.
• HCPCS Q2035 Payment allowance is $17.685.
• HCPCS Q2036 Payment allowance is pending.
• HCPCS Q2037 Payment allowance is $17.685.
• HCPCS Q2038 Payment allowance is pending.

Payment for the following CPT or HCPCS codes may be made if your MAC determines its use is reasonable and necessary for the beneficiary, for the effective dates of August 1, 2017 - July 31, 2018:

• CPT 90630 Payment allowance is $20.343.
• CPT 90654 Payment allowance is pending.
• CPT 90662 Payment allowance is $49.025.
• CPT 90672 Payment allowance is pending.
• CPT 90673 Payment allowance is $40.613.
• CPT 90674 Payment allowance is $24.047.
• CPT 90682 Payment allowance is $46.313. (New code)
• CPT 90756 Payment allowance is $22.793. Effective dates: 1/1/2018 - 7/31/2018 (Note:
• Providers and Medicare Administrative Contractors shall use HCPCS Q2039 for dates of service from 8/1/2017 - 12/31/2017. See special note under HCPCS Q2039 for payment amounts for this product prior to 1/1/2018.)
• HCPCS Q2039 Flu Vaccine Adult -Not Otherwise Classified. Payment allowance is to be determined by your MAC with effective dates of 8/1/2017 - 7/31/2018.

Special note: Until CPT code 90756 is implemented on 1/1/2018, Q2039 shall be used for products described by the following language: influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, antibiotic free, 0.5mL dosage, for intramuscular use. The payment allowance for these products, effective for dates of service 8/1/2017 -12/31/2017 is $22.793.

CMS will post payment limits for influenza vaccines that are approved after the release date of CR10224 on the CMS Seasonal Influenza Vaccines Pricing webpage at [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html) as information becomes available. Effective dates for these vaccines shall be the date of Food and Drug Administration (FDA) approval.

The payment allowances for pneumococcal vaccines are based on 95 percent of the AWP and are updated on a quarterly basis via the Quarterly Average Sales Price (ASP) Drug Pricing Files.

Providers should note that:

• All physicians, non-physician practitioners, and suppliers who administer the influenza virus vaccination and the pneumococcal vaccination must take assignment on the claim for the vaccine.
• The annual Part B deductible and coinsurance amounts do not apply.
• Your MACs will not search their files either to retract payment for claims already paid or to retroactively pay claims. However, MACs will adjust such claims that you bring to their attention.
HCPCS Drug/Biological Code Changes – October 2017 Update

MLN Matters Number: MM10234
Related Change Request (CR) Number: 10234
Related CR Release Date: August 25, 2017
Effective Date: July 24, 2017
Related CR Transmittal Number: R3850CP
Implementation Date: October 2, 2017

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

WHAT YOU NEED TO KNOW
The Healthcare Common Procedure Coding System (HCPCS) code set is updated on a quarterly basis. The October 2017 HCPCS file includes a new HCPCS modifier. CR10234 informs MACs about the new modifier, ZC, Merck/Samsung Bioepis. The ZC modifier will become effective for claims submitted beginning October 1, 2017, and applies retroactively to dates of service on or after July 24, 2017.

MACs shall add the following modifier to the required modifiers that must be used when HCPCS code Q5102 is billed on a claim:

- HCPCS Modifier: ZC
- Short Description: Merck/Samsung Bioepis
- Long Description: Merck/Samsung Bioepis

A second biosimilar version of infliximab was marketed on July 24, 2017, creating a situation where products from two manufacturers may appear on claims. To allow the identification of the manufacturer of the specific biosimilar biological product that was administered to a patient, either existing HCPCS modifier ZB, or new modifier ZC is required when HCPCS code Q5102 is billed on a claim that is submitted after October 1, 2017.

ADDITIONAL INFORMATION
GME Payments to New Teaching Hospitals - Calculating Interim Rates

MLN Matters Number: MM10240  
Related Change Request (CR) Number: N/A  
Related CR Release Date: September 22, 2017  
Effective Date: October 23, 2017  
Related CR Transmittal Number: R1923OTN  
Implementation Date: October 23, 2017

PROVIDER TYPE AFFECTED

This MLN Matters Article is intended for teaching hospitals billing Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

Change Request (CR) 10240 provides instructions to the MACs on calculating interim rates for Graduate Medical Education (GME) payments to new teaching hospitals. Make sure your billing staffs are aware of this notification.

BACKGROUND

Section 1886(h) of the Social Security Act (the Act), currently implemented in the regulations at 42 Code of Federal Regulation (CFR) 413.75 through 413.83, establishes a methodology for determining payments to hospitals for the direct costs of approved GME programs. In general, Medicare direct GME payments are calculated by multiplying the hospital’s updated Per Resident Amount (PRA) by the weighted number of Full-Time Equivalent (FTE) residents working in all areas of the hospital complex (and at nonprovider sites, when applicable), and the hospital’s ratio of Medicare inpatient days to total inpatient days.

Section 1886(d)(5)(B) of the Act, as implemented at 42 CFR 412.105, provides for a payment adjustment known as the Indirect Medical Education (IME) adjustment under the hospital Inpatient Prospective Payment System (IPPS) for hospitals that have residents in an approved GME program, in order to account for the higher indirect patient care costs of teaching hospitals relative to nonteaching hospitals. The hospital’s IME adjustment applied to the Diagnosis Related Group (DRG) payments is calculated based on the ratio of the hospital’s number of FTE residents training in the inpatient and outpatient departments of the IPPS hospital (and at nonprovider sites, when applicable), to the number of inpatient hospital beds. This ratio is referred to as the IME Intern-and-Resident-to-Bed (IRB) ratio.

Under section 1886(h)(4)(F) of the Act, for cost reporting periods beginning on or after October 1, 1997, a hospital’s unweighted FTE count of residents for purposes of direct GME may not exceed the hospital’s unweighted FTE count for direct GME in its most recent cost reporting period ending on or before December 31, 1996. Under section 1886(d)(5)(B)(v) of the Act, a similar limit based on the FTE count for IME during that cost reporting period is applied effective for discharges occurring on or after October 1, 1997. Dental and podiatric residents are not included in this statutory cap.

Section 1886(h)(4)(H)(i) of the Act requires the Secretary to establish rules for calculating the direct GME caps for new teaching hospitals that are training residents in new medical residency training programs established on or after January 1, 1995. Under section 1886(d)(5)(B)(viii) of the Act, such rules also apply to the establishment of a hospital’s IME cap on the number of FTE residents training in new programs. The Centers for Medicare & Medicaid Services (CMS) implemented these statutory requirements in rules published in the following Federal Registers -- August 29, 1997 (62 FR 46002 through 46008), May 12, 1998 (63 FR 26323 through 26327 and 26327 through 26336), and August 27, 2009 (74 FR 43908 through 43919).

Current Regulations on New Program Caps

Generally, under existing regulations at 42 CFR 413.79(e)(1) (for direct GME) and 42 CFR 412.105(f)(1)(viii) (for IME), if a hospital did not train any allopathic or osteopathic residents in its most recent cost reporting period ending on or before December 31, 1996, and it begins to participate in training residents in a new medical residency training program (allopathic or osteopathic) on or after January 1, 1995, the hospital’s unweighted FTE resident cap (which would otherwise be zero) may be adjusted based on the sum of the
product of the highest number of FTE residents in any program year during the fifth year of the first new program’s existence at all of the hospitals to which the residents rotate, the minimum accredited length for each type of program, and the ratio of the number FTE residents in the new program that trained at the hospital over the entire 5-year period to the total number of FTE residents in the program that trained at all hospitals over the entire 5-year period. The number of FTE resident cap slots that a teaching hospital receives for each new program may not exceed the number of accredited slots that are available for each new program. See the August 31, 2012 Federal Register (77 FR 53416) for details on how the cap calculation is made. Similar regulations apply for IME at 42 CFR 412.105(f)(1)(vii). In the August 22, 2014, Federal Register (79 FR 50104 through 50111), CMS again revised the regulations at 42 CFR 413.79(e)(1) for direct GME and 42 CFR 412.105(f)(1)(v)(D) for IME, to state that if a hospital begins training residents in a new program on or after October 1, 2012, the hospital’s FTE caps will take effect with the beginning of the hospital’s cost reporting period that coincides with or follows the start of the sixth program year of the first new program started. Also, under 42 CFR 413.79(d)(5) for direct GME and 42 CFR 412.105(f)(1)(v) and 412.105(a)(1)(i) for IME, FTE residents in new programs are exempt from the application of the 3-year rolling average and the IME intern-and-resident-to-bed (IRB) ratio cap. For programs started after October 1, 2012, these exemptions are applicable during the cost reporting periods prior to the beginning of the cost reporting period that coincides with or follows the start of the sixth program year of the first new program started, in which the FTE cap is established.

Establishment of a Direct GME (DGME) Per Resident Amount (PRA)

Under section 1886(h)(3) of the Act, and implemented at 42 CFR §413.77(e)(1), if a hospital did not previously have a PRA established, but begins training in a cost reporting period beginning on or after July 1, 1985, the MAC establishes a PRA effective with the hospital’s first cost reporting period in which it participates in Medicare and has residents on duty during the first month of that cost reporting period. Effective for cost reporting periods beginning on or after October 1, 2006, if a hospital did not have residents on duty during the first month of that period, the MAC establishes a PRA using the information from the first cost reporting period immediately following the cost reporting period during which the hospital participates in Medicare and residents began training at the hospital.

As 42 CFR §413.77(e)(1) states, any GME costs incurred by the hospital in the cost reporting period prior to the PRA base period are reimbursed on a reasonable cost basis. For example, a hospital with a January 1 to December 31 cost reporting period starts to train residents in an approved residency program for the first time on July 1, 2017. The residents continue to train at the hospital in January 2018 and after. The hospital’s PRA would be established from and effective for direct GME payment during the January 2018 through December 2018 cost report, and the hospital would be paid based on Medicare’s share of the reasonable GME costs in the January 2017 through December 2017 cost report.

In order for a PRA to be established, the residents need not be in a newly approved residency program, nor must the hospital be the sponsor, nor incur costs. Rather, a hospital counts the respective share of the FTE resident that trains in its hospital, whether it employs the resident or not. (See the September 4, 1990 Federal Register, 55 FR 36064-5, which explains that regardless of who employs the resident, each hospital would count the proportion of FTE time spent at its facility, both for the direct GME PRA base year, and in the payment years, while the hospital that incurs the costs of the resident in any year would claim those costs on its cost report). The MAC shall calculate and finalize the hospital’s final PRA as part of the settlement of the base year cost report. See below for instructions for establishing an interim rate PRA for purposes of paying the hospital an interim direct GME payment amount from approximately the time it starts to train residents in an approved program.

Resources for determining weighted average PRA include: –67 FR 50067 through 50069 (August 1, 2002); Determining hospital cost per FTE -- 54 FR 40286 (September 29, 1989), 55 FR 36064 through 36065 (September 4, 1990), HCFA Memorandum, BPO-F12, November 8, 1990, Questions and Answers Pertaining to Graduate Medical Education.

When to Establish Interim Rates for a New Teaching Hospital Participating in a New Program(s)

When a hospital that does not have FTE caps and/or a PRA approaches its MAC and requests in writing (email is sufficient) IME and DGME payments due to training residents for the first time in a new approved GME residency program, the MAC shall, in accordance with the regulations governing interim rate reviews at 42 CFR §412.116(c) and 42 CFR §413.60 and 42 CFR §413.64(a) through (e).
• Use the policy guidance in CR10240 to verify that the hospital does not already have a PRA and/or FTE resident caps established, and the hospital is actually training residents in a new approved program. (Refer to the August 27, 2009 FR, page 43908, to determine if an approved program meets the “new” criteria).

• Establish interim IME and DGME payment rates for the hospital at the earliest scheduled rate review after the hospital submits a written request for payment. MACs need not perform a special rate review exclusively for establishing interim IME and DGME rates; rather, MACs may choose to wait until the next regularly scheduled rate review following receipt of the written request from the hospital, and establish interim rates for IME and DGME payments at that time.

Alternatively, if the hospital is training residents for the first time but the residents are in an existing program, and the new teaching hospital has received IME and/or DGME cap slots from another hospital under a Medicare GME affiliation agreement (under 42 CFR 413.79(f)), if the hospital requests in writing (email is sufficient) IME and DGME payments, the MAC shall

• Establish interim IME and DGME rates for the hospital in accordance with the regulations governing interim rate reviews at 42 CFR 412.116(c) and 42 CFR 413.60 and 42 CFR 413.64(a) through (e).

• A hospital must provide the necessary documentation (discussed below) in order for the MAC to establish the interim rates.

**Documentation Required for Calculating Interim IME and DGME Rates for a New Teaching Hospital**

If a hospital requests in writing (email is sufficient) that a MAC establish interim IME and DGME rates due to training residents for the first time in either new or existing approved program(s), the MAC shall request the following documentation from the hospital:

**For IME and DGME:**

• Formal accreditation letter or proof of accreditation of the applicable program(s) by the relevant accrediting body (ACGME, ADA, CPME. Note –AOA accreditation was subsumed by the ACGME beginning in 2015).

• Number of accredited positions being trained in the program for the relevant cost reporting year for which interim rates are being established

• Rotation schedules, or similar documentation, indicating where the residents are training, from which to develop estimated FTE counts applicable to the requesting hospital. For IME, FTE residents training in locations specified in the regulations at 42 CFR §412.105(f)(1)(ii) (A)—(E) may be counted. For DGME, FTE residents training in accordance with the regulations at 42 CFR §413.78 may be counted. The MAC shall ensure that the number of FTE residents based on which the hospital is paid in a year does not exceed the number of accredited slots available to the hospital for the particular program year.

• If applicable, a copy of the Medicare GME Affiliation Agreement under 42 CFR §413.79(f).

**For IME:**

• Available bed count from the most recently submitted cost report, but modified if appropriate as part of the current interim rate review. Determine the available bed count in accordance with the instructions on the Medicare cost report, CMS Form 2552-10, Worksheet E, Part A, line 4.

• Timely submission of claims for receipt of IME payments on behalf of inpatient services provided to Medicare Fee for Service and Medicare Advantage beneficiaries, in accordance with 42 CFR 424.30 and 424.44.

**For DGME:**

• Medicare utilization – Determine the hospital’s Medicare utilization rate (or ratio of Medicare inpatient days to total inpatient days) in accordance with the instructions on the Medicare cost report, CMS Form 2552-10, Worksheet E-4, lines 26, 27, and 28, columns 1 and 2 for Part A and Part C, using the hospital’s most recently submitted cost report (but modified as appropriate as part of the current interim rate review).
• Timely submission of claims for receipt of IME payments on behalf of inpatient services provided to Medicare Fee for Service and Medicare Advantage beneficiaries, in accordance with 42 CFR 424.30 and 424.44.

• For the PRA, see below.

Calculating an Interim Rate PRA

Under 42 CFR §413.77(e)(1)(i) and (ii), a new PRA is equal to the lower of the hospital’s actual cost per resident incurred in the base period, or the weighted mean average PRA of all of the other existing teaching hospitals located in the same core-based statistical area (CBSA) as the new teaching hospital. Under 42 CFR §413.77(e)(1)(iii), if under §413.77(e)(1)(ii)(A) or (B) there are less than 3 existing teaching hospitals with PRAs located in the same CBSA as the new teaching hospital with PRAs that can be used for the weighted average PRA calculation, the census region PRA is used (updated for inflation to the new teaching hospital’s base year cost reporting period).

Since the hospital’s actual cost per FTE resident information would not be available until the hospital files its base year cost report, and since determination of the weighted average PRA for the CBSA can be labor intensive, the MAC shall use the latest available census region PRA issued by CMS for the census region in which the new teaching hospital is located, updated for inflation to the base period of the new teaching hospital, for the purpose of calculating and paying DGME interim rates. However, once the hospital submits its base year cost report, the MAC shall calculate and assign the appropriate PRA to the new teaching hospital (as part of the normal cost report settlement process for the new teaching hospital). The MAC shall calculate the interim rate subsequently using the hospital’s permanently assigned PRA, updated with inflation.

ADDITIONAL INFORMATION


DOCUMENT HISTORY

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<td>September 26, 2017</td>
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DMEPOS Fee Schedule October 2017 Quarterly Update

MLN Matters Number: MM10248
Related Change Request (CR) Number: CR 10248
Related CR Release Date: September 8, 2017
Effective Date: October 1, 2017
Related CR Transmittal Number: R3859CP
Implementation Date: October 2, 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) 10248 provides instructions regarding the October quarterly update for the 2017 DMEPOS and parenteral and enteral nutrition (PEN) fee schedules and the October 2017 DMEPOS Rural ZIP code file containing the Quarter 4, 2017 Rural ZIP code changes. 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 schedule is updated on a quarterly basis, when necessary, to implement fee schedule amounts for new codes and correct any fee schedule amounts for existing codes, and the quarterly update process for the DMEPOS fee schedule is covered in the Medicare Claims Processing Manual, Chapter 23, Section 60 at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf.

Payment on a fee schedule basis is required for DMEPOS and surgical dressings by the Social Security Act, Section 1834(a), (h), and (i) at https://www.ssa.gov/OP_Home/ssact/title18/1834.htm. Also, payment on a fee schedule basis is a regulatory requirement at 42 CFR §414.102 for PEN, splints and casts, and intraocular lenses (IOLs) inserted in a physician’s office.

Additionally, the Social Security Act (Section 1834(a)(1)(F)(iii)) 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 (Section 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 at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9642.pdf, 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.

Effective with the October update, code K0861 RR KF is removed from the fee schedule file.

The October 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.

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<td>September 12, 2017</td>
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**Clotting Factor Furnishing Fee – 2018 Annual Update**

MLN Matters Number: MM10254  
Related Change Request (CR) Number: CR10254  
Related CR Release Date: September 15, 2017  
Effective Date: January 1, 2018  
Related CR Transmittal Number: R3862CP  
Implementation Date: January 2, 2018

**PROVIDER TYPES AFFECTED**  
This MLN Matters® Article is intended for physicians, providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs) for services related to the administration of clotting factors provided to Medicare beneficiaries.

**PROVIDER ACTION NEEDED**  
Change Request (CR) 10254 announces the clotting factor furnishing fee for 2018 is $0.215 per unit. Make sure that your billing staffs are aware of this update to the annual clotting factor furnishing fee for 2018.

**BACKGROUND**  
The Centers for Medicare and Medicaid Services (CMS) includes the clotting factor furnishing fee in the published national payment limits for clotting factor billing codes. When the national payment limit for a clotting factor is not included on the Average Sales Price (ASP) Medicare Part B Drug Pricing File or the Not Otherwise Classified (NOC) Pricing File, the MACs make payment for the clotting factor as well as payment for the furnishing fee. For dates of service from January 1, 2018, through December 31, 2018, the clotting factor furnishing fee of $0.215 per unit is added to the payment limit for the clotting factor.

**ADDITIONAL INFORMATION**  

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**Physician’s Guide to Medicare Part D MTM Programs – Revised**

MLN Matters® Number: SE1229 Revised  
This article was revised on August 24, 2017, to provide updated information, primarily in the new “Part D Enhanced Medication Therapy Management (MTM) Model” section on page 5. All other information is unchanged.

**Provider Types Affected**  
This MLN Matters® Article Special Edition about Medication Therapy Management (MTM) services is intended for physicians, pharmacists, nurses, and other health care providers who treat Medicare beneficiaries with Part D coverage.

**Provider Action Needed**  
This MLN release is intended to make you aware of Medicare Part D MTM programs that will affect your patients, and introduce you to three MTM forms that your patients are likely to share with you.

Your patients may ask you if they would benefit from MTM services. If you have patients enrolled in Part D MTM programs, you may also be contacted by MTM providers who are required to monitor patients’ medication therapies from all their health care providers. This may result in recommendations that are shared with you about unsafe or dangerous interactions and therapeutic alternatives. Your patients may also receive recommendations about how to use their medications properly.
MTM Providers Are Important Partners with You

MTM providers work with physicians to deliver the best medication therapy to patients and to coordinate their medication therapy across multiple practitioners. The latest clinical information is used by MTM providers when reviewing patients’ medication therapy, such as updates to the Beers criteria for high-risk medications and revised monographs for old and new medications. MTM providers also listen to patients’ concerns about their medications and may offer recommendations to physicians and patients to help achieve their goals of therapy. As always, physicians make the final decisions about changes in drug therapy.

When Will MTM Providers Contact You?

Your patients enrolled in MTM may receive an interactive comprehensive medication review (CMR) any time during the year.

The MTM provider may reach out to you in order to clarify your patient’s medical history prior to a review or information received from your patient during the review, such as why and how they are supposed to use their medications.

After a CMR, the MTM provider may contact you with questions or recommendations about your patient’s medications, or your patient may call you to discuss suggestions they received from the MTM provider.

Targeted medication reviews (TMRs) are processed throughout the year, at least quarterly, to identify specific or potential medication-related problems. You may be contacted by the MTM provider if a TMR identifies a potential medication-related problem for your patient.

Other communications may be sent to you periodically throughout the year. These communications are intended to help resolve other potential medication-related problems or identify other opportunities to optimize your patient’s medication use.

What Materials Will My Patients Receive?

If your patients are enrolled in a Part D MTM program, they will receive a printed standardized summary, Form CMS-10396, as a reference about their CMR. This summary will include a Cover Letter, Medication Action Plan, and Personal Medication List. Your patients are encouraged to share these documents with you and other healthcare providers at their regular visits and request updates as needed. Examples of the three forms follow: See the complete CMS Medicare Learning Network (MLN) Matters (MM) Special Edition (SE) 1229 for form examples and explanation.

How Do You Refer Patients to MTM Services?

Calling the prescription drug plan directly is the best way to find out if your patient is eligible for that plan’s MTM services. You can also refer your patient to their local State Health Insurance Assistance Program (SHIP) office. A local SHIP counselor can be found by searching the following website: https://www.shiptacenter.org.

Part D Enhanced Medication Therapy Management Model

Certain plans in Arizona, Florida, Iowa, Louisiana, Minnesota, Montana, Nebraska, North Dakota, South Dakota, Virginia, and Wyoming are participating in a new test to determine if expanded MTM services can help improve health outcomes and reduce health care expenditures. Participating plans are permitted to target enrollees using a different criteria than the standard MTM program and offer additional services beyond the CMR and TMR to improve their medication usage. If one of your patients is enrolled in a participating plan, the Part D plan may reach out to you to better coordinate care and improve information sharing.

Summary

Medicare Part D MTM programs promote coordinated care and improve medication use through services that engage the patient, their physicians, and other healthcare providers. You may see three forms that your patients will receive if they are enrolled in a Part D MTM program and have received a CMR. These forms are intended to provide the patient with information about their medication use and also be used as a platform for discussion with you and their other health care providers.
Additional Information
For additional information about Medicare Part D MTM programs and the standardized CMR summary documents, go to http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/MTM.html on the CMS website.

Please send any general questions about Part D MTM programs to PartD_MTM@cms.hhs.gov. Questions about a specific plan’s MTM services or eligibility criteria should be addressed to that Part D plan.

**Enforcement of the PHP 20 Hours per Week Billing Requirement – Rescinded**

MLN Matters® Number: SE1607 Rescinded
Effective Date: July 1, 2016
Implementation Date: July 5, 2016

This article was rescinded on August 18, 2017.

Additional Information
If you have any questions, please contact your MAC at their toll-free number, which may be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.


**Hurricane Harvey and Medicare Disaster Related Texas Claims – Fourth Revision**

MLN Matters Number: SE17020 Revised
Article Release Date: September 19, 2017

This article was revised on September 19, 2017, to include information about replacement prescription fills of covered Part B drugs. All other information remains the same.

**PROVIDER TYPE AFFECTED**
This MLN Matters® Special Edition Article is intended for providers and suppliers who submit claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries in the State of Texas who were affected by Hurricane Harvey.

**PROVIDER INFORMATION AVAILABLE**
On August 26, 2017, pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act, President Trump declared that, as a result of the effects of Hurricane Harvey, an emergency exists in the State of Texas, retroactive to August 25, 2017. Also on August 26, 2017, Secretary Price of the Department of Health & Human Services declared that a public health emergency exists in the State of Texas and authorized waivers and modifications under Section 1135 of the Social Security Act (the Act), retroactive to August 25, 2017.

Under Section 1135 or 1812(f) of the Social Security Act, the Centers for Medicare & Medicaid Services (CMS) has issued several blanket waivers in the impacted counties and geographical areas of Texas. These waivers will prevent gaps in access to care for beneficiaries impacted by the emergency. Providers do not need to apply for an individual waiver if blanket waiver has been issued. Providers can request an individual Section 1135 waiver, if there is no blanket waiver, by following the instructions available at https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Requesting-an-1135-Waiver-Updated-11-16-2016.pdf.
Additional blanket waiver requests are being reviewed. The most current waiver information can be found under Administrative Actions at [https://www.cms.gov/About-CMS/Agency-Information/Emergency/Hurricanes.html](https://www.cms.gov/About-CMS/Agency-Information/Emergency/Hurricanes.html). This article will be updated as additional waivers are approved. See the Background section of this article for more details.

**BACKGROUND**

**Section 1135 and Section 1812(f) Waivers**

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

1. Change Request (CR) 6451 (Transmittal 1784, Publication 100-04) issued on July 31, 2009, applies to items and services furnished to Medicare beneficiaries within the State of Texas from August 25, 2017, for the duration of the emergency. In accordance with CR6451, use of the “DR” condition code and the “CR” modifier are mandatory on claims for items and services for which Medicare payment is conditioned on the presence of a “formal waiver” including, but not necessarily limited to, waivers granted under either Section 1135 or Section 1812(f) of the Act.

2. The most current information can be found at [https://www.cms.gov/emergency](https://www.cms.gov/emergency). Medicare FFS Questions & Answers (Q&As) posted in the downloads section at the bottom of the Emergency Response and Recovery webpage and also referenced below are applicable for items and services furnished to Medicare beneficiaries within the State of Texas. These Q&As are displayed in two files:

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

   - The second file addresses policies and procedures that are applicable only with approved Section 1135 waivers or, when applicable, approved Section 1812(f) waivers. These Q&As are applicable for approved Section 1135 blanket waivers and approved individual 1135 waivers requested by providers and are effective August 25, 2017, for Texas.

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

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

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

**Blanket Waivers Issued by CMS**

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

**Skilled Nursing Facilities**

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

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

**Home Health Agencies**

- 42 CFR 484.20(c)(1): This waiver provides relief to Home Health Agencies on the timeframes related to OASIS Transmission. (Blanket waiver for all impacted agencies)
• Home health agencies should monitor information posted at https://www.cms.gov/About-CMS/Agency-Information/Emergency/Hurricanes.html under Administrative Actions for updates on waivers.

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

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

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

Application Deadline Extended for Reclassifications Submission to MGCRB
In accordance with Waiver or Modification of Requirements under Section 1135 of the Social Security Act issued August 26, 2017 by Secretary Price, CMS is modifying the September 1, 2017, deadline for applications for FY 2019 reclassifications to be submitted to the Medicare Geographic Classification Review Board (MGCRB). CMS is currently granting a 31-day extension to the deadline at § 412.256(a)(2) for the State of Texas. Applications for FY 2019 reclassifications from hospitals in these areas must be received by the MGCRB not later than October 2, 2017.

Deadline Extended for IPPS Wage Index Requests
Regarding the FY 2019 wage index, CMS is modifying the September 1, 2017, deadline specified in the FY 2019 Hospital Wage Index Development Time Table for these hospitals to request revisions to and provide documentation for their FY 2015 Worksheet S-3 wage data and CY 2016 occupational mix data, as included in the May 18, 2017, and July 12, 2017, preliminary PUFs, respectively. CMS is currently granting an extension for hospitals in the State of Texas until October 2, 2017. MACs must receive the revision requests and supporting documentation by this date. If hospitals encounter difficulty meeting this extended deadline of October 2, 2017, hospitals should communicate their concerns to CMS via their MAC, and CMS may consider an additional extension if CMS determines it is warranted.

Facilities Quality Reporting
CMS is granting exceptions under certain Medicare quality reporting and value-based purchasing programs without having to submit an extraordinary circumstances exception request if they are located in one of the Texas counties, all of which have been designated by the Federal Emergency Management Agency (FEMA) as a major disaster county. Further information can be found in the memo on applicability of reporting requirements to certain providers in the Downloads section at https://www.cms.gov/About-CMS/Agency-Information/Emergency/Hurricanes.html.
Medicare-dependent small, rural hospitals (MDHs) In accordance with Waivers or Modifications of Requirements under Section 1135 of the Social Security Act issued August 26, 2017 by Secretary Price, CMS is modifying the September 1, 2017 deadline for Medicare-dependent small, rural hospitals (MDHs) to apply for sole community hospital (SCH) status in advance of the expiration of the MDH program with an effective date of an approval of SCH status that is the day following the expiration date of the MDH program (that is, September 30, 2017 under current law). CMS is currently granting a 31-day extension to the deadline at § 412.92(b)(2)(v) for the State of Texas. If a hospital located in these areas that is classified as an MDH applies for classification as an SCH under the provisions of § 412.92(b)(2)(v), and that hospital’s SCH status is approved, the effective date of approval of SCH status will be the day following the expiration date of the MDH program if such hospital applies for classification as a SCH not later than October 2, 2017.

Low-volume hospital

In accordance with Waivers or Modifications of Requirements under Section 1135 of the Social Security Act issued August 26, 2017 by Secretary Price, CMS is modifying the September 1, 2017 deadline for hospitals to make a written request for low-volume hospital status that is received by its Medicare Administrative Contractor (MAC) in order for the 25-percent low-volume hospital payment adjustment to be applied to payments for its discharges beginning on or after the start of the Federal fiscal year (FY) 2018. CMS is currently granting a 31-day extension to the deadline established in the FY 2018 Inpatient Prospective Payment System (IPPS)/LTCH PPS Long-Term Care Hospital Prospective Payment System (LTCH PPS) final rule (82 FR 38186) for the State of Texas. Requests for low-volume hospital status for FY 2018 from a hospital located in these areas must be received by the MAC no later than October 2, 2017 in order for the low-volume hospital payment adjustment to be applied beginning with the start of the FY 2018 (that is, for discharges occurring on or after October 1, 2017).

Appeal Administrative Relief for Areas Affected by Hurricane Harvey

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

Replacement Prescription Fills – This information added on September 19, 2017.

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

Moratoria on Part B Non-emergency Ambulance Suppliers

CMS has authority under 42 C.F.R. § 424.570(d) to lift a moratorium at any time if the President declares an area a disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act. On August 25, 2017, the President of the United States signed the Presidential Disaster Declaration for several counties in the State of Texas. As a result of the President’s declaration CMS has carefully reviewed the potential impact of continued moratorium in Texas and is lifting the temporary enrollment moratoria on Part B non-emergency ambulance suppliers in Texas in order to aid in the disaster response. This lifting applies to Medicare, Medicaid and the Children’s Health Insurance Program (CHIP) and became effective September 1, 2017. CMS will also publish a document in the Federal Register to announce that the moratoria on Part B non-emergency ambulance suppliers has been lifted. Providers and suppliers that were unable to enroll because of the moratorium will be designated to CMS’ high screening level under 42 CFR § 424.518(c)(3)(iii) to the extent these providers and suppliers enroll in Medicare in the future.

Requesting an 1135 Waiver

Information for requesting an 1135 waiver, when a blanket waiver hasn’t been approved, can be found at https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Requesting-an-1135-Waiver-Updated-11-16-2016.pdf.
ADDITIONAL INFORMATION
The Centers for Disease Control and Prevention released ICD-10-CM coding advice to report healthcare encounters in the hurricane aftermath.


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Tropical Storm Harvey and Medicare Disaster Related Louisiana Claims – Fourth Revision

MLN Matters Number: SE17021 Revised
Article Release Date: September 19, 2017

This article was revised on September 19, 2017, to include information on replacement prescription fills of covered Part B drugs. All other information remains the same.

PROVIDER TYPES AFFECTED
This MLN Matters® Special Edition Article is intended for providers and suppliers who submit claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries in the State of Louisiana who were affected by Tropical Storm Harvey.

PROVIDER INFORMATION AVAILABLE
On August 28, 2017, pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act, President Trump declared that, as a result of the effects of Tropical Storm Harvey, an emergency exists in the State of Louisiana, retroactive to August 27, 2017. Also on August 28, 2017, Secretary Price of the Department of Health & Human Services declared that a public health emergency exists in the State of Louisiana and authorized waivers and modifications under Section 1135 of the Social Security Act (the Act), retroactive to August 27, 2017.

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

Additional blanket waiver requests are being reviewed. The most current waiver information can be found under Administrative Actions at https://www.cms.gov/About-CMS/Agency-Information/Emergency/Hurricanes.html. This article will be updated as additional waivers are approved. See the Background section of this article for more details.

BACKGROUND

Section 1135 and Section 1812(f) Waivers

As a result of the aforementioned declarations, CMS has instructed the MACs as follows:
1. Change Request (CR) 6451 (Transmittal 1784, Publication 100-04) issued on July 31, 2009, applies to items and services furnished to Medicare beneficiaries within the State of Louisiana from August 27, 2017, for the duration of the emergency. In accordance with CR6451, use of the “DR” condition code and the “CR” modifier are mandatory on claims for items and services for which Medicare payment is conditioned on the presence of a “formal waiver” including, but not necessarily limited to, waivers granted under either Section 1135 or Section 1812(f) of the Act.

2. The most current information can be found at [https://www.cms.gov/emergency](https://www.cms.gov/emergency). Medicare FFS Questions & Answers (Q&As) posted in the downloads section at the bottom of the Emergency Response and Recovery webpage and also referenced below are applicable for items and services furnished to Medicare beneficiaries within the State of Louisiana. These Q&As are displayed in two files:

- The first listed file addresses policies and procedures that are applicable without any Section 1135 or other formal waiver. These policies are always applicable in any kind of emergency or disaster, including the current emergency in Louisiana.
- The second file addresses policies and procedures that are applicable only with approved Section 1135 waivers or, when applicable, approved Section 1812(f) waivers. These Q&As are applicable for approved Section 1135 blanket waivers and approved individual 1135 waivers requested by providers and are effective August 27, 2017, for Louisiana.

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

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

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

**Blanket Waivers Issued by CMS**

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

**Skilled Nursing Facilities**

- Section 1812(f): Waiver of the requirement for a 3-day prior hospitalization for coverage of a skilled nursing facility (SNF) stay provides temporary emergency coverage of SNF services without a qualifying hospital stay, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of Tropical Storm Harvey in the State of Louisiana in 2017. In addition, for certain beneficiaries who recently exhausted their SNF benefits, it authorizes renewed SNF coverage without first having to start a new benefit period. (Blanket waiver for all impacted facilities)

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

**Home Health Agencies**

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


**Critical Access Hospitals**

This action waives the requirements that Critical Access Hospitals limit the number of beds to 25, and that the length of stay be limited to 96 hours. (Blanket waiver for all impacted hospitals)
Housing Acute Care Patients In Excluded Distinct Part Units

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

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

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


Application Deadline Extended for Reclassifications Submission to MGCRB

In accordance with Waiver or Modification of Requirements under Section 1135 of the Social Security Act issued August 28, 2017, by Secretary Price, CMS is modifying the September 1, 2017, deadline for applications for FY 2019 reclassifications to be submitted to the Medicare Geographic Classification Review Board (MGCRB). CMS is currently granting a 31-day extension to the deadline at § 412.256(a)(2) for the State of Louisiana. Applications for FY 2019 reclassifications from hospitals in these areas must be received by the MGCRB not later than October 2, 2017.

Deadline Extended for IPPS Wage Index Requests

Regarding the FY 2019 wage index, CMS is modifying the September 1, 2017, deadline specified in the FY 2019 Hospital Wage Index Development Time Table for these hospitals to request revisions to and provide documentation for their FY 2015 Worksheet S-3 wage data and CY 2016 occupational mix data, as included in the May 18, 2017, and July 12, 2017, preliminary PUFs, respectively. CMS is currently granting an extension for hospitals in the State of Louisiana until October 2, 2017. MACs must receive the revision requests and supporting documentation by this date. If hospitals encounter difficulty meeting this extended deadline of October 2, 2017, hospitals should communicate their concerns to CMS via their MAC, and CMS may consider an additional extension if CMS determines it is warranted.

Facilities Quality Reporting

CMS is granting exceptions under certain Medicare quality reporting and value-based purchasing programs without having to submit an extraordinary circumstances exception request if they are located in one of the Louisiana parishes, all of which have been designated by the Federal Emergency Management Agency (FEMA) as a major disaster county. Further information can be found in the memo on applicability of reporting requirements to certain providers in the Downloads section at https://www.cms.gov/About-CMS/Agency-Information/Emergency/Hurricanes.html.

Medicare-dependent small, rural hospitals (MDHs)

In accordance with Waivers or Modifications of Requirements under Section 1135 of the Social Security Act issued August 28, 2017 by Secretary Price, CMS is modifying the September 1, 2017 deadline for Medicare-dependent small, rural hospitals (MDHs) to apply for sole community hospital (SCH) status in advance of the expiration of the MDH program with an effective date of an approval of SCH status that is the day following the expiration date of the MDH program (that is, September 30, 2017 under current law). CMS is currently granting a 31-day extension to the deadline at § 412.92(b)(2)(v) for the State of Louisiana. If a hospital located in these areas that is classified as an MDH applies for classification as an SCH under
the provisions of § 412.92(b)(2)(v), and that hospital’s SCH status is approved, the effective date of approval of SCH status will be the day following the expiration date of the MDH program if such hospital applies for classification as a SCH not later than October 2, 2017.

Low-volume hospital

In accordance with Waivers or Modifications of Requirements under Section 1135 of the Social Security Act issued August 28, 2017 by Secretary Price, CMS is modifying the September 1, 2017 deadline for hospitals to make a written request for low-volume hospital status that is received by its Medicare Administrative Contractor (MAC) in order for the 25-percent low-volume hospital payment adjustment to be applied to payments for its discharges beginning on or after the start of the Federal fiscal year (FY) 2018. CMS is currently granting a 31-day extension to the deadline established in the FY 2018 Inpatient Prospective Payment System (IPPS)/LTCH PPS Long-Term Care Hospital Prospective Payment System (LTCH PPS) final rule (82 FR 38186) for the State of Louisiana. Requests for low-volume hospital status for FY 2018 from a hospital located in these areas must be received by the MAC no later than October 2, 2017 in order for the low-volume hospital payment adjustment to be applied beginning with the start of the FY 2018 (that is, for discharges occurring on or after October 1, 2017).

Appeal Administrative Relief for Areas Affected by Tropical Storm Harvey

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

Replacement Prescription Fills – This information added on September 19, 2017.

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

Requesting an 1135 Waiver

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

ADDITIONAL INFORMATION

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


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<tr>
<td>September 5, 2017</td>
<td>The article was revised on September 5, 2017, to include additional information about housing acute care patients in excluded distinct part units. In addition, information has been added to the Facilities Quality Reporting Section on page 4 and the second paragraph of the Provider Information Available section is modified to clarify that waivers prevent gaps in access to care.</td>
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</table>
September 1, 2017 | The article was revised to include additional waiver information for Medicare-dependent small, rural hospitals and for low-volume hospitals. Information regarding administrative relief related to timely filing of appeals was added. All other information remained the same.

August 31, 2017 | Initial article released.

Hurricane Irma and Medicare Disaster Related United States Virgin Islands, Commonwealth of Puerto Rico and State of Florida Claims – Second Revision

MLN Matters Number: SE17022 Revised
Article Release Date: September 19, 2017

This article was revised on September 19, 2017, to include new waivers regarding care for excluded inpatient psychiatric unit patients in the acute care unit of a hospital and care for excluded inpatient rehabilitation unit patients in the acute care unit of a hospital, to add information on replacement prescription fills of covered Part B drugs, and information on Facilities Quality Reporting. All other information remains the same.

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

PROVIDER INFORMATION AVAILABLE

On September 7, 2017, the Administrator of the Centers for Medicare & Medicaid Services (CMS) authorized waivers under Section 1812(f) of the Social Security Act for the United States Virgin Islands, Commonwealth of Puerto Rico and State of Florida, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of Hurricane Irma in 2017.

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

Additional blanket waiver requests are being reviewed. The most current waiver information can be found under Administrative Actions at https://www.cms.gov/About-CMS/Agency-Information/Emergency/Hurricanes.html. This article will be updated as additional waivers are approved. See the Background section of this article for more details.
BACKGROUND

Section 1135 and Section 1812(f) Waivers

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

1. Change Request (CR) 6451 (Transmittal 1784, Publication 100-04) issued on July 31, 2009, applies to items and services furnished to Medicare beneficiaries within the United States Virgin Islands and Commonwealth of Puerto Rico from September 5, 2017, and the State of Florida from September 4, 2017, for the duration of the emergency. In accordance with CR6451, use of the “DR” condition code and the “CR” modifier are mandatory on claims for items and services for which Medicare payment is conditioned on the presence of a “formal waiver” including, but not necessarily limited to, waivers granted under either Section 1135 or Section 1812(f) of the Act.

2. The most current information can be found at https://www.cms.gov/emergency. Medicare FFS Questions & Answers (Q&As) posted in the downloads section at the bottom of the Emergency Response and Recovery webpage and also referenced below are applicable for items and services furnished to Medicare beneficiaries within the United States Virgin Islands, Commonwealth of Puerto Rico and State of Florida. These Q&As are displayed in two files:

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

- The second file addresses policies and procedures that are applicable only with approved Section 1135 waivers or, when applicable, approved Section 1812(f) waivers. These Q&As are applicable for approved Section 1135 blanket waivers and approved individual 1135 waivers requested by providers and are effective September 5, 2017, for the United States Virgin Islands and Commonwealth of Puerto Rico and September 4, 2017, for the State of Florida.

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

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

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

Blanket Waivers Issued by CMS

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

Skilled Nursing Facilities

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

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

Home Health Agencies

- 42 CFR 484.20(c)(1): This waiver provides relief to Home Health Agencies on the timeframes related to OASIS Transmission. (Blanket waiver for all impacted agencies)
Critical Access Hospitals
This action waives the requirements that Critical Access Hospitals limit the number of beds to 25, and that the length of stay be limited to 96 hours. (Blanket waiver for all impacted hospitals)

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

Care for Excluded Inpatient Psychiatric Unit Patients in the Acute Care Unit of a Hospital – This information added on September 19, 2017.
CMS has determined it is appropriate to issue a blanket waiver to IPPS and other acute care hospitals with excluded distinct part inpatient psychiatric units that, as a result of Hurricane Irma, need to relocate inpatients from the excluded distinct part psychiatric unit to an acute care bed and unit. The hospital should continue to bill for inpatient psychiatric services under the inpatient psychiatric facility prospective payment system for such patients and annotate the medical record to indicate the patient is a psychiatric inpatient being cared for in an acute care bed because of capacity or other exigent circumstances related to the hurricane. This waiver may be utilized where the hospital’s acute care beds are appropriate for psychiatric patients and the staff and environment are conducive to safe care. For psychiatric patients, this includes assessment of the acute care bed and unit location to ensure those patients at risk of harm to self and others are safely cared for.

Care for Excluded Inpatient Rehabilitation Unit Patients in the Acute Care Unit of a Hospital – This information added on September 19, 2017.
CMS has determined it is appropriate to issue a blanket waiver to IPPS and other acute care hospitals with excluded distinct part inpatient Rehabilitation units that, as a result of Hurricane Irma, need to relocate inpatients from the excluded distinct part Rehabilitation unit to an acute care bed and unit. The hospital should continue to bill for inpatient rehabilitation services under the inpatient rehabilitation facility prospective payment system for such patients and annotate the medical record to indicate the patient is a rehabilitation inpatient being cared for in an acute care bed because of capacity or other exigent circumstances related to the hurricane. This waiver may be utilized where the hospital’s acute care beds are appropriate for providing care to rehabilitation patients and such patients continue to receive intensive rehabilitation services.

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


Facilities Quality Reporting – This information added on September 19, 2017.
CMS is granting exceptions under certain Medicare quality reporting and value-based purchasing programs without having to submit an extraordinary circumstances exception request if they are located in one of the Florida counties, Puerto Rico municipios, or U.S. Virgin Islands county-equivalents, all of which have been designated by the Federal Emergency Management Agency (FEMA) as a major disaster county, municipio, or county-equivalent. Further information can be found in the memo on applicability of reporting

**Appeal Administrative Relief for Areas Affected by Hurricane Irma**

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

**Replacement Prescription Fills – This information added on September 19, 2017.**

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

**Requesting an 1135 Waiver**

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

**ADDITIONAL INFORMATION**

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


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<td>September 8, 2017</td>
<td>Initial article released.</td>
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**Hurricane Irma and Medicare Disaster Related South Carolina and Georgia Claims – Second Revision**

**MLN Matters Number: SE17024 Revised**

**Article Release Date: September 19, 2017**

This article was revised on September 19, 2017, to include new waivers regarding care for excluded inpatient psychiatric unit patients in the acute care unit of a hospital and care for excluded inpatient rehabilitation unit patients in the acute care unit of a hospital and to add information on replacement prescription fills of covered Part B drugs. All other information remains the same.

**PROVIDER TYPES AFFECTED**

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

**PROVIDER INFORMATION AVAILABLE**

On September 7, 2017, pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act, President Trump declared that, as a result of the effects of Hurricane Irma, an emergency exists in the State of South Carolina. On September 8, 2017, pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act, President Trump declared that, as a result of the effects of Hurricane Irma, an emergency
exists in the State of Georgia. Also on September 8, 2017, Secretary Price of the Department of Health & Human Services declared that a public health emergency exists in the States of South Carolina and Georgia and authorized waivers and modifications under Section 1135 of the Social Security Act (the Act), retroactive to September 6, 2017, for the State of South Carolina and retroactive to September 7, 2017, for the State of Georgia.

On September 8, 2017, the Administrator of the Centers for Medicare & Medicaid Services (CMS) authorized waivers under Section 1812(f) of the Social Security Act for the States of South Carolina and Georgia, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of Hurricane Irma in 2017.

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

The most current waiver information can be found under Administrative Actions at https://www.cms.gov/About-CMS/Agency-Information/Emergency/Hurricanes.html. See the Background section of this article for more details.

BACKGROUND

Section 1135 and Section 1812(f) Waivers

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

1. Change Request (CR) 6451 (Transmittal 1784, Publication 100-04) issued on July 31, 2009, applies to items and services furnished to Medicare beneficiaries within the State of South Carolina from September 6, 2017, and the State of Georgia from September 7, 2017, for the duration of the emergency. In accordance with CR6451, use of the “DR” condition code and the “CR” modifier are mandatory on claims for items and services for which Medicare payment is conditioned on the presence of a “formal waiver” including, but not necessarily limited to, waivers granted under either Section 1135 or Section 1812(f) of the Act.

2. The most current information can be found at https://www.cms.gov/emergency. Medicare FFS Questions & Answers (Q&As) posted in the downloads section at the bottom of the Emergency Response and Recovery webpage and also referenced below are applicable for items and services furnished to Medicare beneficiaries within the States of South Carolina and Georgia. These Q&As are displayed in two files:

- The first listed file addresses policies and procedures that are applicable without any Section 1135 or other formal waiver. These policies are always applicable in any kind of emergency or disaster, including the current emergency in the States of South Carolina and Georgia.

- The second file addresses policies and procedures that are applicable only with approved Section 1135 waivers or, when applicable, approved Section 1812(f) waivers. These Q&As are applicable for approved Section 1135 blanket waivers and approved individual 1135 waivers requested by providers and are effective September 6, 2017, for the State South Carolina and September 7, 2017, for the State of Georgia.

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

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

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

Blanket Waivers Issued by CMS

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

**Skilled Nursing Facilities**

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

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

**Home Health Agencies**

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

**Critical Access Hospitals**

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

**Housing Acute Care Patients In Excluded Distinct Part Units**

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

**Care for Excluded Inpatient Psychiatric Unit Patients in the Acute Care Unit of a Hospital – This information added on September 19, 2017.**

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

**Care for Excluded Inpatient Rehabilitation Unit Patients in the Acute Care Unit of a Hospital – This information added on September 19, 2017.**

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

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

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


**Appeal Administrative Relief for Areas Affected by Hurricane Irma**

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

**Replacement Prescription Fills – This information added on September 19, 2017.**

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

**Requesting an 1135 Waiver**

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

**ADDITIONAL INFORMATION**

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


**DOCUMENT HISTORY**

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<tr>
<td>September 19, 2017</td>
<td>The article was revised to include new waivers regarding care for excluded inpatient psychiatric unit patients in the acute care unit of a hospital and care for excluded inpatient rehabilitation unit patients in the acute care unit of a hospital and to add information on replacement prescription fills of covered Part B drugs. All other information remains the same.</td>
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<tr>
<td>September 11, 2017</td>
<td>Initial article released.</td>
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**Hurricane Maria and Medicare Disaster Related United States Virgin Islands and Commonwealth of Puerto Rico Claims**

**MLN Matters Number: SE17028**

**Article Release Date: September 21, 2017**

**PROVIDER TYPE AFFECTED**

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

**PROVIDER INFORMATION AVAILABLE**

On September 18, 2017, pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act, President Trump declared that, as a result of the effects of Hurricane Maria, an emergency exists
in the United States Virgin Islands and the Commonwealth of Puerto Rico. Also on September 19, 2017, Secretary Price of the Department of Health & Human Services declared that a public health emergency exists in the United States Virgin Islands and the Commonwealth of Puerto Rico and authorized waivers and modifications under Section 1135 of the Social Security Act (the Act), retroactive to September 16, 2017, for the United States Virgin Islands and retroactive to September 17, 2017, for the Commonwealth of Puerto Rico.

On September 19, 2017, the Administrator of the Centers for Medicare & Medicaid Services (CMS) authorized waivers under Section 1812(f) of the Social Security Act for the United States Virgin Islands and the Commonwealth of Puerto Rico, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of Hurricane Maria in 2017.

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

The most current waiver information can be found at https://www.cms.gov/About-CMS/Agency-Information/Emergency/Hurricanes.html. See the Background section of this article for more details.

BACKGROUND

Section 1135 and Section 1812(f) Waivers

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

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

2. The most current information can be found at https://www.cms.gov/emergency. Medicare FFS Questions & Answers (Q&As) posted in the downloads section at the bottom of the Emergency Response and Recovery webpage and also referenced below are applicable for items and services furnished to Medicare beneficiaries within the United States Virgin Islands and the Commonwealth of Puerto Rico. These Q&As are displayed in two files:

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

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

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

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

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

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

**Skilled Nursing Facilities**

- Section 1812(f): Waiver of the requirement for a 3-day prior hospitalization for coverage of a skilled nursing facility (SNF) stay provides temporary emergency coverage of SNF services without a qualifying hospital stay, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of Hurricane Maria in the United States Virgin Islands and the Commonwealth of Puerto Rico in 2017. In addition, for certain beneficiaries who recently exhausted their SNF benefits, it authorizes renewed SNF coverage without first having to start a new benefit period. (Blanket waiver for all impacted facilities)
- 42 CFR 483.20: Waiver provides relief to Skilled Nursing Facilities on the timeframe requirements for Minimum Data Set assessments and transmission. (Blanket waiver for all impacted facilities)

**Home Health Agencies**

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

**Critical Access Hospitals**

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

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

(Blanket waiver for all IPPS hospitals located in the affected areas that need to use distinct part beds for acute care patients as a result of the hurricane.)

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

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

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

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


Appeal Administrative Relief for Areas Affected by Hurricane Maria

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Replacement Prescription Fills

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

Requesting an 1135 Waiver

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

ADDITIONAL INFORMATION

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


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New PEPPER Available for Partial Hospitalization Programs

The Centers for Medicare & Medicaid Services (CMS) have made available free provider-specific comparative data reports for partial hospitalization programs (PHPs) nationwide. The Program for Evaluating Payment Patterns Electronic Report (PEPPER) summarizes PHP claims data statistics for areas that may be at risk for improper Medicare payments. PHPs can use the data to support internal auditing and monitoring activities. PEPPER is a free report comparing a PHP’s Medicare billing practices with other PHPs in the nation, Medicare Administrative Contractor (MAC) jurisdiction and state. CMS has contracted with TMF® Health Quality Institute to develop and distribute the reports.

Free-standing PHPs can access their PEPPER via the PEPPER Resources Portal:

- Visit the Distribution Schedule - Get Your PEPPER page at PEPPERresources.org.
- Review the instructions and obtain the information required to authenticate access through the PEPPER Resources Portal (the PHP’s CMS certification number and a medical record number or patient control
number from a paid traditional Medicare fee-for-service claim for services with a “from” or “through” date between October 1-December 31, 2016).

- Access the PEPPER Resources Portal.
- Complete all the fields.
- Download the PEPPER.

PHPs administered by short-term acute care hospitals or inpatient psychiatric facilities received their PEPPER via the QualityNet secure portal. The PEPPER file was uploaded to the inbox of QualityNet account administrators and those with user accounts with the PEPPER recipient roles. Updated in this release:

- The “Group Therapy” target area was revised to identify group therapy by HCPCS codes (not revenue code).
- The “No Individual Psychotherapy” target area was revised to only consider individual psychotherapy (not psychiatric testing) and to identify individual psychotherapy using HCPCS codes (not revenue code).
- The “Outlier Payments” has been discontinued.

For more information on the PHP PEPPER, such as the PHP PEPPER User’s Guide and a sample PHP PEPPER, please visit PEPPERresources.org. A WebEx training session reviewing the PEPPER is scheduled for August 10; for more information see here. Questions about PEPPER may be submitted through the Help Desk.

New PEPPER Available for Home Health Agencies

The Centers for Medicare & Medicaid Services (CMS) have made available free provider-specific comparative data reports for home health agencies (HHAs) nationwide. The Program for Evaluating Payment Patterns Electronic Report (PEPPER) summarizes HHA claims data statistics for areas that may be at risk for improper Medicare payments.

HHAs can use the data to support internal auditing and monitoring activities. PEPPER is a free report comparing an HHA’s Medicare billing practices with other HHAs in the nation, Medicare Administrative Contractor (MAC) jurisdiction and state. CMS has contracted with TMF® Health Quality Institute to develop and distribute the reports. To access the HHA PEPPER:

- Visit the Distribution Schedule - Get Your PEPPER page at PEPPERresources.org.
- Review the instructions and obtain the information required to authenticate access through the PEPPER Resources Portal (the HHA’s CMS certification number and a medical record number or patient control number from a paid traditional Medicare fee-for-service claim for services with a “from” or “through” date between October 1-December 31, 2016).
- Access the PEPPER Resources Portal.
- Complete all the fields.
- Download the PEPPER.

For more information on the HHA PEPPER, such as the HHA PEPPER User’s Guide and a sample HHA PEPPER, please visit PEPPERresources.org. A WebEx training session reviewing the PEPPER is scheduled for August 3; for more information see here. Questions about PEPPER may be submitted through the Help Desk.

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.
IOM Update – Pub. 100-04, Chapter 15 – Ambulance, to Restore Multiple Patients on One Trip Instructions

MLN Matters Number: MM10245
Related Change Request (CR) Number: 10245
Related CR Release Date: September 1, 2017
Effective Date: October 2, 2017
Related CR Transmittal Number: R3855CP
Implementation Date: October 2, 2017

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

PROVIDER ACTION NEEDED
Change Request (CR) 10245 alerts providers that instructions in Section 30.1.2 of Chapter 15 – Ambulance, concerning “Multiple Patients on One Trip” were inadvertently omitted from the current version of the Medicare Claims Processing Manual. CR10245 restores the missing instructions to Section 30.1.2. Be aware that this CR10245 contains no policy changes but does update the manual section.

BACKGROUND
The omitted language that is being added back into the manual is as follows:

Ambulance suppliers submitting a claim using the ASC X12 professional format or the CMS-1500 paper form for an ambulance transport with more than one Medicare patient onboard must use the “GM” modifier (“Multiple Patients on One Ambulance Trip”) for each service line item. In addition, suppliers are required to submit documentation to A/B MACs (Part B) to specify the particulars of a multiple patient transport. The documentation must include the total number of patients transported in the vehicle at the same time and the health insurance claim numbers (HICN) for each Medicare beneficiary.

Ambulance claims submitted on or after January 1, 2011 in version 5010 of the ASC X12 837 professional claim format require the presence of a diagnosis code and the absence of diagnosis code will cause the ambulance claim to not be accepted into the claims processing system. The presence of a diagnosis code on an ambulance claim is not required as a condition of ambulance payment policy. The adjudicative process does not take into account the presence (or absence) of a diagnosis code but a diagnosis code is required on the ASC X12 837 professional claim format.

ADDITIONAL INFORMATION
Redetermination Requests Which Contain Multiple ICNs

When submitting a Redetermination request that contains multiple Internal Control Numbers (ICNs), include and follow the below to ensure proper review and prompt response.

- Attach a spreadsheet. If submitting multiple spreadsheets, include page numbers. It/they must contain the below and follow the same order as the included beneficiary appeal specific documentation.
  - Each beneficiary name
  - Each beneficiary Health Insurance Claim Number (HICN)
  - Claim(s) Date(s) of Service (DOS)
  - Procedure code(s) and associated ICN(s)
  - Letter Number located on the Demand letter if applicable
  - Accounts Receivable (AR) number(s) if applicable
- Separate each beneficiary documentation with a spacer page.
- Include documentation relevant to the request only
Recovery Auditor Program (RAC) Updates

HMS, Region 4 Recovery Auditor Contractor, has been approved by the Centers for Medicare & Medicaid Services (CMS) to begin auditing claims.

Providers can customize their address within the HMS Provider Portal Contact Customization. The HMS Provider Portal is available for all Region 4 Providers. Providers may contact HMS for further information regarding the HMS portal located at [https://racinfo.hms.com/home.aspx](https://racinfo.hms.com/home.aspx). Providers customizing their address will ensure HMS mails letters to the correct address.

The list of audit issues that are identified by HMS must first be approved by CMS. The listing of new issues is located at [https://racinfo.hms.com/Public1/NewIssues.aspx](https://racinfo.hms.com/Public1/NewIssues.aspx).

Office of Inspector General Reports Highlight Hospital Billing Issues

MLN Matters Number: SE17017
Initial Article Release Date: September 7, 2017

**PROVIDER TYPE AFFECTED**
This MLN Matters Article is intended for hospitals billing Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

**PROVIDER ACTION NEEDED**
In two recent reports, the Office of Inspector General (OIG) cites two significant issues in which hospitals are making coding errors on Medicare claims. Correct coding of claims is important for hospitals to avoid improper payments, which can lead to recoveries of overpayments. The Centers for Medicare & Medicaid Services (CMS) encourages hospital billing and coding personnel to review the OIG reports and take steps to avoid the problems identified in those reports. It is also very important that claims submitted are supported by documentation in the beneficiary’s medical records.

**BACKGROUND**
The OIG reports referenced in this article focused on claims for Right Heart Catheterizations (RHCs) with heart biopsies that used modifier -59 and claims for 96 or more continuous hours of mechanical ventilation.

**Improper Use of Modifier -59**
In the first report, “Hospitals Nationwide Generally Did Not Comply with Medicare Requirements for Billing Outpatient Right Heart Catheterizations with Heart Biopsies,” the OIG analyzed claims to determine if hospitals were correctly reporting modifier -59 for RHCs and heart biopsies. The OIG found that in billing for outpatient RHCs with heart biopsies, hospitals often use modifier -59 inappropriately, which leads to significant overpayments and overpayment recoveries on claims for these services. Providers may want to review MLN Matters Special Edition Article SE1418 on the Proper Use of Modifier 59. Providers may also want to review MLN Matters article MM8863 (based on Change Request (CR) 8863.

Medicare billing policy allows hospitals to include modifier -59, which indicates that a procedure is separate and distinct from another procedure performed on the same patient on the same day when the procedures performed were separate and distinct. Some hospitals incorrectly billed outpatient RHCs that were performed during the same patient encounter as heart biopsies. By appending modifier -59 to the HCPCS code to claims for RHCs and heart biopsies, some hospitals represented that the RHCs were separate and distinct from the heart biopsies; however, the payment for a heart biopsy is generally intended to cover an RHC when the RHC is performed during the same encounter.

For example, a hospital billed a procedure with modifier -59 for a beneficiary who received an RHC and a heart biopsy on the same date of service. The medical record documentation did not support the use of the modifier and, as a result, Medicare made an overpayment on the claim. Medicare recovered the overpayment.

**Incorrect Procedure Coding for Mechanical Ventilation**
In the second report, “Medicare Improperly Paid Hospitals for Beneficiaries Who Had Not Received 96 or More Consecutive Hours of Mechanical Ventilation,” the OIG states that hospitals often use...
incorrect procedure codes when billing for mechanical ventilation. In their study of mechanical ventilation billings, the OIG looked at the relation between Medicare Severity - Diagnosis Related Groups (MS-DRGs) billed to the procedures coded for those DRGs.

Specifically, the OIG looked at the MS-DRG 207 (Respiratory system diagnosis [with] ventilator support 96+ hours) and MS-DRG 870 (Septicemia or severe sepsis [with mechanical ventilation] 96+ hours). The OIG focused on claims where the estimated potential mechanical ventilation procedure length was 4 days or less, based on the date the hospital reported on the claim that mechanical ventilation started. Some hospitals billed MS-DRGs that indicated a stay where 96 or more consecutive hours of mechanical ventilation was provided to the beneficiary, while the estimated potential mechanical ventilation procedure length indicated 4 days or less. Such claims represent overpayments.

In some instances, it appears that coders were likely looking at the number of days in a stay when coding the procedure code for ventilator support. For example, medical record documentation (physician’s notes and ventilation records) showed a beneficiary received 68 hours of mechanical ventilation with a stay of 4 days or fewer. However, the claim procedure code showed 96 or more hours of mechanical ventilation were provided. This caused the claim to be grouped to MS-DRG 870 rather than MS-DRG 871. This resulted in a significant overpayment that Medicare recovered from the hospital.

In another example, medical record documentation (ventilation records) showed that a beneficiary was in the hospital for 5 days and received a total of 91 hours of ventilation, but the procedure code on the claim indicated 96 or more consecutive hours of mechanical ventilation was provided. This also resulted in grouping the claim to a MS-DRG that led to a higher and incorrect payment, which Medicare recovered from the hospital.

**ADDITIONAL INFORMATION**

Medicare encourages hospital billing and coding staff to review the Medicare manual sections and other sources noted in the resources below to ensure proper billing of ventilation support services and on the proper use of modifier -59. The “Medicare Claims Processing Manual,” Chapter 3, Inpatient Hospital Billing, Section 10, General Inpatient Requirements at [https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c03.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c03.pdf) is a good starting point.


The OIG report, “Hospitals Nationwide Generally Did Not Comply with Medicare Requirements for Billing Outpatient Right Heart Catheterizations with Heart Biopsies,” is available at [https://oig.hhs.gov/oas/reports/region1/11300511.pdf](https://oig.hhs.gov/oas/reports/region1/11300511.pdf).

The OIG report, “Medicare Improperly Paid Hospitals for Beneficiaries Who Had Not Received 96 or more Consecutive Hours of Mechanical Ventilation,” is available at [https://oig.hhs.gov/oas/reports/region9/91402041.pdf](https://oig.hhs.gov/oas/reports/region9/91402041.pdf).

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

**DATE OF CHANGE**

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<td>September 7, 2017</td>
<td>Initial article released.</td>
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QMB Indicator in the Medicare Fee-For-Service Claims Processing System – Second Revision

MLN Matters® Number: MM9911 Revised
Related Change Request (CR) #: CR 9911
Related CR Release Date: June 28, 2017
Effective Date: for claims processed on or after October 2, 2017
Related CR Transmittal #: R3802CP
Implementation Date: October 2, 2017

The article was revised on June 29, 2017, to reflect a revised CR9911 issued on June 28, 2017. In the article, the CR release date, transmittal number, and the Web address of CR9911 are revised. Clarifications are also made to the second paragraph of the Background section. 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.

Federal law bars Medicare providers from billing a QMB individual for Medicare Part A and B deductibles, coinsurance, or copayments, under any circumstances. Sections 1902(n)(3)(B); 1902(n)(3)(C); 1905(p) (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 payment for Medicare cost-sharing, under certain circumstances. Regardless, QMB individuals have no legal liability to pay Medicare providers for Medicare Part A or Part B cost-sharing. Providers may seek reimbursement for unpaid Medicare deductible and coinsurance amounts as a Medicare bad debt related to dual eligible beneficiaries under CMS Pub. 15-1, Chapter 3 of the Provider Reimbursement Manual (PRM).

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**


**CWF to Modify Provider Queries to Only Accept NPI as Valid Provider Number**

MLN Matters Number: MM10098
Related Change Request (CR) Number: CR10098
Related CR Release Date: July 27, 2017
Effective Date: January 1, 2018
Related CR Transmittal Number: R1877OTN
Implementation Date: January 2, 2018

**PROVIDER TYPES AFFECTED**

This MLN Matters® Article is intended for physicians, providers, and suppliers querying Medicare’s Common Working File (CWF) for checking eligibility and entitlement status for Medicare beneficiaries.
PROVIDER ACTION NEEDED
This article is based on Change Request (CR) 10098, which informs the MACs about modifications to the CWF Provider Queries, ELGA, ELGH, HIQA, HIQH, and HUQA, to only accept the National Provider Identifier (NPI) as a valid Provider Number. Make sure that your billing staffs are aware of these changes.

BACKGROUND
Providers, clearinghouses, and/or third-party vendors, herein referred to as “Trading Partners,” verify an individual’s Medicare eligibility and entitlement status prior to and/or while the individual is receiving services before billing Medicare for services rendered to Medicare beneficiaries using HIPAA Eligibility Transaction System (HETS) and/or CWF.

Within CWF, Trading Partners use CWF Provider Queries, ELGA, ELGH, HIQA, HIQH, and HUQA. Currently, Trading Partners are allowed to use either legacy Provider Numbers (CMS Certification Number (CCN) or Unique Physician Identification Number (UPIN)) or NPI on CWF Provider Queries.

The Centers for Medicare & Medicaid Services (CMS) is requiring CWF to modify CWF Provider Queries to only accept NPI as a valid Provider Number.

ADDITIONAL INFORMATION

HPTCs Code Set – October 2017 Update
MLN Matters Number: MM10141
Related Change Request (CR) # 10141
CR Release Date: August 18, 2018
Effective Date: October 1, 2017
Related CR Transmittal Number: R3842CP
Implementation Date: January 2, 2018 – Contractors with capability to do so will implement effective October 1, 2017

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

PROVIDER ACTION NEEDED
Change Request (CR) 10141 instructs MACs to obtain the most recent Healthcare Provider Taxonomy Code (HPTC) set and to update their internal HPTC tables and/or reference files.

BACKGROUND
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that covered entities comply with the requirements in the electronic transaction format implementation guides adopted as national standards. The institutional and professional claim electronic standard implementation guides (X12 837-I and 837-P) each require use of valid codes contained in the HPTC set when there is a need to report provider type or physician, practitioner, or supplier specialty for a claim.

You should note that:
• Valid HPTCs are those codes approved by the National Uniform Claim Committee (NUCC) for current use.
• Terminated codes are not approved for use after a specific date.
• Newly approved codes are not approved for use prior to the effective date of the code set update in which each new code first appears.
Specialty and/or provider type codes issued by any entity other than the NUCC are not valid.

Medicare would be guilty of non-compliance with HIPAA if MACs accepted claims that contain invalid HPTCs.

The HPTC set is maintained by the NUCC for standardized classification of health care providers. The NUCC updates the code set twice a year with changes effective April 1 and October 1. The HPTC list is available for view from the Washington Publishing Company (WPC) website at www.wpc-edi.com/codes and can be downloaded from the NUCC’s website http://www.nucc.org/index.php/code-sets-mainmenu-41/provider-taxonomy-mainmenu-40.

Although the NUCC generally posts their updates on the WPC webpage 3 months prior to the effective date, changes are not effective until April 1 or October 1 as indicated in each update. The changes to the code set include the addition of a new code and addition of definitions to existing codes. When reviewing the Health Care Provider Taxonomy code set online, you can identify revisions made since the last release by color code:

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

**ADDITIONAL INFORMATION**


**ICD-10 Coding Revision to NCDs**

**MLN Matters Number:** MM10184  
**Related Change Request Number:** 10184  
**Related CR Release Date:** July 27, 2017  
**Effective Date:** January 1, 2018  
**Related CR Transmittal Number:** R1875OTN  
**Implementation Date:** September 13, 2017 for local edits; January 2, 2018 - shared systems

**PROVIDER TYPES AFFECTED**

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

**PROVIDER ACTION NEEDED**

Change Request (CR) 10184 outlines edits to International Classification of Diseases, 10th Revision (ICD-10) and other coding updates specific to National Coverage Determinations (NCDs) that will be included in subsequent, quarterly releases as needed. No policy-related changes are included with these updates. Any policy-related changes to NCDs continue to be implemented via the current, long-standing NCD process. The following link provides the NCD spreadsheets included with this CR10184 at https://www.cms.gov/Medicare/Coverage/DeterminationProcess/downloads/CR10184.zip.

**BACKGROUND**

CR10184 constitutes a maintenance update of ICD-10 conversions and other coding updates specific to NCDs. These NCD coding changes are the result of newly available codes, coding revisions to NCDs released separately, or coding feedback received.

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

Coding (as well as payment) are separate and distinct areas of the Medicare Program from coverage policy/criteria. Revisions to codes within an NCD are carefully and thoroughly reviewed and vetted by the Centers for Medicare & Medicaid Services (CMS) and are not intended to change the original intent of the NCD. The exception to this is when coding revisions are released as official implementation of new or reconsidered NCD policy following a formal national coverage analysis.

NOTE: The translations from ICD-9 to ICD-10 are not consistent 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.

CR10084 makes coding and clarifying adjustments to the following NCDs:

- NCD160.18 - Vagus Nerve Stimulation
- NCD210.4.1 - Counseling to Prevent Tobacco Use
- NCD220.6.17 - Positron Emission Tomography (PET) for Solid Tumors
- NCD220.6.20 - PET Beta Amyloid in Dementia/Neurological Disorders
- NCD210.13 - Screening for Hepatitis C Virus

NOTE/CLARIFICATION: MACs will use default Council for Affordable Quality Healthcare Committee on Operating Rules (CAQH CORE) messages where appropriate:

- Remittance Advice Remark Code (RARC) N386 with Claim Adjustment Reason Code (CARC) 50, 96, and/or 119
- See latest CAQH CORE update

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

- Group Code PR (Patient Responsibility) assigning financial responsibility to the beneficiary (if a claim is received with occurrence code 32, or with occurrence code 32 and a GA modifier, indicating a signed ABN is on file)
- Group Code CO (Contractual Obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file)

ADDITIONAL INFORMATION

Influenza Virus Vaccine Code – January 2018 Update – Revised

MLN Matters Number: MM10196 Revised
Related Change Request (CR) Number: 10196
Related CR Release Date: August 4, 2017
Effective Date: August 1, 2017
Related CR Transmittal Number: R3827CP
Implementation Date: January 2, 2018

This article was revised on August 9, 2017, to correctly show in all appropriate places the code of Q2039. In the original article, Q0239 was mistakenly referenced in two places and that is corrected to show Q2039. All other information remains the same.

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

PROVIDER ACTION NEEDED
Change Request (CR) 10196, from which this article was developed, provides instructions for payment and edits for the Common Working File (CWF) and the Fiscal Intermediary Shared System (FISS) to include and update new or existing influenza virus vaccine codes. The influenza virus vaccine code set is updated on a quarterly basis. This update will include one new influenza virus vaccine code: 90756. Please make sure your billing staffs are aware of this update.

BACKGROUND
Effective for claims processed with dates of service (DOS) on or after January 1, 2018, influenza virus vaccine code 90756 (Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, antibiotic free, 0.5mL dosage, for intramuscular use) will be payable by Medicare. This new code will be included on the 2018 Medicare Physician Fee Schedule Database file update and the annual Healthcare Common Procedure Coding System (HCPCS) update.

During the interim period of August 1, 2017, through December 31, 2017, MACs will use code Q2039 (Influenza virus vaccine, not otherwise specified) to handle bills for this new influenza virus vaccine product (Influenza virus vaccine, quadrivalent (ccIIV4). Q2039 is already an active code.

The new influenza virus vaccine code 90756 will then be implemented with the January 2018 release for DOS on or after January 1, 2018.

Effective for dates of service on or after August 1, 2017, MACs will use the CMS Seasonal Influenza Vaccines Pricing website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html to determine the payment rate for influenza virus vaccine code Q2039 and 90756.

Medicare will issue further instructions on how to handle claims using Q2039 for the new influenza virus vaccine product between August 1, 2017, and December 31, 2017. MACs will use existing processes to handle these claims.

The new influenza virus vaccine code (90756) is not retroactive to August 1, 2017. Claims will not be accepted for influenza virus vaccine code 90756 between the DOS August 1, 2017, and December 31, 2017. If claims are received in January 2018 with code 90756 for DOS between August 1, 2017, and December 31, 2017, claims will be rejected or returned as unprocessable.

New Vaccine Description
Code 90756 – Long Description: Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, antibiotic free, 0.5mL dosage, for intramuscular use TOS Code: V

- Short Description: CCIIV4 VACC ABX FREE IM
- Medium Description: CCIIV4 VACCINE ANTIBIOTIC FREE 0.5 ML DOS IM USE Long
Payment Basis

Based on reasonable cost, MACs will pay for influenza virus vaccine codes Q2039 and 90756 to:

- Hospitals (Type of Bill 12X and 13X)
- Skilled Nursing Facilities (22X and 23X)
- Home Health Agencies (34X)
- Hospital-based renal dialysis facilities (72X) and
- Critical Access Hospitals (85X)

Based on the lower of the actual charge or 95 percent of the Average Wholesale Price (AWP), MACs will pay for influenza virus vaccine codes Q2039 and 90756 to:

- Indian Service Hospitals (IHS) (12X and 13X)
- IHS Hospices (81X and 82X) and
- IHS Critical Access Hospitals (85X)
- Comprehensive Outpatient Rehabilitation Facilities (CORFs) (75X), and
- Independent RDFs (72X)

Note: In all cases, coinsurance and deductible to not apply.

MACS will suspend and manually price claims when the HCPC File rate is blank for:

- IHS Hospitals (12X, 13X), hospices (81X and 82X), and IHS CAHs (85X)
- CORFs (75X) and
- Independent RDFs (72X)

Messages for Denied Claims

MACs will return as unprocessable claims submitted with Q2039 for the DOS January 1, 2018, through July 31, 2018, when code 90756 should have been submitted, using the following messages:

- Claims Adjustment Reason Code (CARC): 181 – “Procedure code was invalid on the date of service.”
- Remittance Advice Remark Code (RARC): N56 – “Procedure code billed is not correct/valid for the services billed or the date of service billed.”
- Group Code: CO (Contractual Obligation)

ADDITIONAL INFORMATION


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

MLN Matters® Number: SE1128 Revised
Release Date of Revised Article: August 23, 2017

This article was revised on August 23, 2017, to highlight upcoming system changes that identify the QMB status of beneficiaries and exemption from Medicare cost-sharing, recommend key ways to promote compliance with QMB billing rules, and remind certain types of providers that they may seek reimbursement for unpaid deductible and coinsurance amounts as a Medicare bad debt.

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

Look for new information and messages in CMS’ HIPAA Eligibility Transaction System (HETS) and the Provider Remittance Advice (RA) to identify patients’ QMB status and exemption from cost-sharing prior to billing. If you are an MA provider, contact the MA plan for more information about verifying the QMB status of plan members.

Implement key measures to ensure compliance with QMB billing requirements. Ensure that billing procedures and third-party vendors exempt individuals enrolled in the QMB program from Medicare charges. If you have erroneously billed an individual enrolled in the QMB program, recall the charges (including referrals to collection agencies) and refund the invalid charges he or she paid. For information about obtaining payment for Medicare cost-sharing, contact the Medicaid agency in the States in which you practice. Refer to the Background and Additional Information Sections below for further details and important steps to promote compliance.

Background
All original Medicare and MA providers and suppliers—not only those that accept Medicaid—must refrain from charging individuals enrolled in the QMB program for Medicare cost-sharing. Providers who inappropriately bill individuals enrolled in QMB are subject to sanctions. Providers and suppliers may bill State Medicaid programs for these costs, but States can limit Medicare cost-sharing payments under certain circumstances.

Billing of QMBs Is Prohibited by Federal Law
Federal law bars Medicare providers and suppliers from billing an individual enrolled in the QMB program for Medicare Part A and Part B cost-sharing under any circumstances (see Sections 1902(n)(3)(B), 1902(n)(3)(C), 1905(p)(3), 1866(a)(1)(A), and 1848(g)(3)(A) of the Social Security Act [the Act]). The QMB program is a State Medicaid benefit that assists low-income Medicare beneficiaries with Medicare Part A and Part B premiums and cost-sharing, including deductibles, coinsurance, and copays. In 2015, 7.2 million individuals (more than one out of 10 beneficiaries) were enrolled in the QMB program. See the chart at the end of this article for more information about the QMB benefit.

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

Note that certain types of providers may seek reimbursement for unpaid Medicare deductible and coinsurance amounts as a Medicare bad debt discussed in Chapter 3 of the Provider Reimbursement Manual (Pub.15-1).

Refer to the Important Reminders Concerning QMB Billing Requirements Section below for key policy clarifications.

Inappropriate Billing of QMB Individuals Persists
Despite Federal law, improper billing of individuals enrolled in the QMB program 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.

Ways to Promote Compliance with QMB Billing Rules
Take the following steps to ensure compliance with QMB billing prohibitions:
1. Establish processes to routinely identify the QMB status of your Medicare patients prior to billing for items and services.

- Beginning November 4, 2017, providers and suppliers can use Medicare eligibility data provided to Medicare providers, suppliers, and their authorized billing agents (including clearinghouses and third party vendors) by CMS’ HETS to verify a patient’s QMB status and exemption from cost-sharing charges. For more information on HETS, see https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/index.html.

- Starting October 3, 2017, original Medicare providers and suppliers can readily identify the QMB status of patients and billing prohibitions from the Medicare Provider RA, which will contain new notifications and information about a patient’s QMB status. Refer to Qualified Medicare Beneficiary Indicator in the Medicare Fee-For-Service Claims Processing System for more information about these improvements.

- MA providers and suppliers should also contact the MA plan to learn the best way to identify the QMB status of plan members.

- Providers and suppliers may also verify a patient’s QMB status through State online Medicaid eligibility systems or other documentation, including Medicaid identification cards and documents issued by the State proving the patient is enrolled in the QMB program.

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

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

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

- Understand the processes you need to follow to request payment 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.

**Important Reminders Concerning QMB Billing Requirements**

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

1. All original Medicare and MA providers and suppliers—not only those that accept Medicaid—must abide by the billing prohibitions.

2. Individuals enrolled in the QMB program retain their protection from billing when they cross State lines to receive care. Providers and suppliers cannot charge individuals enrolled in QMB even if their QMB benefit is provided by a different State than the State in which care is rendered.

3. Note that individuals enrolled in QMB 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.
**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>
</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 file 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**

MSP Liability Insurance Billing Situations

MLN Matters Number: SE17018
Article Release Date: September 19, 2017

PROVIDER TYPE AFFECTED
This MLN Matters® Article is intended for all providers, physicians, and other suppliers who bill in a situation where liability insurance (including self-insurance) is a consideration. The article is of particular importance for those who elect not to file the claim with Medicare, and instead seek payment for their services from a Medicare beneficiary’s liability insurance (including self-insurance) claim.

PROVIDER ACTION NEEDED
This article is based on information received from Medicare beneficiaries, their legal counsel and other entities that assist these individuals, indicating that providers, physicians, and other suppliers that elect to seek payment from the beneficiary’s liability insurance claim instead of submitting the claim for items or services to Medicare have not generally billed in accordance with the instructions provided or referenced in this article. The FAQs in this article are intended to remind providers, physicians, and other suppliers of the fundamental guidance governing billing where liability insurance (including self-insurance) is involved. Please review your billing practices to be sure they are in line with the information below.

BACKGROUND
Liability insurance (including self-insurance), no-fault insurance, and workers’ compensation benefits are primary payers to Medicare. However, CMS’ regulations and policy for liability insurance billing are distinct from those for no-fault insurance and workers’ compensation benefits. Because the liability insurance billing rules are different and place distinct obligations on providers, physicians, and other suppliers (including termination of liens tied to the expiration of Medicare’s timely filing requirements), it is important that these rules be reviewed in detail.

The options when seeking payment from the liability insurance, and the obligations and restrictions that accompany them, are discussed with more specificity in the “Internet Only Medicare Secondary Payer Manual” (Pub 100-05), Chapter 2, Section 40.2 found at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/msp105c02.pdf. See also, MLN Matters Article MM7355 “Clarification of Medicare Conditional Payment Policy and Billing Procedures for Liability, No-Fault, and Workers’ Compensation (WC) Medicare Secondary Payer (MSP) Claims”. This article is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7355.pdf. (Although not the subject of this article, the instructions for situations involving no-fault insurance or workers’ compensation benefits can be found in Chapter 3 of the MSP Manual.)

FAQs for Liability Insurance (Including Self-Insurance) Billing

Q1. What are the “promptly period” rules and do they apply when billing in situations involving liability insurance (including self-insurance)?

A1. The “promptly period” is 120 days after the earlier of: 1) the date the claim is filed with an insurer or a lien is filed against a potential liability settlement; or 2) the date the service was furnished or, in the case of inpatient hospital services, the date of discharge. The “promptly period” does apply even when a provider, physician, or other supplier is aware that liability insurance may end up indirectly funding the defendant’s settlement. However, following expiration of the 120 days or during that time if it is demonstrated (for example, a bill/claim that had been submitted but not paid) that liability insurance will not pay during the promptly period, the provider, physician, or other supplier has an option (with certain limitations) to bill Medicare or maintain a claim/lien against the liability insurance/beneficiary’s liability insurance settlement.

Q2. Who do I bill...Medicare or the liability insurance/beneficiary’s liability insurance settlement? (I hear so many different things. My patient was in an accident and I need to know whether to bill Medicare or the patient. My other patient is suing some manufacturer, what do I do about my bill for services to this patient?)

A2. Once the “promptly period” has expired, with the exception of the special rule for Oregon (see below), the provider, physician, or other supplier may bill either Medicare or the liability insurer/beneficiary’s liability insurance settlement as long as the Medicare timely filing period has not expired. Billing both Medicare
and maintaining a claim against the liability insurance/beneficiary’s liability insurance settlement is not permitted. Once Medicare has been billed, the provider, physician, or other supplier is limited to Medicare’s approved amount or the limiting charge if the claim is non-assigned, even if they subsequently return any payment made by Medicare. Claims/liens against the liability insurance/beneficiary’s liability settlement must be dropped once Medicare’s timely filing period has expired. See also the Q’s/A’s below for more detail.

Q3. What is the Oregon rule?

A3. By court order, there are very specific alternative billing rules for Oregon. Generally speaking, the provider, physician, or other supplier may bill either Medicare or the liability insurance if the liability insurer pays within 120 days. See the MSP Manual (CMS Pub. 100-05), Chapter 2, Section 40.2 for specifics on the Oregon rule.

Q4. Do Medicare’s timely filing rules still apply if the timely filing period expires while the provider, physician, or other supplier is waiting for the liability insurance payment/beneficiary’s liability insurance settlement? (It’s been 3 years and the patient’s case still hasn’t settled. Can I bill Medicare now?)

A4. The existence of a liability insurance or potential liability insurance situation does not change or extend Medicare’s timely filing requirements. If Medicare is not billed within the applicable timely filing period, the claim will be denied. Additionally, see the information below regarding the requirement that claims/liens against the liability insurance/beneficiary’s liability insurance settlement (with certain exceptions) be withdrawn once the timely filing period has expired.

Q5. How long can a claim/lien be maintained against the liability insurer/the beneficiary’s liability insurance settlement? (Can I direct bill/maintain my lien once Medicare’s timely filing period has expired?)

A5. CMS’ liability insurance billing policy is that providers are required to drop their claims/liens and terminate all billing efforts to collect from a liability insurer or a beneficiary once the Medicare timely filing period expires, unless the liability insurance claim was paid or settled prior to the expiration of the Medicare timely filing period.

• All such claims/liens must be withdrawn (except for claims related to items or services not covered by Medicare and for Medicare deductibles and co-insurance) when the provider, physician, or other supplier bills Medicare or when Medicare’s timely filing period has expired – whichever occurs first.

• If there is a settlement, judgment, award, or other payment before the timely filing period expires, the provider, physician, or supplier may maintain its claim/lien despite the expiration of the timely filing period.

• All such claims/liens are limited by state lien laws/requirements. The MSP provisions do not create lien rights when those rights do not exist under state law.

• Under the Oregon rule all such claims/liens must be withdrawn following the expiration of the applicable 120 day period.

Q6. How much can the provider, physician or other supplier bill the liability insurance/beneficiary’s liability insurance settlement? (What if the beneficiary’s case settled, but the amount was not large enough to pay everyone? What if Medicare and the attorney were paid, but because very little remained the attorney asked all the doctors and other providers to take reduced amounts; do we have to; what about our bill?)

A6. Where Medicare has a recovery claim, Medicare’s claim has the priority right of recovery. In general, the provider, physician, or other supplier:

• Is limited to the Medicare approved amount (limiting charge when non-assigned) once they have billed Medicare, even if they return any payment received from Medicare.

• May charge actual charges but is limited to the amount available from the settlement less applicable procurement costs (for example, attorney fees, other litigation costs).

• May only bill for non-covered services, or co-insurance and deductibles, if Medicare timely filing has expired before payment or settlement. (In this context, non-covered services are the program exclusions
CLAIMS SUBMISSION

such as measuring of eye refractions or services rendered to family members. Medical necessity denials are not included and are not billable in the example.)

- May not collect from the beneficiary until the proceeds are available to the beneficiary.

Q7. What about physician and other suppliers who do not participate in Medicare and do not submit an assigned claim (and would not be required to submit an assigned claim if they submitted a claim to Medicare) – what can they pursue?

A7. Such physicians and other suppliers can pursue liability insurance, but the amount may not exceed the limiting charge.

Q8. Are there risks involved in deciding whether to pursue the liability insurance vs. billing Medicare once the promptly period has expired?

A8. Providers, physicians, and other suppliers who do not file a Medicare claim once the “promptly period” has expired (and before timely filing has expired) run the risk that insurance proceeds will not be available or may be less than Medicare’s payment would have been if Medicare had been billed. They also run the risk that they will be limited to billing for co-insurance and deductibles if there is no payment or settlement before Medicare’s timely filing expires.

Q9. Are there additional rules if a patient receives both Medicare and Medicaid or other benefits?

A9. If the individual receives assistance from the state, additional regulations govern provider billing. If a Medicare beneficiary received Medicaid benefits at the time the services were rendered, providers should contact their state Medicaid office to obtain the state’s policy on provider billing.

Q10. What if the items or services in question are not covered by Medicare?

A10. If the items or services rendered are services that are not covered by the Medicare program, providers, physicians, and other suppliers may charge and collect actual charges without regard to whether the proceeds of the liability insurance are available to the beneficiary. (In this context, non-covered services are the program exclusions such as measuring of eye refractions or services rendered to family members. Medical necessity denials are not included and are not billable in the example.)

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/.

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Accepting Payment from Patients with WCMSA, LMSA or NFMSA

MLN Matters Number: SE17019
Article Release Date: September 19, 2017

PROVIDER TYPE AFFECTED
This MLN Matters® Article is intended for providers, physicians, and other suppliers who are told by patients that they must pay the bill themselves because they have a Workers’ Compensation Medicare Set-Aside Arrangement (WCMSA), a Liability Insurance Medicare Set-Aside Arrangement (LMSA), or a No-Fault Insurance Medicare Set-Aside Arrangement (NFMSA).

WHAT YOU NEED TO KNOW
This article is based on information received from Medicare beneficiaries, their legal counsel, and other entities that assist these individuals indicating that physicians, providers, and other suppliers are often reluctant to accept payment directly from Medicare beneficiaries who state they have a Medicare Set-Aside Arrangement (MSA) and must pay for their services themselves. This article explains what a MSA is and explains why it is appropriate to accept payment from a patient that has a funded MSA.

Please review your billing practices to be sure they are in line with the information provided.

BACKGROUND
Medicare is always a secondary payer to liability insurance (including self-insurance), no-fault insurance, and workers’ compensation benefits. The law precludes Medicare payment for services to the extent that payment has been made, or can reasonably be expected to be made promptly, under liability insurance (including self-insurance), no-fault insurance, or Workers’ Compensation (WC). (See Section 1862(b)(2)(A) of the Social Security Act, cited in the U.S. code at 42 U.S.C. § 1395y(b)(2)(A)(i)). When future medical care is claimed, or a settlement, judgment, award, or other payment releases (or has the effect of releasing) claims for future medical care, it can reasonably be expected that the monies from the settlement, judgment, award, or other payment are available to pay for future medical items and services which are otherwise covered and reimbursable by Medicare.

Whether those services are associated with a liability insurance, no-fault insurance, or WC situation, Medicare should not be billed for future medical services until those funds are exhausted by payments to providers for services that would otherwise be covered and reimbursable by Medicare.

Reminders:

- Liability insurance (including self-insurance) includes all types of liability insurance. No-fault insurance is not limited to automobile no-fault. It is sometimes referred to as “med-pay” or “personal injury protection/PIP”.
- WC includes a WC law or plan of the United States or any state. It also applies to the WC plans of the District of Columbia, American Samoa, Guam, Puerto Rico, and the Virgin Islands as well as to the Federal WC plans provided under the Federal Employees Compensation Act, the U.S. Longshoremen’s and Harbor Workers’ Compensation Act (and its extensions).

(See also 42 C.F.R. §§ 411.40, 411.43, and 411.50.)

A MSA is a financial arrangement that allocates a portion of a settlement, judgment, award, or other payment to pay for future medical services. The law mandates protection of the Medicare trust funds but does not mandate a MSA as the vehicle used for that purpose. MSAs are the most frequently used formal method of preserving those funds for the Medicare beneficiary to pay for future items or services which are otherwise covered and reimbursable by Medicare and which are related to what was claimed or the settlement, judgment, award, or other payment had the effect of releasing. These funds must be exhausted before Medicare will pay for treatment related to the claimed injury, illness, or disease.

Medicare beneficiaries are advised that before receiving treatment for services to be paid by their MSA, they should advise their health care provider about the existence of the MSA. They are also notified that their health care providers should bill them directly, and that they should pay those charges out of the MSA if:
The treatment or prescription is for the liability insurance, no-fault insurance or workers’ compensation injury/illness/accident; AND

The treatment or prescription is something Medicare would cover.

For WC, the Centers for Medicare & Medicaid Services (CMS) has a formal process that allows for the review of proposed MSA amounts if specific criteria are met. While CMS recommends use of this process, proposed WCMSA amounts are not required to be submitted to CMS for review. CMS utilizes its Workers’ Compensation Review Contractor for the review of voluntarily-submitted proposed WCMSA amounts. CMS currently has no such review process for proposed LMSA amounts or proposed NFMSA amounts.

The obligation to protect the Medicare trust funds exists regardless of whether or not there is a formal CMS approved MSA amount. Because the CMS review process is voluntary for WCMSA amounts, and there is no formal process for reviewing proposed LMSA or NFMSA amounts, a Medicare beneficiary may or may not have documentation they can provide the physician, provider, or supplier from Medicare approving a Medicare Set-Aside amount.

**PROVIDER ACTION NEEDED**
Where a patient who is a Medicare beneficiary:

- States that he/she was involved in a liability insurance, no-fault insurance, or workers’ compensation situation;
- States that he/she is required to use funds from the settlement, judgment, award, or other payment to pay for the items or services related to what was claimed or which the settlement, judgment, award, or other payment;

It is appropriate for you to document your records with that information and accept payment directly from the patient for such services.

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

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Coding and Billing Date of Service on Professional Claims Guidance

MLN Matters Number: SE17023
Article Release Date: September 19, 2017

PROVIDER TYPES AFFECTED
This MLN Matters Article is intended for physicians, non-physician practitioners, and others submitting claims on a CMS-1500 form or the X12 837 Professional Claim to Medicare Administrative Contractors (MACs) for reimbursement for Medicare Part B services.

PROVIDER ACTION NEEDED
Physicians and non-physician practitioners need to identify the correct date of service for the services they provide to a Medicare patient.

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

Providers need to determine the Medicare rules and regulations concerning the date of service and submit claims appropriately. Be sure your billing and coding staffs are aware of this information.

BACKGROUND
The information below will not provide all the billing instructions for the individual services. The article does not present any new or revised Medicare policy. Instead, the article reiterates current Medicare policy. This information concentrates on the date(s) of service to submit when billing for these services. If you are providing these services, please take advantage of the information available on the CMS website in addition to your MACs. The Medicare Benefit Policy Manual, Chapter 15, Section 20 shows that expenses are considered to have been incurred on the date the beneficiary received the item or service, regardless of when it was paid for or ordered. You may review this manual section at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf.

Radiology Services
Typically, radiology services have two separate components, a professional and technical component. These services will have a PC/TC indicator of “1” on the Medicare Physician Fee Schedule Relative Value File. The technical component is billed on the date the patient had the test performed. The professional component is billed on the date the physician provided the interpretation and report of the radiology service. If these are furnished on different dates, they must be billed on different dates using the TC Modifier for the technical component and the 26 Modifier for the professional component.

The Medicare Physician Fee Schedule Relative Value File is available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html.

Surgical and Anatomical Pathology
Surgical and anatomical pathology services may have two components: a professional and a technical component. These services will have a PC/TC indicator of “1” on the Medicare Physician Fee Schedule Relative Value File. The technical component is billed on the date the specimen was collected. This would be the surgery date. The professional component is billed on the date of service when the physician provided the interpretation and report of the pathology service. If these occur on different dates, these must be billed on different dates using the TC Modifier for the technical component and the 26 Modifier for the professional component.

When the collection spans two calendar dates, use the date the specimen collected ended.

Stored specimens – If the test is performed on a stored specimen (stored less than or equal to 30 calendar days), the date of service must be the date the test was performed only if:

- The test is ordered by the patient’s physician at least 14 days following the date of the patient’s discharge from the hospital.
- The specimen was collected while the patient was undergoing a hospital procedure.
It would be medically inappropriate to have collected the specimen other than during the hospital procedure for which the patient was admitted.

The results of the test do not guide treatment provided during the hospital stay.

The test was reasonable and medically necessary for treatment of illness or injury.

If the test is ordered on a specimen stored more than 30 days, the date of service for the technical service is the date the specimen is retrieved from storage. The professional component is billed on the date the physician provided the interpretation and report.

For more information, see the Medicare Claims Processing Manual, Chapter 16, Section 40.8, which is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c16.pdf.

Care Plan Oversight (CPO)

CPO is physician supervision of a patient receiving complex and/or multidisciplinary care as part of Medicare covered services provided by a participating home health agency or Medicare approved hospice. Providers must provide physician supervision of a patient involving 30 or more minutes of the physician’s time per month to report CPO services. The claim for CPO must not include any other services and is only billed after the end of the month in which CPO was provided. The date of service submitted on the claim is the date the provider completed the 30 minutes of supervision.


Home Health Certification and Recertification

The date of service is the date the physician completes the plan of care. The physician should sign and date at that time allowing for a few days delay when a transcriptionist is involved.


Physician End-Stage Renal Disease Services

A physician may provide monthly or daily oversight of a patient on dialysis with End-Stage Renal Disease (ESRD). For physicians billing the monthly capitation payment, the date of service is the first through the last day of the month. For transient or less than a full month service, these can be billed on a per diem basis. The date of service is the date of responsibility for the patient by the billing physician. This would also include when a patient’s dies during the calendar month.


Transitional Care Management (TCM)

TCM services are a 30-day service provided when a patient is discharged from an appropriate facility and requires moderate or high-complexity medical decision making. The date of service is the date the practitioner completes the required face-to-face visit. Keep in mind, there are additional services to be provided during the 30-day period.

Transitional Care Management Guidance including Questions and Answers and Fact Sheets are available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Care-Management.html.

Clinical Lab Services

Generally, the date of service is the date the specimen was collected. If the specimen is collected over a period that spans two calendar dates, the date of service is the date the collection ended. There are two exceptions to the general date of service rule for laboratory tests performed on stored specimens and chemotherapy sensitivity tests performed on live tissue if specific criteria are met.

CODING

Home Prothrombin Time (PT/INR) Monitoring

There are three procedure codes applicable to this service. The G0248 describes the initial demonstration use of home INR monitoring and instructions for reporting. The date of service is the date the demonstration and instructions for reporting are given in a face-to-face setting with the patient. G0249 describes the provision of test materials and equipment for home INR monitoring. The date of service is the date the test materials and equipment are given to the patient. G0250 describes the physician review, interpretation, and patient management of home INR testing. The date of service is the date of the fourth test interpretation.


Cardiovascular Monitoring Services

There are many different procedure codes that represent the cardiovascular monitoring services. These can be identified as professional components, technical components, or a combination of the two. Some of these monitoring services may take place at a single point in time, others may take place over 24 or 48 hours, or over a 30-day period. The determination of the date of service is based on the description of the procedure code and the time listed. When the service includes a physician review and/or interpretation and report, the date of service is the date the physician completes that activity. If the service is a technical service, the date of service is the date the monitoring concludes based on the description of the service. For example, if the description of the procedure code includes 30 days of monitoring and a physician interpretation and report, then the date of service will be no earlier than the 30th day of monitoring and will be the date the physician completed the professional component of the service.


Diagnostic Psychological and Neuropsychological Tests

In some cases, for various reasons, psychological and neuropsychological tests (96101/96127) are completed in multiple sessions that occur on different days. In these situations, the date of service that should be reported on the claim is the date of service on which the service (based on CPT code description) concluded. Documentation should reflect that the service began on one day and concluded on another day (the date of service reported on the claim). If documentation is requested, medical records for both days should be submitted.

Psychiatric Testing when provided over multiple days based on the patient being able to provide information, is billed based on the time involved as described by CPT and the last date of the test. For more information, see the Medicare Benefit Policy Manual, Chapter 15, Section 80.2, at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf.

Surgical Services

Medicare’s payment for most surgical services is made using the global surgery rules. All services considered to be part of the global package including follow-up visits, are considered to have occurred on the same day as the surgical service and are not submitted separately. Surgeons who transfer post-operative care to another practitioner will submit their claims using the date of the surgery as the date of service along with Modifier 55. The practitioner receiving the transfer of care will submit his/her post-operative services using the surgical procedure code along with the date of the surgery as his/her date of service. For more information, see the Medicare Claims Processing Manual, Chapter 12, Section 40 https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf.

Maternity Benefits

All expenses incurred for surgical and obstetrical care including preoperative/prenatal examinations, testing, and post-operative/postnatal services are part of the maternity package and may be billed under the appropriate surgical code on the date of delivery or termination. Charges the practitioner may impose that are not related to the delivery are incurred on the date furnished.

Services which transpire over to another calendar date

This category could include multiple types of services, anesthesia when the administration of anesthesia service continues to a new calendar date; the services of teaching physicians when the resident service was provided late at night and the teaching physician sees the patient the next day, MOHS surgery when the service must continue a second date if the patient cannot tolerate the original surgery.

In these cases, the date of service is the date the service concluded. The anesthesia service is billed with the date for the second day. The teaching physician is billed based on the date the teaching physician had a face-to-face with the patient. The date of service for the MOHS surgery will be the date completed.

Note: This document was developed through the A/B Medicare Administrative Contractor (MAC) Provider Outreach & Education (POE) Collaboration Team. This joint effort ensures consistent communication and education throughout the nation on a variety of topics and will assist the provider and physician community with information necessary to submit claims appropriately and receive proper payment in a timely manner.

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/.

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Bariatric Surgery Coverage – R9

The following Noridian coverage requirements for the Bariatric Surgery for Treatment of Morbid Obesity National Coverage Determination (NCD) have been published under contract numbers 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601 (WY) in the CMS Medicare Coverage Database (MCD and on our (Noridian) website.

**NCD Title:** Bariatric Surgery for Treatment of Morbid Obesity (100.1)

**Summary of Changes:** The Article has been revised to add ICD-10-PCS code 0DB64Z3, Excision of Stomach, Percutaneous Endoscopic Approach, Vertical and 0DV64CZ, Medical and Surgical Gastrointestinal System Restriction Stomach Percutaneous Endoscopic Extraluminal Device to the listing for laparoscopic gastroenterostomy (laparoscopic roux-en-y).

**Effective Date:** October 1, 2016

Read the complete National Coverage Determination requirements article.

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

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

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

Billing Medicare for the SphenoCath and Other Similar Devices – R1

The “Billing Medicare for the SphenoCath and Other Similar Devices” coverage article has been revised and published for notice under contract numbers: 02101 (AK), 02201 (ID), 02301(OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601 (WY).

**Summary of Changes:** Revised Article Title, Text and Group 1 Paragraph to allow for other approved delivery devices used for Sphenopalatine Ganglion Blocks and updated the Internet Only Manual Source and quotation in the Article Text.

**Effective Date:** January 1, 2017

View the locally hosted Medicare Coverage Article PDF.

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

Botulinum Toxin Types A and B Coding Guidelines Article Retirement – Effective July 17, 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) and 03601 (WY).

**Medicare Coverage Database Number:** A55013

**Article Title:** Botulinum Toxin Types A and B Coding Guidelines

**Effective Date:** July 17, 2017

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

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

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

On the “Medicare Coverage Articles” page, select the state of interest in the table under “Retired Articles.”

- This link will redirect you to the CMS website.

Locate the above-listed CMS Medicare Coverage Database (MCD) number and article title and select the title of interest.

**Intraocular Bevacizumab Coding/Billing Guidelines – R6**

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

**Summary of Changes:** The following diagnoses have been moved to Group 2:

- H44.21 - Degenerative myopia, right eye
- H44.22 - Degenerative myopia, left eye
- H44.23 - Degenerative myopia, bilateral

**Effective Date:** July 15, 2017

View the complete Noridian coverage article.

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

Go to the Noridian Medicare Coverage Articles webpage to:

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

**MolDX: IKBKAP Genetic Testing Billing and Coding Guidelines**

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

**Summary of Article:** To provide billing and coverage criteria for the MolDX: IKBKAP Genetic Testing.

**Effective Date:** October 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:
Coverage

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

**MolDX: L1CAM Gene Sequencing Billing and Coding Guidelines**

The MolDX: L1CAM Gene Sequencing Billing and Coding Guidelines coverage article has been revised and published for notice under contract numbers: 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601 (WY) in the CMS Medicare Coverage Database (MCD).

**Summary of Changes:** The DEX Z-code reference has been added to the article.

**Effective Date:** October 9, 2017

View the complete Noridian coverage article.

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

Go to the Noridian Medicare Coverage Articles webpage to:

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

**MolDX: Myriad’s BRACAnalysis CDx Billing and Coding Guidelines**

The MolDX: Myriad’s BRACAnalysis CDx Billing and Coding Guidelines coverage article has been published for notice under contract numbers: 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601 (WY).

**Summary of Article:** To provide billing and coverage criteria for the MolDX: Myriad’s BRACAnalysis CDx™.

**Effective Date:** October 15, 2017

View the complete Noridian coverage article.

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

Go to the Noridian Medicare Coverage Articles webpage to:

- View complete list of Noridian coverage articles
- Access the CMS MCD to view a comprehensive revision history for this corresponding article
  - Scroll to bottom of webpage
  - Select state/contract of interest from Active, Future or Retired column (This link will redirect you to the CMS website.)
  - Once in the CMS MCD, select corresponding article title
**MolDX: NSD1 Gene Tests Billing and Coding Guidelines**

The MolDX: NSD1 Gene Tests Billing and Coding Guidelines coverage article has been published for notice under contract numbers: 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601 (WY).

**Summary of Article:** To provide billing and coverage criteria for the MolDX: NSD1 Gene Tests.

**Effective Date:** October 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
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  - Once in the CMS MCD, select corresponding article title

**MolDX: PIK3CA Gene Tests Billing and Coding Guidelines**

The MolDX: PIK3CA Gene Tests Billing and Coding Guidelines coverage article has been published for notice under contract numbers: 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601 (WY).

**Summary of Article:** To provide billing and coverage criteria for the MolDX: PIK3CA Gene Tests.

**Effective Date:** August 28, 2017

View the complete Noridian coverage article.

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

Go to the Noridian Medicare Coverage Articles webpage to:

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

**MolDX: ResponseDX Tissue of Origin – R2**

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

**Summary of Changes:** Article is revised to update reference to required identifier and add Part A claim filing instructions.

**Effective Date:** October 1, 2016

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

Go to the Noridian Medicare Coverage Articles webpage to:

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

**MolDX: RPS19 Gene Tests Billing and Coding Guidelines**

The MolDX: RPS19 Gene Tests Billing and Coding Guidelines coverage article has been revised and published for notice under contract numbers: 02101 (AK), 02201 (ID), 02301(OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601 (WY).

**Summary of Article:** To provide billing and coverage criteria for the MolDX: RPS19 Gene Tests.

**Effective Date:** October 1, 2017

View the complete Noridian coverage article.

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

Go to the Noridian Medicare Coverage Articles webpage to:

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

**MolDX: SULT4A1 Genetic Testing Billing and Coding Guidelines**

The MolDX: SULT4A1 Genetic Testing Billing and Coding Guidelines coverage article has been revised and published for notice under contract numbers: 02101 (AK), 02201 (ID), 02301(OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601 (WY) in the CMS Medicare Coverage Database (MCD).

**Summary of Article:** To provide billing and coverage criteria for the MolDX: SULT4A1 Genetic testing.

**Effective Date:** August 28, 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).

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• View complete list of Noridian coverage articles
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Select state/contract of interest from Active, Future or Retired column (This link will redirect you to the CMS website.)

Once in the CMS MCD, select corresponding article title

**MolDX: TERC Gene Tests Billing and Coding Guidelines**

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

**Summary of Article:** To provide billing and coverage criteria for the MolDX: TERC Gene Tests.

**Effective Date:** October 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

**Positron Emission Tomography Scans Coverage – R10**

The following Noridian coverage requirements for the Positron Emission Tomography Scans National Coverage Determination (NCD) have been published under contract numbers 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601 (WY) in the CMS Medicare Coverage Database (MCD and on our (Noridian) website.

**NCD Title:** Positron Emission Tomography (PET) Scans (220.6)

**Summary of Changes:** Per CMS Change Request (CR)10086 the following changes have been made.

Effective 10/1/2015, deleted the following ICD-10 diagnoses from List I:

- D03.0 - Melanoma in situ of lip
- D03.11 - Melanoma in situ of right eyelid, including canthus
- D03.12 – Melanoma in situ of left eyelid, including canthus
- D03.21 – Melanoma in situ of right ear and external auricular canal
- D03.22 – Melanoma in situ of left ear and external auricular canal
- D03.30 – Melanoma in situ of unspecified part of face
- D03.39 – Melanoma in situ of other parts of face
- D03.51 – Melanoma in situ of anal skin
- D03.52 – Melanoma in situ of breast (skin) (soft tissue)
- D03.59 – Melanoma in situ of other part of trunk
- D03.61 – Melanoma in situ of right upper limb, including shoulder
- D03.62 – Melanoma in situ of left upper limb, including shoulder
- D03.71 – Melanoma in situ of right lower limb, including hip
• D03.72 – Melanoma in situ of left lower limb, including hip
• D03.8 – Melanoma in situ of other sites
• D03.9 – Melanoma in situ, unspecified
Effective 1/1/2017, added the following ICD-10 diagnosis code for A9588:
• C61 – malignant neoplasm of prostate

Effective Date: As noted above.

Read the complete National Coverage Determination requirements article.
• The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).

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

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

**Single Chamber and Dual Chamber Permanent Cardiac Pacemakers – Coding and Billing – R3**

The following Noridian coverage requirements for the Single Chamber and Dual Chamber Permanent Cardiac Pacemakers National Coverage Determination (NCD) have been published under contract numbers 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601 (WY) in the CMS Medicare Coverage Database (MCD and on our (Noridian) website.

**NCD Title:** Single Chamber and Dual Chamber Permanent Cardiac Pacemakers NCD 20.8.3

**Summary of Changes:** Clarified the SC modifier is not to be billed with any Group I or Group II diagnosis code.

**Effective Date:** May 1, 2016

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

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

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

**Zika Virus Testing by PCR and ELSA Methods - R6**

The Zika Virus Testing by PCR and ELSA Methods 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.

**Article Summary of Changes:**

This LCD has been updated to include ICD-10 code:
• Z36.89: Encounter for other specified antenatal screening.

Deleted Code:
• Z36: Encounter for antenatal screening of mother.

**Effective Date:** October 1, 2017

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

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

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

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

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

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

Policy

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

Implementation Process

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

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

Part A Enrollment on Demands

That’s right, you read that correctly, Provider Enrollment has created Part A Enrollment on Demands (EoDs)!

Currently there are 11 different specialties with EoDs:

- Critical Access Hospital (CAH)
- Community Mental Health Center (CMHC)
- Comprehensive Outpatient Rehabilitation Facility (CORF)
- End-Stage Renal Disease Facility (ESRD)
- Federally Qualified Health Center (FQHC)
- Home Health Agency (HHA)
- Hospice
- Hospital
- Outpatient Occupational Therapy (OT), Physical Therapy (PT), and Speech Language Pathology (SLP)
- Rural Health Clinic (RHC)
- Skilled Nursing Facility (SNF)

Buyer and Seller CHOW, Change of Information, Method II enrollment for providers and updating EFT are on the EoD on Demand Tutorials for Part A Provider Types webpage to view while completing the application.

Currently, there are only paper EoDs available. Internet-based PECOS EoDs for Part A are on the horizon. Stayed tuned for more exciting updates with EoD and Provider Enrollment.
ESRD

Transitional Drug Add-On Payment Adjustment for ESRD Drugs

MLN Matters Number: MM10065
Related Change Request (CR) Number: CR 10065
Related CR Release Date: August 4, 2017
Effective Date: January 1, 2018
Related CR Transmittal Number: R1889OTN
Implementation Date: January 2, 2018

PROVIDER TYPE AFFECTED
This MLN Matters Article is intended for End-Stage Renal Disease (ESRD) facilities submitting claims to Medicare Administrative Contractors (MACs) for certain ESRD drugs provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED
This article informs you about Change Request (CR) 10065, which directs the MACs to implement the Transitional Drug Add-On Payment Adjustment. Please be sure your billing staffs are informed of this change.

BACKGROUND
In accordance with section 217(c) of the Protecting Access to Medicare Act, the Centers for Medicare & Medicaid Services (CMS) implemented a drug designation process for: (1) determining when a product is no longer an oral-only drug; and (2) including new injectable and intravenous products into the ESRD Prospective Payment System (PPS). Under the drug designation process, CMS provides payment using a Transitional Drug Add-on Payment Adjustment (TDAPA) for new injectable or intravenous drugs and biologicals that qualify under 42 Code of Federal Regulations (CFR) 413.234(c)(1).

To be considered a new injectable or intravenous product, the drug should be approved by the Food and Drug Administration (FDA), commercially available, assigned a Healthcare Common Procedure Coding System (HCPCS) code, and designated by CMS as a renal dialysis service. CMS considers the new injectable or intravenous drug to be included in the ESRD PPS bundled payment (with no separate payment available) if used to treat or manage a condition for which there is an ESRD PPS functional category. CMS will pay for the drug or biological using a transitional drug add-on payment adjustment, if the new injectable or intravenous drug or biological is used to treat or manage a condition for which there is not an existing ESRD PPS functional category. While calcimimetics are included in the bone and mineral metabolism ESRD PPS functional category, they are an exception to the drug designation process as discussed in the Calendar Year (CY) 2016 ESRD PPS final rule (80 FR 69027). CMS bases the TDAPA on payment methodologies under section 1847A of the Social Security Act which are discussed in the “Medicare Claims Processing Manual”, Chapter 17, Section 20. This payment is applicable for a period of 2 years. While the TDAPA applies to a new injectable or intravenous drug or biological, the drug or biological is not considered an outlier service.

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

Transitional Drug Add-On Payment Adjustment
Effective January 1, 2018, injectable, intravenous, and oral calcimimetics qualify for the TDAPA. ESRD facilities should report the AX modifier (Item furnished in conjunction with dialysis services) with the HCPCS for these drugs and biologicals to receive payment for these drugs using the TDAPA. While these drugs are eligible for the TDAPA, they do not qualify toward outlier calculation. Currently, calcimimetics are the only drug class that qualifies for payment using the TDAPA. **ESRD facilities should not use the AX modifier for any other drug until notified by CMS.**

Effective January 1, 2018, MACs will return to provider (RTP) ESRD claims (TOB 72X) when:

- HCPCS code J0604 or J0606 is present without modifier AX or
• Modifier AX is present without HCPCS code J0604 or J0606

J0604 and J0606 are drugs that are used for bone and mineral metabolism. Bone and mineral metabolism is an ESRD PPS functional category where drugs and biologicals that fall in this category are always considered to be used for the treatment of ESRD.

ESRD facilities will not receive separate payment for J0604 and J0606 with or without the AY modifier and the MACs will process the line item as covered with no separate payment under the ESRD PPS. The ESRD PPS CB requirements will be updated to include J0604 and J0606.

CR 10065 also implements the payer only value code Q8 – Total TDAPA Amount, to be used to capture the add-on payment. CR10065 has an example of the calculation used in PRICER.

ADDITIONAL INFORMATION


ESRD PPS Quarterly Update

MLN Matters Number: MM10193
Related Change Request (CR) Number: CR 10193
Related CR Release Date: August 11, 2017
Effective Date: October 1, 2017
Related CR Transmittal Number: R3833CP
Implementation Date: October 2, 2017

PROVIDER TYPE AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 10193 provides the October 1, 2017, update to the lists of items and services that are subject to Part B Consolidated Billing (CB) and are therefore no longer separately payable when provided to ESRD beneficiaries by providers other than ESRD facilities. Make sure your billing staff is aware of these changes.

BACKGROUND

The Medicare Improvements for Patients and Providers Act (MIPPA; Section 153(b)) required the implementation of an ESRD PPS effective January 1, 2011. The ESRD PPS provides a single payment to ESRD facilities that covers all of the resources used in furnishing an outpatient dialysis treatment.

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

For October, the CB requirements for laboratory services included in the ESRD PPS are updated by adding the following Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes to the list:

• G0499 - Hepatitis B screening in non-pregnant, high risk individual includes Hepatitis B Surface Antigen (HBSAG) followed by a neutralizing confirmatory test for initially reactive results, and antibodies to HBSAG (anti-hbs) and hepatitis B core antigen (anti-hbc)
- 87341 - Infectious agent antigen detection by immunoassay technique, (e.g., enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multistep method; Hepatitis B Surface Antigen (HBSAG) neutralization

ADDITIONAL INFORMATION
IPF PPS FY 2018

MLN Matters Number: MM10214
Related Change Request (CR) Number: 10214
Related CR Release Date: August 4, 2017
Effective Date: October 1, 2017
Related CR Transmittal Number: R3826CP
Implementation Date: October 2, 2017

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

PROVIDER ACTION NEEDED
Change Request (CR) 10214 identifies changes that are required as part of the annual Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) update from the fiscal year (FY) 2018 IPF PPS Notice, displayed on August 2, 2017. These changes are applicable to IPF discharges occurring during fiscal year October 1, 2017 through September 30, 2018. This Recurring Update applies to “Claims Processing Manual”, Chapter 3, Section 190.4.3. Make sure your billing staff is aware of these changes.

BACKGROUND
On November 15, 2004, the Centers for Medicare & Medicaid Services (CMS) published in the Federal Register a final rule that established the PPS for IPF under the Medicare program in accordance with provisions of Section 124 of Public Law 106-113, the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999 (BBRA). Payments to IPFs under the IPF PPS are based on a federal per diem base rate that includes both inpatient operating and capital-related costs (including routine and ancillary services), but excludes certain pass-through costs (that is, bad debts, and graduate medical education). CMS is required to make updates to this prospective payment system annually.

Key Points of CR 10214
Market Basket Update
For FY 2018, CMS is using the 2012-based IPF market basket to update the IPF PPS payments (that is, the Federal per diem base rate and Electroconvulsive Therapy (ECT) payment per treatment). The 2012-based IPF market basket update for FY 2018 is 2.6 percent. However, this 2.6 percent is subject to two reductions required by the Social Security Act (the Act), as described below.

Section 1886(s)(2)(A)(ii) of the Act requires the application of an “Other Adjustment” that reduces any update to the IPF market basket update by percentages specified in Section 1886(s)(3) of the Act for Rate Year (RY) beginning in 2010 through the RY beginning in 2019. For the FY beginning in 2017 (that is, FY 2018), Section 1886(s)(3)(E) of the Act requires the reduction to be 0.75 percentage point. CMS implemented that provision in the FY 2018 IPF PPS Notice.

In addition, Section 1886(s)(2)(A)(ii) of the Act requires the application of the Productivity Adjustment described in Section 1886(b)(3)(B)(xii)(II) of the Act to the IPF PPS for the RY beginning in 2012 (that is, a RY that coincides with a FY), and each subsequent RY. For the FY beginning in 2017 (that is, FY 2018), the reduction is 0.6 percentage point. CMS implemented that provision in the FY 2018 IPF PPS Notice.

CMS updated the IPF PPS base rate for FY 2018 by applying the adjusted market basket update of 1.25 percent (which includes the 2012-based IPF market basket update of 2.6 percent, an ACA required 0.75 percentage point reduction to the market basket update, and an ACA required productivity adjustment reduction of 0.6 percentage point) and the wage index budget neutrality factor of 1.0006 to the FY 2017 Federal per diem base rate of $761.37 to yield a FY 2018 Federal per diem base rate of $771.35. Similarly, applying the adjusted market basket update of 1.25 percent and the wage index budget neutrality factor of 1.0006 to the FY 2017 ECT payment per treatment of $327.78 yields an ECT payment per treatment of $332.08 for FY 2018.
Inpatient Psychiatric Facilities Quality Reporting Program (IPFQR)

Section 1886(s)(4) of the Act requires the establishment of a quality data reporting program for the IPF PPS beginning in FY 2014. CMS finalized new requirements for quality reporting for IPFs in the “Hospital Inpatient Prospective Payment System for Acute Care Hospitals and the Long Term Care Hospital. "Prospective Payment System and Fiscal Year 2013 Rates”, Final Rule (August 31, 2012) (77 FR 53258, 53644 through 53360). Section 1886(s)(4)(A)(i) of the Act requires that, for FY 2014 and each subsequent FY, the Secretary will reduce any annual update to a standard Federal rate for discharges occurring during the FY by two percentage points for any IPF that does not comply with the quality data submission requirements with respect to an applicable year. Therefore, a two percentage point reduction is applied to the Federal per diem base rate and the ECT payment per treatment as follows:

- For IPFs that fail to submit quality reporting data under the IPFQR program, a -0.75 percent annual update (an update consisting of 1.25 percent annual update (that is, the adjusted market basket update) reduced by 2.0 percentage points in accordance with Section 1886(s)(4)(A)(ii) of the Act) and the wage index budget neutrality factor of 1.0006 are applied to the FY 2017 Federal per diem base rate of $761.37, yielding a Federal per diem base rate of $756.11 for FY 2018.

- Similarly, a -0.75 percent annual update and the 1.0006 wage index budget neutrality factor are applied to the FY 2017 ECT payment per treatment of $327.78, yielding an ECT payment per treatment of $325.52 for FY 2018.

PRICER Updates: IPF PPS Fiscal Year 2018 (October 1, 2017 – September 30, 2018)

- The Federal per diem base rate is $771.35 for IPFs that complied with quality data submission requirements.

- The Federal per diem base rate is $756.11 when applying the two percentage point reduction, for IPFs that failed to comply with quality data submission requirements.

- The fixed dollar loss threshold amount is $11,425.

- The IPF PPS wage index is based on the FY 2017 pre-floor, pre-reclassified acute care hospital wage index.

- The labor-related share is 75.0 percent.

- The non-labor related share is 25.0 percent.

- The ECT payment per treatment is $332.08 for IPFs that complied with quality data submission requirements.

- The ECT payment per treatment is $325.52 when applying the two percentage point reduction, for IPFs that failed to comply with quality data submission requirements.

The National Urban and Rural Cost to Charge Ratios for the IPF PPS Fiscal Year 2018

<table>
<thead>
<tr>
<th>CCRs</th>
<th>Rural</th>
<th>Urban</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Median CCRs</td>
<td>0.5930</td>
<td>0.4420</td>
</tr>
<tr>
<td>National Ceiling CCRs</td>
<td>1.9634</td>
<td>1.7071</td>
</tr>
</tbody>
</table>

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

- For new IPF facilities that have not submitted their first Medicare cost report, CMS is using these national ratios until the facility’s actual CCR can be computed using the first tentatively settled or final settled cost report, which will then be used for the subsequent cost report period.

- The IPFs whose operating or capital CCR is in excess of 3 standard deviations above the corresponding national geometric mean (that is, above the ceiling).

- Other IPFs for whom the fiscal intermediary obtains inaccurate or incomplete data with which to calculate either an operating or capital CCR or both.
International Classification of Diseases, Tenth Revision Clinical Modifications/Procedural Classification System (ICD-10- CM/PCS) Updates

The adjustment factors are unchanged for the FY 2018 IPF PPS. However, CMS updated the ICD-10- CM/PCS code set as of October 1, 2017. These updates affect the ICD-10-CM/PCS codes which underlie the IPF PPS MS-DRG categories, the IPF PPS comorbidity categories and the IPF PPS code first list. The updated FY 2018 MS-DRG code lists are available on the IPPS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html, and the updated FY 2018 IPF PPS comorbidity categories, and IPF PPS code first list are available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/tools.html.

FY 2018 IPF PPS Wage Index

The FY 2018 final IPF PPS wage index is available online at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/WageIndex.html. This FY 2018 IPF PPS final wage index adopts minor OMB changes to a few statistical area delineations.

Cost of Living Adjustment (COLA) Adjustment

The IPF PPS COLA factors list were updated for FY 2018. See Table 1 and 2 below:

Table 1: Alaska COLAs for IPF Prospective Payment System Fiscal Year 2018

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

Table 2: Hawaii COLAs for IPF Prospective Payment System Fiscal Year 2018

<table>
<thead>
<tr>
<th>Hawaii</th>
<th>Cost of Living Adjustment Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>City and County of Honolulu</td>
<td>1.25</td>
</tr>
<tr>
<td>County of Hawaii</td>
<td>1.21</td>
</tr>
<tr>
<td>County of Kauai</td>
<td>1.25</td>
</tr>
<tr>
<td>County of Maui and County of Kalawao</td>
<td>1.25</td>
</tr>
</tbody>
</table>

Rural Adjustment

Due to the OMB CBSA changes implemented in FY 2016, several IPFs had their status changed from “rural” to “urban” as of FY 2016. As a result, these rural IPFs were no longer eligible for the 17 percent rural adjustment which is part of the IPF PPS. Rather than ending the adjustment abruptly, CMS phased out the adjustment for these providers over a three year period. In FY 2016, the adjustment for these newly-urban providers was two-thirds of 17 percent, or 11.3 percent. For FY 2017, the adjustment for these providers is one-third of 17 percent, or 5.7 percent. For FY 2018 and subsequent years, no rural adjustment will be given to these providers. There is no rural phase-out for the single provider whose status changed from rural to urban as a result of the July 15, 2015, OMB Bulletin 15-01.

ADDITIONAL INFORMATION

Payment Correction of IPPS Transfer Claims Assigned to MS DRG 385 – Revised

MLN Matters Number: MM10145 Revised
Related Change Request (CR) Number: 10145
Related CR Release Date: September 13, 2017
Effective Date: January 1, 2018
Related CR Transmittal Number: R1918OTN
Implementation Date: January 2, 2018

This article was revised on September 13, 2017, to reflect a revised CR. That CR removed a business requirement to the MACs. The CR release date, transmittal number, and link to the transmittal also changed. All other information is unchanged.

PROVIDER TYPE AFFECTED
This MLN Matters Article is intended for Inpatient Hospitals submitting transfer claims assigned to MS DRG 385 to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED
This article, based on CR 10145, informs the MACs about a correction to Medicare’s Fiscal Intermediary Shared System (FISS) assignment of review code for Inpatient Prospective Payment System (IPPS) transfer claims assigned Medicare Severity Diagnosis Related Group (MS-DRG) 385, so that the IPPS Pricer will calculate the per diem transfer payment. Another correction allows Part A deductible, identified by a value code, on MSP same day transfer claims. Please be sure your billing staffs are aware of these corrections.

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) recently discovered that IPPS transfer claims classified into MS DRG 385 are receiving the full prospective payment as defined in 42 Code of Federal Regulations (CFR) 412.2(b), instead of the graduated per diem rate for each day of the patient’s stay in that hospital, not to exceed the amount that would have been paid if the patient had been discharged to another setting (42 CFR 412.4(f)).

Prior to October 1, 2007, transferring hospitals with discharges classified into DRG 385 (Neonates, Died or Transferred) had their payments calculated on the same basis as those receiving the full prospective payment because the weighting factors for this DRG assume that the patient will be transferred, since a transfer is part of the definition.

With the implementation of MS-DRGs in FY 2008, MS DRG 385 became inflammatory bowel disease with major complication or comorbidity (MCC). Since the definition of this MS DRG does not include a transfer, it should be subject to the transfer payment policy.

An unrelated correction also contained in this CR will allow Medicare covered and payable expenses paid by a primary payer and billed with the value code for Medicare Part A deductible

As a result, MACs will no longer bypass transfer logic when assigning review codes on IPPS claims classified into MS-DRG 385 with a discharge status code 02, 07, 66, 82, or 94 and the through date of service is equal to or later than 01/01/2018.

An unrelated correction also contained in this CR will allow the Part A deductible, identified by a value code, on Medicare Secondary Payer (MSP) same day transfer claims, as it currently does for regular MSP claims, for Medicare covered services that are paid by the primary payer.

CR 10145 contains no new policy. It improves the implementation of existing Medicare payment policies and allows the claims processing system to conform to 42 CFR 411.30(b) which states, “Expenses for Medicare covered services that are paid for by primary payers are credited toward the Medicare Part A and Part B deductibles.”
ADDITIONAL INFORMATION
The official instruction, CR10145, issued to your MAC regarding this change, is available at
IRF PPS FY 2018 Pricer Changes

MLN Matters Number: MM10125
Related Change Request (CR) Number: CR 10125
Related CR Release Date: August 25, 2017
Effective Date: October 1, 2017
Related CR Transmittal Number: R3849CP
Implementation Date: October 2, 2017

PROVIDER TYPE AFFECTED
This MLN Matters Article is intended for Inpatient Rehabilitation Facilities (IRFs) submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

WHAT YOU NEED TO KNOW
This article is based on CR 10125, which notifies you that a new IRF PRICER software package will be released prior to October 1, 2017, that will contain the updated rates that are effective for claims with discharges that fall within October 1, 2017, through September 30, 2018. MACs will install and pay IRF claims with the FY 2018 IRF Prospective Payment System (PPS) PRICER for discharges on or after October 1, 2017.

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

KEY POINTS FOR FY 2018 IRF PPS
The FY 2018 IRF PPS Final Rule, issued on July 31, 2017, sets forth the prospective payment rates applicable for IRFs for FY 2018. A new IRF PRICER software package will be released prior to October 1, 2017, that will contain the updated rates that are effective for claims with discharges that fall within October 1, 2017 through September 30, 2018.

1. Phase Out of Rural Adjustment
CMS has implemented a 3-year budget neutral phase out of the rural adjustment for those IRFs that meet the definition in Section 412.602 as rural in FY 2015 and became urban under the FY 2016 CBSA-based designations. CMS will afford existing IRFs designated in FY 2015 as rural IRFs (pursuant to Section 412.602) and re-designated as an urban facility in FY 2016 (pursuant to Section 412.602), a 3-year phase out in order to mitigate the payment effect upon a rural facility that is re-designated as an urban facility (effective FY 2016) and thereby loses the rural adjustment of 1.149. This is the third year of the phase out of rural adjustment.

2. Removal of 25 Percent Payment Penalty

3. PRICER Updates for IRF PPS FY 2018 (October 1, 2017 – September 30, 2018)

<table>
<thead>
<tr>
<th>PRICER UPDATE</th>
<th>AMOUNT</th>
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<tbody>
<tr>
<td>Standard Federal rate</td>
<td>$15,838</td>
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<tr>
<td>Adjusted standard Federal rate</td>
<td>$15,524</td>
</tr>
<tr>
<td>Fixed loss amount</td>
<td>$8,679</td>
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<tr>
<td>Labor-related share</td>
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<tr>
<td>Non-labor related share</td>
<td>0.293</td>
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<tr>
<td>Urban national average CCR</td>
<td>0.416</td>
</tr>
<tr>
<td>Rural national average CCR</td>
<td>0.518</td>
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</table>
Section 1886(j)(7)(A)(i) of the Act requires application of a 2 percentage point reduction of the applicable market basket increase factor for IRFs that fail to comply with the quality data submission requirements. The mandated reduction will be applied in FY 2018 for IRFs that failed to comply with the data submission requirements during the data collection period January 1, 2016 through December 31, 2016. Thus, in compliance with 1886(j)(7)(A)(i) of the Act, we will apply a 2 percentage point reduction to the applicable FY 2018 market basket increase factor (1.0 percent) in calculating an adjusted FY 2018 standard payment conversion factor to apply to payments for only those IRFs that failed to comply with the data submission requirements.

Application of the 2 percentage point reduction may result in an update that is less than 0.0 for a fiscal year and in payment rates for a fiscal year being less than such payment rates for the preceding fiscal year. Also, reporting-based reductions to the market basket increase factor will not be cumulative; they will only apply for the FY involved.

The adjusted FY 2018 standard payment conversion factor that will be used to compute IRF PPS payment rates for any IRF that failed to meet the quality reporting requirements for the period from January 1, 2016 through December 31, 2016 will be $15,524.

**ADDITIONAL INFORMATION**


**DOCUMENT HISTORY**

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
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<tbody>
<tr>
<td>August 29, 2017</td>
<td>Initial Article Released</td>
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Screening for Lung Cancer with LDCT – Second Revision – Republished

This article is being republished on August 29, 2017 by Noridian to include the Document History section of the MLN. This is not a revision. All information in the MLN remains the same.

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/MedicareApprovedFacilitie/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](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.

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. 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.”

Document History

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<th>Date of Change</th>
<th>Description</th>
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<tr>
<td>June 12, 2017</td>
<td>The article was revised on June 9, 2017, to include a paragraph on page 3 to show that IDTFs may be eligible facilities.</td>
</tr>
<tr>
<td>June 24, 2016</td>
<td>The article was revised to add a link to a related article MM9540. That article provides a ICD-10 code that has been added for Lung Cancer Screening with Low Dose Computed Tomography (LDCT).</td>
</tr>
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<td>November 16, 2015</td>
<td>Initial article posted.</td>
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HBV Infection Screening – Fourth Revision

MLN Matters® Number: MM9859 Revised
Related Change Request (CR) #: CR 9859
Related CR Release Date: August 4, 2017
Effective Date: September 28, 2016
Related CR Transmittal #: R3831CP and R198NCD
Implementation Date: January 2, 2018

This article was revised on August 8, 2017, to reflect an updated Change Request (CR) 9859. In the article, the CR release date, transmittal numbers, and the Web address of the CR are revised. Also, a clarification was made on page 3 to denote that HBV is not separately payable for ESRD TOB 72X unless reported with modifier AY. Another bullet point was added on page 3 to show that contractor pricing applies to G0499 with dates of service September 28, 2016 through December 31, 2017. 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

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 G049
- 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 unless reported with modifier AY.)
- Contractor pricing applies to G0499 with dates of service September 28, 2016 through December 31, 2017.

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 submitted 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 life style.

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>
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<tr>
<td>Z34.00</td>
<td>Encounter for supervision of normal first pregnancy, unspecified trimester</td>
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<td>Z34.01</td>
<td>Encounter for supervision of normal first pregnancy, first trimester</td>
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<td>Z34.02</td>
<td>Encounter for supervision of normal first pregnancy, second trimester</td>
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**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 CO** (Contractual Obligation) - Assigning financial liability to the provider 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 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.

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** (Contractual Obligation)

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. 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. 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. 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](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).

**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 Section1869(f)(1)(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**


**Document History**

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>August 8, 2017</td>
<td>This article was revised to reflect an updated CR9859. In the article, the CR release date, transmittal numbers, and the Web address of the CR are revised. A clarification was made on page 3 to denote that HBV is not separately payable for ESRD TOB 72X unless reported with modifier AY. Another bullet point was added on page 3 to show that contractor pricing applies to G0499 with dates of service September 28, 2016 through December 31, 2017. All other information is unchanged.</td>
</tr>
<tr>
<td>June 30, 2017</td>
<td>This article was revised to reflect an updated CR9859. In the article, the CR release date, transmittal numbers, and the Web address of the CR are revised. All other information is unchanged.</td>
</tr>
</tbody>
</table>
Screening for the HIV Infection - Revised

MLN Matters® Number: MM9980 Revised
Related Change Request (CR) #: CR 9980
Related CR Release Date: August 16, 2017
Effective Date: April 13, 2015
Related CR Transmittal #: R3835CP
Implementation Date: October 2, 2017

This article was revised on August 17, 2017, to reflect a revised CR9980 issued on August 16. In the article, the CR release date, transmittal number, and the Web address for accessing CR9980 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) 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

**IPPS LTCH PPS Changes for 2017 - Revised**

MLN Matters® Number: MM9723 Revised  
Related Change Request (CR) #: CR 9723  
Related CR Release Date: August 9, 2017  
Effective Date: October 1, 2016  
Related CR Transmittal #: R3832CP  
Implementation Date: October 3, 2016

This article was revised on August 11, 2017, to reflect a revised Change Request (CR) 9723 issued on August 9, 2017. In the CR, the out migration values in attachment 7 of the CR were revised. In the article, the CR release date, transmittal number, and the Web address for accessing the CR are revised. All other information remains the same.

**Provider Types Affected**

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

**Provider Action Needed**

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

**Background**

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

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

**IPPS FY 2017 Update**

**FY 2017 IPPS Rates and Factors**

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

<table>
<thead>
<tr>
<th>Standardized Amount Applicable Percentage Increase</th>
<th>1.0165 if Quality = ‘1’ and EHR = ‘blank’ in Provider Specific File (PSF); or 1.00975 if Quality = ‘0’ and EHR = ‘blank’ in PSF; or 0.99625 if Quality = ‘1’ and EHR = ‘Y’ in PSF; or 0.9895 if Quality = ‘0’ and EHR = ‘Y’ in PSF</th>
</tr>
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<tbody>
<tr>
<td>Common Fixed Loss Cost Outlier Threshold</td>
<td>$23,573</td>
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<tr>
<td>Federal Capital Rate</td>
<td>$446.79</td>
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Hospital Submitted Quality Data and is a Meaningful Electronic Health Record (EHR) User (Update = 1.65 Percent)  
Hospital Did NOT Submit Quality Data and is a Meaningful EHR User (Update = 0.975 Percent)  
Hospital Submitted Quality Data and is NOT a Meaningful EHR User (Update = -0.375 Percent)  
Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User (Update = -1.05 Percent)

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<th>Labor</th>
<th>Nonlabor</th>
<th>Labor</th>
<th>Nonlabor</th>
<th>Labor</th>
<th>Nonlabor</th>
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<th>Nonlabor</th>
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Operating Rates for Wage Index > 1

Operating Rates Wage Index < or = 1

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<td>$3,420.01</td>
<td>$2,096.13</td>
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<td>$2,096.13</td>
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MS-DRG Grouper and Medicare Code Editor (MCE) Changes

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

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

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

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

Post-acute Transfer and Special Payment Policy

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

New Technology Add-On

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

1. Name of Approved New Technology: CardioMEMSTM HF Monitoring System
   - Maximum Add on Payment: $8,875
   - Identify and make new technology add-on payments with ICD-10-PCS procedure code 02HQ30Z or 02HR30Z
2. Name of Approved New Technology: Blinatumomab (BLINCYTO™)
   • Maximum Add on Payment: $27,017.85
   • Identify and make new technology add-on payments with ICD 10 PCS procedure code XW03351 or XW04351

3. Name of Approved New Technology: LUTONIX® Drug Coated Balloon (DCB) Percutaneous Transluminal Angioplasty (PTA) and IN.PACT™Admiral™ Pacliaxel Coated Percutaneous Transluminal Angioplasty (PTA) Balloon Catheter
   • Maximum Add on Payment: $1,035.72
   • Identify and make new technology add-on payments with any of the following ICD-10-PCS procedure codes: 047K041, 047K0D1, 047K0Z1, 047K341, 047K3D1, 047K3Z1, 047K441, 047K4D1, 047K4Z1, 047LO41, 047LOD1, 047LOZ1, 047L341, 047L3D1, 047L3Z1, 047L441, 047L4D1, 047L4Z1, 047M041, 047M0D1, 047M0Z1, 047M341, 047M3D1, 047M3Z1, 047M441, 047M4D1, 047M4Z1, 047N041, 047N0D1, 047N0Z1, 047N341, 047N3D1, 047N3Z1, 047N441, 047N4D1, 047N4Z1

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

   • Maximum Add on Payment: $15,750
   • Identify and make new technology add-on payments with ICD-10-PCS procedure codes XNS0032, XNS0432, XNS3032, XNS3432, XNS4032 or XNS4432

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

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

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

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

Cost of Living Adjustment (COLA) Update for IPPS PPS

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

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

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

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

<table>
<thead>
<tr>
<th>Hawaii</th>
<th>Cost of Living Adjustment Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>City and County of Honolulu</td>
<td>1.25</td>
</tr>
<tr>
<td>County of Hawaii</td>
<td>1.19</td>
</tr>
<tr>
<td>County of Kauai</td>
<td>1.25</td>
</tr>
<tr>
<td>County of Maui and County of Kalawao</td>
<td>1.25</td>
</tr>
</tbody>
</table>

FY 2017 Wage Index Changes and Issues

1. New Wage Index Labor Market Areas and Transitional Wage Indexes

Effective October 1, 2014, CMS revised the labor market areas used for the wage index based on the most recent labor market area delineations issued by the Office of Management and Budget (OMB) using 2010 Census data.

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

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

As discussed in the FY 2017 IPPS/LTCH PPS final rule (81 FR 56913), among other changes, OMB Bulletin No. 15-01 made the following changes that are relevant to the IPPS wage index:

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

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

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

3. Section 505 Hospitals (Out-Commuting Adjustment)

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

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

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

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

Multicampus Hospitals with Inpatient Campuses in Different CBSAs

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

Medicare-Dependent, Small Rural Hospital (MDH) Program Expiration

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

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

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

Hospital Specific (HSP) Rate Factors for Sole Community Hospitals (SCHs) and Medicare-Dependent, Small Rural Hospitals (MDHs)

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

Low-Volume Hospitals – Criteria and Payment Adjustments for FY 2017

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

In order to qualify as a low-volume hospital in FY 2017, a hospital must be located more than 15 road miles from another “subsection (d) hospital” and have less than 1600 Medicare discharges (which includes Medicare Part C discharges and is based on the latest available MedPAR data). The applicable low-volume percentage increase is determined using a continuous linear sliding scale equation that results in a low-volume hospital payment adjustment ranging from an additional 25 percent for hospitals with 200 or fewer Medicare discharges to a zero percent additional payment adjustment for hospitals with 1,600 or more.
Medicare discharges. For FY 2017, qualifying low-volume hospitals and their payment adjustment are determined using Medicare discharge data from the March 2016 update of the FY 2015 MedPAR file. Table 14 of the FY 2017 IPPS/LTCH PPS final rule (available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2017-IPPS-Final-Rule-Home-Page.html) lists the "subsection (d)" hospitals with fewer than 1,600 Medicare discharges based on the March 2016 update of the FY 2015 MedPAR file and their low-volume hospital payment adjustment for FY 2017 (if eligible). CMS notes that the list of hospitals with fewer than 1,600 Medicare discharges in Table 14 does not reflect whether or not the hospital meets the mileage criterion (that is, the hospital is located more than 15 road miles from any other subsection (d) hospital, which, in general, is an IPPS hospital).

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

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

Hospital Quality Initiative

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

Hospital Acquired Condition Reduction Program (HAC)

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

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

Hospital Value Based Purchasing

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

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

Hospital Readmissions Reduction Program

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

NOTE: Hospitals located in Maryland (for FY 2017) and in Puerto Rico are not subject to the Hospital Readmissions Reduction Program, and therefore, are not listed in Table 15.

Medicare Disproportionate Share Hospitals (DSH) Program

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

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

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

Recalled Devices

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

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

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

LTCH PPS FY 2017 Update

FY 2017 LTCH PPS Rates and Factors are as follows:

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

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

1. Application of the Site Neutral Payment Rate

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

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

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

Discharge Payment Percentage

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

LTCH Quality Reporting (LTCHQR) Program

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

Cost of Living Adjustment (COLA) under the LTCH PPS

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

Additional Information

SSI/Medicare Beneficiary Data for FY 2015 for IPPS Hospitals, IRFs and LTCH

MLN Matters Number: MM10026
Related Change Request (CR) Number: CR10026
Related CR Release Date: June 30, 2017
Effective Date: July 31, 2017
Related CR Transmittal Number: R1863OTN
Implementation Date: July 31, 2017

PROVIDER TYPES AFFECTED
This MLN Matters® Article is intended for providers submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED
Change Request (CR) 10026 informs MACs about updated data for determining the disproportionate share adjustment for Inpatient Prospective Payment System (IPPS) hospitals and the low income patient (LIP) adjustment for IRFs as well as payments as applicable for Long Term Care Hospitals (LTCH) discharges (for example, discharges paid the IPPS comparable amount under the short-stay outlier payment adjustment). Make sure that your billing staffs are aware of these changes.

BACKGROUND
The SSI/Medicare beneficiary data for hospitals are available electronically and contains the name of the hospital, Centers for Medicare & Medicaid Services (CMS) certification number, Supplemental Security Income (SSI) days, total Medicare days, and the ratio of days for patients entitled to Medicare Part A attributable to SSI recipients. The files are available at the following:

- IPPS Hospitals: http://www.cms.gov/Medicare/Medicare-Fee-For-Service-Payment/AcuteInpatientPPS/dsh.html
- IRFs: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/SSIData.html
- LTCH: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/download.html

The data are used for settlement purposes for IPPS hospitals and IRFs with cost reporting periods beginning during fiscal year (FY) 2015 (cost reporting periods beginning on or after October 1, 2014, and before October 1, 2015), except as explicitly directed otherwise by the Centers for Medicare & Medicaid Services (CMS).

These instructions also provide guidance for accepting FY 2015 amended cost reports from hospitals requesting to revise Worksheet S-10 (cost reports starting on or after October 1, 2014 and prior to October 1, 2015) in light of CMS’s proposal to begin using Worksheet S-10 data to determine uncompensated care payments starting in FY 2019. For revisions to be considered, hospitals must submit their amended cost report containing the revised Worksheet S-10 (or a completed Worksheet S-10 if no data had been included on the previously submitted cost report) no later than September 30, 2017. CMS notes that the amended cost report must be received by the MAC by September 30, 2017. Submissions received on or after October 1, 2017 will not be accepted.

Providers should follow the current requirements for electronic submission of cost reports found at 42 CFR §413.24(f)(i)(iv), which specify “a provider must submit a hard copy of a settlement summary, a statement of certain worksheet totals found within the electronic file, and a statement signed by its administrator or chief financial officer certifying the accuracy of the electronic file or the manually prepared cost report.” (See 42 CFR §413.24(f)(i)(iv).) This instruction applies only to Worksheet S-10 of FY 2015 cost reports for IPPS hospitals. Revisions to Worksheet S-10 from other fiscal years, revisions to other worksheets of the FY 2015 cost reports, or revisions to Worksheet S-10 by non-IPPS hospitals are not subject to this instruction.
If an IPPS hospital whose FY 2015 cost report has been finalized requests to revise Worksheet S-10 for that FY 2015 cost report and the request is received by the MAC on or before September 30, 2017, MACs will issue a notice of Reopening in order to accept the revisions to or newly submitted Worksheet S-10 and issue a revised notice of program reimbursement on or before October 31, 2017.

Section 9105 of the Consolidated Omnibus Budget Reconciliation Act of 1985 provides that for discharges occurring on or after May 1, 1986, an additional payment must be made to IPPS hospitals serving a disproportionate share of low income patients. The additional payment is determined by multiplying the federal portion of the Diagnosis-Related Group (DRG) payment by the Disproportionate Share Hospital (DSH) adjustment factor, and beginning for discharges occurring on or after October 1, 2014, the additional payment is determined by multiplying the DRG payment by the DSH adjustment factor reduced by 75 percent. (See 42 CFR 412.106.) Under the IRF prospective payment system (PPS), IRFs receive an additional payment amount to account for the cost of furnishing care to low income patients. The additional payment is determined by multiplying the federal prospective payment by the LIP adjustment formula. (See 42 CFR 412.624(e)(2).)

Under the LTCH PPS, the payment adjustment for short-stay outlier (SSO) cases at 42 CFR 412.529 requires the calculation of an amount comparable to the amount that would otherwise be paid under the IPPS (that is, the “IPPS comparable amount.”). This calculation includes an “IPPS Comparable” DSH adjustment, where applicable, that is determined using the best available SSI data at the time of claim payment (See 42 CFR 412.529(d)(4)).

ADDITIONAL INFORMATION


IPPS and LTCH PPS FY 2018 Changes
MLN Matters Number: MM10273
Related Change Request (CR) Number: 10273
Related CR Release Date: September 8, 2017
Effective Date: October 1, 2017
Related CR Transmittal Number: R3858CP
Implementation Date: October 2, 2017

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

PROVIDER ACTION NEEDED
Change Request (CR) 10273 implements policy changes for the Fiscal Year (FY) 2018 Inpatient Prospective Payment System (IPPS) and LTCH Prospective Payment System (PPS). Failure to adhere to these new policies could affect payment of Medicare claims.

BACKGROUND
The Social Security Amendments of 1983 (P.L. 98-21) provided for establishment of a PPS for Medicare payment of inpatient hospital services. In addition, the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA), as amended by the Medicare, Medicaid, and SCHIP Benefits
Improvement and Protection Act of 2000 (BIPA), required that a budget neutral, per discharge PPS for LTCHs based on diagnosis-related groups (DRGs) be implemented for cost reporting periods beginning on or after October 1, 2002.

**IPPS FY 2018 Update**

The following policy changes for FY 2018 were displayed in the Federal Register on August 2, 2017, with a publication date of August 14, 2017. All items covered in CR10273 are effective for hospital discharges occurring on or after October 1, 2017, through September 30, 2018, unless otherwise noted.

New IPPS and LTCH PPS Pricer software packages will be released prior to October 1, 2017, that will include updated rates that are effective for claims with discharges occurring on or after October 1, 2017, through September 30, 2018.

Files for download listed throughout the CR are available on the Centers for Medicare & Medicaid Services (CMS) website. The key links are:


**IPPS FY 2018 Update**

**A. FY 2018 IPPS Rates and Factors**

For the Operating Rates/Standardized Amounts and the Federal Capital Rate, refer to Tables 1A-C and Table 1D, respectively, of the FY 2018 IPPS/LTCH PPS Final Rule, available on the FY 2018 Final Rule Tables webpage. For other IPPS factors, including applicable percentage increase, budget neutrality factors, high cost outlier (HCO) threshold, and cost-of-living adjustment (COLA) factors, refer to the MAC Implementation Files 1 available on the FY 2018 MAC Implementation Files webpage.

**B. Medicare Severity - Diagnosis Release Group (MS-DRG) Grouper and Medicare Code Editor (MCE) Changes**

The Grouper Contractor, 3M Health Information Systems (3M-HIS), developed the new International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10) MS-DRG Grouper, Version 35.0, software package effective for discharges on or after October 1, 2017. The GROUPER assigns each case into a MS-DRG on the basis of the reported diagnosis and procedure codes and demographic information (that is age, sex, and discharge status). The ICD-10 MCE Version 35.0 which is also developed by 3M-HIS, uses edits for the ICD-10 codes reported to validate correct coding on claims for discharges on or after October 1, 2017.

For discharges occurring on or after October 1, 2017, the Fiscal Intermediary Shared System (FISS) calls the appropriate GROUPER based on discharge date. For discharges occurring on or after October 1, 2017, the MCE selects the proper internal code edit tables based on discharge date.

For the October update, CMS has:

- Reduced the number of MS-DRGs from 757 to 754 for FY 2018. CMS is not implementing any new MS-DRGs for FY 2018. In addition, CMS is deleting MS-DRGs 984, 985 and 986.
- Revised the title to MS-DRG 023 to Craniotomy with Major Device Implant or Acute Complex Central Nervous System (CNS) Principal Diagnosis (PDX) with MCC or Chemotherapy Implant or Epilepsy with Neurostimulator.
- Modified the titles for MS-DRGs 061, 062, and 063 to Ischemic Stroke, Precerebral Occlusion or Transient Ischemia with Thrombolytic Agent w MCC, CC and without CC/MCC, respectively, and retitled MS-DRG 069 to Transient Ischemia without Thrombolytic.
- Revised the titles for MS-DRGs 246 and 248 to state “arteries” instead of “vessels” to better reflect
the I-10 terminology in the classification. The revised titles for MS-DRGs 246 and 248 are Percutaneous cardiovascular procedures with drug-eluting stent with MCC or 4+ arteries or stents and Percutaneous cardiovascular procedures with nondrug-eluting stent with MCC or 4+ arteries or stents, respectively.

- Modified the title for MS-DRGs 469 and 470 to Major Hip and Knee Joint Replacement or Reattachment of Lower Extremity with MCC or Total Ankle Replacement and Major Hip and Knee Joint Replacement or Reattachment of Lower Extremity without MCC, respectively.

- Revised the titles for MS-DRGs 823, 824 and 825 to Lymphoma and Non-Acute Leukemia with Other Procedure with MCC, with CC and without CC/MCC, respectively.

- Revised the titles for MS-DRGs 829 and 830 to Myeloproliferative Disorders or Poorly Differentiated Neoplasms with Other Procedure with CC/MCC and without CC/MCC, respectively.

C. Post-acute Transfer and Special Payment Policy

The changes to MS-DRGs for FY 2018 have been evaluated against the general post-acute care transfer policy criteria using the FY 2016 MedPAR data according to the regulations under Sec. 412.4 (c). As a result of this review, no new MS-DRGs will be added to the list of MS-DRGs subject to the post-acute care transfer policy; however MS-DRGs 987, 988 and 989 (Non-Extensive O.R. Procedure Unrelated To Principal Diagnosis with major complication or comorbidity (MCC), with complication or comorbidity (CC), without CC/MCC, respectively) were added to the special payment policy list. See Table 5 of the FY 2018 IPPS/LTCH PPS Final Rule for a listing of all Post-acute and Special Post-acute MS-DRGs available on the FY 2018 Final Rule Tables webpage.

D. New Technology Add-On

The following items will continue to be eligible for new-technology add-on payments in FY 2018:

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

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

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

4. Name of Approved New Technology: Vistogard™
   - Maximum Add-on Payment: $40,130 (Note: The maximum payment has changed from FY 2018)
   - Identify and make new technology add-on payments with any of the following ICD-10 clinical modification (ICD-10-CM) diagnosis codes T45.1x1A, T45.1x1D, T45.1x1S, T45.1x5A, T45.1x5D, or T45.1x5S in combination with ICD-10-PCS procedure code XW0DX82

The following items are eligible for new-technology add-on payments in FY 2018:

5. Name of Approved New Technology: ZINPLAVA™
   - Maximum Add-on Payment: $1,900
   - Identify and make new technology add-on payments with ICD-10-PCS procedure codes XW033A3 or XW043A3.
6. Name of Approved New Technology: Stelara®
   - Maximum Add-on Payment: $2,400
   - Identify and make new technology add-on payments with ICD-10-PCS procedure code XW033F3.

7. Name of Approved New Technology: EDWARDS INTUITY Elite™ Valve System (INTUITY) and LivaNova Perceval Valve (Perceval)
   - Maximum Add-on Payment: $6,110.23
   - Identify and make new technology add-on payments with ICD-10-PCS code X2RF032.

E. Cost of Living Adjustment (COLA) Update for IPPS PPS

The IPPS incorporates a COLA for hospitals located in Alaska and Hawaii. CMS has updated the COLAs for FY 2018, and the COLAs for the qualifying counties in all of Alaska and in Hawaii is 1.25, except for the county of Hawaii which is 1.21. For reference, a table showing the applicable COLAs that are effective for discharges occurring on or after October 1, 2017, are available in the FY 2018 IPPS/LTCH PPS final rule and in MAC Implementation File 1 available on the FY 2018 MAC Implementation Files webpage.

F. FY 2017 Wage Index Changes and Issues

1. Transitional Wage Indexes

Effective October 1, 2014, CMS revised the labor market areas used for the wage index based on the most recent labor market area delineations issued by the Office of Management and Budget (OMB) using 2010 Census data.

For hospitals that were located in an urban county prior to October 1, 2014, that became rural effective October 1, 2014, CMS assigned a hold-harmless urban wage index value of the labor market area in which they are physically located for FY 2014 for 3 years for FY 2015, 2016 and 2017. These hold harmless wage indexes have expired for FY 2018. MACs will ensure hospitals that were eligible for transitional wage indexes in FY 2017 no longer receive a transitional wage index for FY 2018.

2. Adoption of Federal Information Processing Standard (FIPS) County Codes

Core Based Statistical Areas (CBSAs) are made up of one or more constituent counties. Each CBSA and constituent county has its own unique identifying codes. There are two different lists of codes associated with counties: Social Security Administration (SSA) codes and FIPS codes. Historically, CMS has listed and used SSA and FIPS county codes to identify and crosswalk counties to CBSA codes for purposes of the hospital wage index. CMS has learned that SSA county codes are no longer being maintained and updated. However, the FIPS codes continue to be maintained by the U.S. Census Bureau. The Census Bureau’s most current statistical area information is derived from ongoing census data received since 2010; the most recent data are from 2015. For the purposes of crosswalking counties to CBSAs, in the FY 2018 IPPS/LTCH PPS final rule, CMS finalized that it would discontinue the use of SSA county codes and begin using only the FIPS county codes beginning in FY 2018.

Based on information included in the Census Bureau’s website, since 2010, the Census Bureau has made the following updates to the FIPS codes for counties or county equivalent entities:

- Petersburg Borough, AK (FIPS State County Code 02-195), CBSA 02, was created from part of former Petersburg Census Area (02-195) and part of Hoonah-Angoon Census Area (02-105). The CBSA code remains 02.

- The name of La Salle Parish, LA (FIPS State County Code 22-059), CBSA 14, is now LaSalle Parish, LA (FIPS State County Code 22-059). The CBSA code remains as 14.

- The name of Shannon County, SD (FIPS State County Code 46-113), CBSA 43, is now Oglala Lakota County, SD (FIPS State County Code 46-102). The CBSA code remains as 43.

CMS adopted the implementation of these FIPS code updates, effective October 1, 2017, beginning with the FY 2018 wage indexes. A County to CBSA Crosswalk File is available on the FY 2018 Final Rule Data Files webpage.
Note: The county update changes listed above changed the county names. However, the CBSAs to which these counties map did not change from the prior counties. Therefore, there is no payment impact or change to hospitals in these counties; they continue to be considered rural for the hospital wage index under these changes.

3. Treatment of Certain Providers Redesignated Under Section 1886(d)(8)(B) of the Act

42 CFR 412.64(b)(3)(ii) implements section 1886(d)(8)(B) of the Act, which redesignates certain rural counties adjacent to one or more urban areas as urban for the purposes of payment under the IPPS. (These counties are commonly referred to as “Lugar counties.”) Accordingly, hospitals located in Lugar counties are deemed to be located in an urban area and their IPPS payments are determined based upon the urban area to which they are redesignated. A hospital that waives its Lugar status in order to receive the out-migration adjustment has effectively waived its deemed urban status, and is considered rural for all IPPS purposes. The following is a list of hospitals that have waived LUGAR status for FY 2018: 010164, 070004, 070011, 140167, 250117, 390008, 390031, 390150 and 520102.

4. Section 505 Hospital (Out-Commuting Adjustment)

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

G. Treatment of Certain Urban Hospitals Reclassified as Rural Hospitals Under § 412.103 and Hospitals reclassified under the MGCRB

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

Prior to April 21, 2016, the regulations at § 412.230(a)(5)(ii) and § 412.230(a)(5)(iii) prohibited hospitals from simultaneously receiving an urban to rural reclassification under § 412.103 and a reclassification under the MGCRB. Also, the regulations did not allow a Lugar hospital to keep its Lugar status if it was approved for an urban to rural reclassification under § 412.103. Effective April 21, 2016, hospitals nationwide that have an MGCRB reclassification or Lugar status during FY 2016 and subsequent years can simultaneously seek urban to rural reclassification under § 412.103 for IPPS payment and other purposes, and keep their existing MGCRB reclassification or Lugar status.

H. Multicampus Hospitals with Inpatient Campuses in Different CBSAs

Beginning with the FY 2008 wage index, CMS instituted a policy that allocates the wages and hours to the CBSA in which a hospital campus is located when a multicampus hospital has campuses located in different CBSAs. Medicare payment to a hospital is based on the geographic location of the hospital facility at which the discharge occurred. Therefore, if a hospital has a campus or campuses in different CBSAs, the MAC adds a suffix to the CMS Certification Number (CCN) of the hospital in the Provider Specific File (PSF), to identify and denote a subcampus in a different CBSA, so that the appropriate wage index associated with each campus’s geographic location can be assigned and used for payment for Medicare discharges from each respective campus. Also note that, under certain circumstances, it is permissible for individual campuses to have reclassifications to another CBSA, in which case, the appropriate reclassified CBSA and wage index needs to be noted in the PSF.

I. Updating the PSF for Wage Index, Reclassifications and Redesignations

MACs will update the PSF by following the steps, in order, in Attachment 1 of CR10273 to determine the appropriate wage index based on policies mentioned above.

J. Expiration of Medicare-Dependent, Small Rural Hospital (MDH) Program

The MDH program is currently effective through September 30, 2017, as provided by section 205 of the Medicare Access and CHIP Reauthorization Act of 2015. Under current law, beginning in October 1, 2017, all previously qualifying hospitals will no longer have MDH status and will be paid based solely on the Federal rate. (Note that, the SCH policy at § 412.92(b) allows MDHs to apply for SCH status and be paid as
such under certain conditions, following the expiration of the MDH program.) Provider Types 14 and 15 will no longer be valid beginning October 1, 2017.

K. Hospital Specific (HSP) Rate Factors for Sole Community Hospitals (SCHs)

For FY 2018, the HSP amount in the PSF for SCHs (and MDHs as applicable) will continue to be entered in FY 2012 dollars. PRICER will apply the cumulative documentation and coding adjustment factor for FYs 2011 through 2014 of 0.9480 and apply all of the updates and DRG budget neutrality factors to the HSP amount for FY 2013 and beyond.

Note: The FY 2017 2 midnight rule one time prospective increase of 1.006 (as well as the removal of 0.998 2 midnight rule adjustment applied in 2014) are not applied to the HSP update for FY 2018.

L. Low-Volume Hospitals – Criteria and Payment Adjustments for FY2018

The temporary changes to the low-volume hospital payment adjustment originally provided by the Affordable Care Act, and extended by subsequent legislation, which expanded the definition of a low-volume hospital and modified the methodology for determining the payment adjustment for hospitals meeting that definition, is currently effective through September 30, 2017, as provided by section 204 of the Medicare Access and CHIP Reauthorization Act of 2015. Under current law, beginning in October 1, 2017, the low-volume hospital qualifying criteria and payment adjustment methodology will revert to that which was in effect prior to the amendments made by the Affordable Care Act and subsequent legislation (that is, the low-volume hospital payment adjustment policy in effect for FYs 2005 through 2010). The regulations implementing the hospital payment adjustment policy are at § 412.101.

In addition, CMS is implementing an adjustment parallel to the low-volume hospital payment adjustment so that, for discharges occurring in FY 2018 and subsequent years, only the distance between Indian Health Service (IHS) or Tribal hospitals will be considered when assessing whether an IHS or Tribal hospital meets the mileage criterion under § 412.101(b)(2). Similarly, only the distance between non-IHS hospitals would be considered when assessing whether a non-IHS hospital meets the mileage criterion under § 412.101(b)(2). This parallel adjustment is implemented in 42 CFR 412.101(e).

For FY 2018, a hospital must make a written request for low-volume hospital status that is received by its MAC no later than September 1, 2017, in order for the 25-percent, low-volume, add-on payment adjustment to be applied to payments for its discharges beginning on or after October 1, 2017 (through September 30, 2018). Under this procedure, a hospital that qualified for the low-volume hospital payment adjustment for FY 2017 may continue to receive a low-volume hospital payment adjustment for FY 2018 without reapplying if it meets both the discharge criterion and the mileage criterion applicable for FY 2018. As in previous years, such a hospital must send written verification that is received by its MAC no later than September 1, 2017, stating that it meets the mileage criterion applicable for FY 2018. For FY 2018, this written verification must also state, based upon the most recently submitted cost report, that the hospital meets the discharge criterion applicable for FY 2018 (that is, less than 200 discharges total, including both Medicare and non-Medicare discharges). If a hospital’s request for low-volume hospital status for FY 2018 is received after September 1, 2017, and if the MAC determines the hospital meets the criteria to qualify as a low-volume hospital, the MAC will apply the 25-percent, low-volume hospital payment adjustment to determine the payment for the hospital’s FY 2018 discharges, effective prospectively within 30 days of the date of the MAC’s low-volume hospital status determination. CMS notes that this process mirrors its established application process but is updated to ensure that providers currently receiving the low-volume hospital payment adjustment verify that they meet both the mileage criterion and the discharge criterion applicable for FY 2018 to continue receiving the adjustment for FY 2018.

The low-volume hospital payment is based on and in addition to all other IPPS per discharge payments, including capital, DSH (including the uncompensated care payment), Indirect Medical Education (IME) and outliers. For SCHs (and MDHs, when applicable), the low-volume hospital payment is based on and in addition to either payment based on the Federal rate or the hospital-specific rate, whichever results in a greater operating IPPS payment.

M. Hospital Quality Initiative

The hospitals that will receive the quality initiative bonus are listed at www.qualitynet.org. Should a provider later be determined to have met the criteria after publication of this list, they will be added to the list.
N. Hospital Acquired Condition Reduction Program (HAC)

Under the HAC Reduction Program, a 1-percent payment reduction applies to a hospital whose ranking is in the top quartile (25 percent) of all applicable hospitals, relative to the national average, of HACs acquired during the applicable period, and applies to all of the hospital’s discharges for the specified fiscal year.

A list of providers subject to the HAC Reduction Program for FY 2018 was not publicly available in the final rule because the review and correction process was not yet completed. MACs will receive a preliminary list of hospitals subject to the HAC Reduction Program. Updated hospital level data for the HAC Reduction Program will be made publicly available following the review and corrections process.

O. Hospital Value Based Purchasing (VBP)

For FY 2018, CMS will implement the base operating DRG payment amount reduction and the value-based incentive payment adjustments, as a single value-based incentive payment adjustment factor applied to claims for discharges occurring in FY 2018. CMS expects to post the value-based incentive payment adjustment factors for FY 2018 in the near future in Table 16B of the FY 2018 IPPS/LTCH PPS final rule (which will be available through the Internet on the FY 2018 IPPS Final Rule Tables webpage).

P. Hospital Readmissions Reduction Program

The readmissions payment adjustment factors for FY 2018 are in Table 15 of the FY 2018 IPPS/LTCH PPS final rule (which are available through the Internet on the FY 2018 IPPS Final Rule Tables webpage). Hospitals that are not subject to a reduction under the Hospital Readmissions Reduction Program in FY 2018 (such as Maryland hospitals), have a readmission adjustment factor of 1.0000. For FY 2018, hospitals should only have a readmission adjustment factor between 1.0000 and 0.9700.

NOTE: Hospitals located in Maryland (for FY 2018) and in Puerto Rico are not subject to the Hospital Readmissions Reduction Program, and therefore, are not listed in Table 15. Therefore, MACs shall follow the instructions in the second bullet above for the PSF for these hospitals.

Q. Medicare Disproportionate Share Hospitals (DSH) Program

Section 3133 of the Affordable Care Act modified the Medicare DSH program beginning in FY 2014. Under current law, hospitals received 25 percent of the amount they previously would have received under the current statutory formula for Medicare DSH. The remainder, equal to 75 percent of what otherwise would have been paid as Medicare DSH, will become an uncompensated care payment after the amount is reduced for changes in the percentage of individuals that are uninsured. Each Medicare DSH hospital will receive a portion of this uncompensated care pool based on its share of total uncompensated care reported by Medicare DSH hospitals. A Medicare DSH hospital’s share of uncompensated care for FY 2018 is based on the average of three individual Factor 3s calculated based on cost reporting periods beginning in FY 2012, FY 2013, and FY 2014. The individual Factor 3s for FY 2012 and FY 2013 are based on Medicaid days and Medicare SSI days, while the Factor 3 for FY 2014 is based on hospital uncompensated care costs. For FY 2018, the denominators used in the calculation of Factor 3 for FY 2012, FY 2013, and FY 2014 cost reporting years are 36,967,682 days, 37,321,428 days, and $25,186,285,084, respectively.

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

The total uncompensated care payment amount to be paid to Medicare DSH hospitals was finalized in the FY 2018 IPPS Final Rule, and the uncompensated care payment will continue to be paid on the claim as an estimated per discharge amount to the hospitals that have been projected to receive Medicare DSH for FY 2018. The estimated per discharge uncompensated care payment amount will be included in the outlier payment determinations. In addition the estimated per discharge uncompensated care payment amount will be included as a Federal payment for SCHs to determine if a claim is paid under the hospital-specific rate or Federal rate (and for MDHs to determine if the claim is paid 75 percent of the difference between payment under the hospital-specific rate and payment under the Federal rate, when applicable). The total uncompensated care payment amount displayed in the Medicare DSH Supplemental Data File on the CMS website will be reconciled at cost report settlement with the interim estimated uncompensated care payments that are paid on a per discharge basis.
The Uncompensated Care Per Discharge Amount and Projected DSH Eligibility are located in the Medicare DSH Supplemental Data File for FY 2018, which are available through the Internet on the FY 2018 Final Rule Data Files webpage. Column A of the Medicare DSH Supplemental Data File is the provider CCN; Column I is the uncompensated care per discharge amount, and Column K states whether the provider is eligible for DSH.

R. Recalled Devices

A hospital’s IPPS payment is reduced, for specified MS-DRGs when the implantation of a device is replaced without cost or with a credit equal to 50 percent or more of the cost of the replacement device. New MS-DRGs are added to the list subject to the policy for payment under the IPPS for replaced devices offered without cost or with a credit when they are formed from procedures previously assigned to MS-DRGs that were already on the list. There are no new MS-DRGs for FY 2018 subject to the policy for replaced devices offered without cost or with a credit.

CMS is revising the titles to MS-DRGs 023 (Craniotomy with Major Device Implant or Acute Complex Central Nervous System (CNS) Principal Diagnosis (PDX) with MCC or Chemotherapy Implant or Epilepsy with Neurostimulator), 469 (Major Hip and Knee Joint Replacement or Reattachment of Lower Extremity with MCC or Total Ankle Replacement), and 470 (Major Hip and Knee Joint Replacement or Reattachment of Lower Extremity without MCC). These MS-DRGs continue to be subject to the replaced devices offered without cost or with a credit policy, effective October 1, 2017.

LTCH PPS FY 2018 Update

2018 LTCH PPS Rates and Factors

The FY 2018 LTCH PPS Standard Federal Rates are located in Table 1E available on the FY 2018 Final Rule Tables webpage. Other FY 2018 LTCH PPS Factors are in MAC Implementation File 2 available on the FY 2018 MAC Implementation File webpage.

The LTCH PPS Pricer has been updated with the Version 35.0 MS-LTC-DRG table, weights and factors, effective for discharges occurring on or after October 1, 2017, and on or before September 30, 2018.

A. Application of the Site Neutral Payment Rate

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


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

Effective with discharges occurring in LTCHs’ cost reporting periods beginning on or after October 1, 2017 (FY 2018), the transitional blended payment rate for site neutral payment rate cases is no longer applicable, and such cases will be paid based on 100 percent of the site neutral payment rate for the discharge.
B. Changes to the Short-Stay Outlier (SSO) Payment Adjustment

CMS is revising the payment formula used to determine payments for SSO cases beginning in FY 2018. This change is reflected in the LTCH PPS Pricer logic.

Effective for LTCH PPS discharges occurring on or after October 1, 2017, the adjusted payment for a SSO case is equal to the “blended payment amount option” under the previous SSO policy. That is, the adjusted payment for a SSO case is equal a blend of an amount comparable to what would otherwise be paid under the IPPS, computed as a per diem, and capped at the full IPPS DRG comparable amount, and the 120 percent LTC-DRG per diem amount. Note there has been no change in the definition of a SSO case (and it continues to be for discharges where the covered length of stay is less than or equal to five sixths of the geometric average length of stay for each MS-LTC-DRG).

C. Changes to High-Cost Outlier (HCO) Payments for LTCH PPS Standard Federal Payment Rate Cases

When CMS implemented the LTCH PPS, it established a policy allowing for HCO payments to cases where the estimated cost of the case exceeds the outlier threshold. In general, the outlier threshold is the LTCH PPS payment plus a fixed-loss amount that is determined annually. Historically, CMS set this threshold so that aggregate estimated HCO payments accounted for 8 percent of the estimated total aggregate payments to LTCH PPS Standard Federal payment rate cases. In addition, to ensure these estimated HCO payments did not increase or decrease its estimated payments to LTCH PPS Standard Federal Payment Rates, CMS reduced the LTCH PPS Standard Federal payment rate by 8 percent.

Section 15004(b) of the 21st Century Cures Act (Pub. L. 114-255) requires that beginning in FY 2018, CMS continue to reduce the LTCH PPS standard Federal payment rate by 8 percent, but establish the HCO fixed-loss amount so that aggregate HCO payments are estimated to be 7.975 percent of estimated aggregate payments for standard Federal payment rate cases. Accordingly, the FY 2018 fixed-loss amount of $27,382 for LTCH PPS Standard Federal Payment Rate cases reflects this statutory requirement.

D. LTCH Quality Reporting (LTCHQR) Program

Section 3004(a) of the Affordable Care Act requires the establishment of the Long-Term Care Hospital Quality Reporting (LTCHQR) Program. For FY 2018, the annual update to a standard Federal rate will continue to be reduced by 2.0 percentage points if a LTCH does not submit quality reporting data in accordance with the LTCHQR Program for that year.

E. Provider Specific File (PSF)

The PSF required fields for all provider types which require a PSF is available in the Medicare Claims Processing Manual, Chapter 3, §20.2.3.1 at https://www.cms.gov/Regulations-and-Guidance/Guidance-Manuals/Downloads/clm104c03.pdf.

As noted above in section A.1., effective with discharges occurring in LTCHs’ cost reporting periods beginning on or after October 1, 2017 (FY 2018), the transitional blended payment rate for site neutral payment rate cases is no longer applicable, and such cases will be paid based 100 percent of the site neutral payment rate for the discharge. MACs shall ensure that the Fiscal Year Beginning Date field in the PSF (Data Element 4, Position 25) is updated as applicable with the correct date.

Table 8C contains the FY 2018 Statewide average LTCH total cost-to-charge ratios (CCRs) for urban and rural LTCHs. Table 8C is available on the FY 2018 Final Rule Tables webpage. Per the regulations in 42 CFR sections 412.525(a)(4)(iv)(C) and 412.529(f)(4)(iii), for FY 2018, Statewide average CCRs are used in the following instances:

- New hospitals that have not yet submitted their first Medicare cost report. (For this purpose, a new hospital is defined as an entity that has not accepted assignment of an existing hospital’s provider agreement in accordance with 42 CFR 489.18).
- LTCHs with a total CCR is in excess of 1.280 (referred to as the total CCR ceiling).
- Any hospital for which data to calculate a CCR is not available.

NOTE: Hospitals and/or MACs can request an alternative CCR to the statewide average CCR per the instructions in section 150.24 of chapter 3 of the Medicare Claims Processing Manual.
F. Cost of Living Adjustment (COLA) under the LTCH PPS

The LTCH PPS incorporates a COLA for hospitals located in Alaska and Hawaii. The COLAs, which have been updated for FY 2018, and effective for discharges occurring on or after October 1, 2017, can be found in the FY 2018 IPPS/LTCH PPS final rule and are also located in MAC Implementation File 2 available on the FY 2018 MAC Implementation Files webpage. (Note that the same COLA factors are used under the IPPS and the LTCH PPS for FY 2018.)

G. 25-percent Threshold Policy

Section 15006 of the 21st Century Cures Act established a moratorium on the implementation of the 25-percent threshold policy until October 1, 2017. CMS also established an additional regulatory moratorium on the implementation of the 25-percent threshold policy effective until October 1, 2018. CMS codified changes to the regulations at § 412.538 in the FY 2018 final rule.

H. Average Length of Stay Calculation

Section 15007 of the 21st Century Cures Act excluded Medicare Advantage and site neutral discharges from the calculation of the average length of stay for all LTCHs. CMS codified changes to the regulations at § 412.23(e)(3) in the FY 2018 final rule.

I. Discharge Payment Percentage

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

J. Extended Neoplastic Disease Care Hospitals

Section 15008 of the 21st Century Cures Act removed certain hospitals, previously referred to as “subclause (II) LTCHs,” from the IPPS-exclude hospital designation of an LTCH and created a new category of IPPS-excluded hospital for these entities, now referred to as “extended neoplastic disease care hospitals.” As such, these hospitals are no longer subject to the LTCH PPS effective with for cost reporting periods beginning on or after January 1, 2015.

Section 15008 of the 21st Century Cures Act further specifies that, for cost reporting periods beginning on or after January 1, 2015, payment for inpatient operating costs for such hospitals is to be made as described in 42 CFR 412.526(c)(3), and payment for capital costs is to be made as described in 42 CFR 412.526(c)(4). (Note that any prior instructions issued by CMS for the payment of such hospitals redesignated by Section 15008 of the 21st Century Cures Act for cost reporting periods beginning on or after January 1, 2015 (for example, CR 9912), any references to “subclause (II) LTCHs” shall be read as “extended neoplastic disease care hospitals”.)

Hospitals Excluded from the IPPS

The update to extended neoplastic disease care hospital’s target amount is the applicable annual rate-of-increase percentage specified in § 413.40(c)(3), which is equal to the percentage increase projected by the hospital market basket index. In the FY 2018 final rule, CMS established an update to an extended neoplastic disease care hospital’s target amount for FY 2018 of 2.7 percent.

ADDITIONAL INFORMATION


DOCUMENT HISTORY

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<th>Date of Change</th>
<th>Description</th>
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<td>September 11, 2017</td>
<td>Initial article released.</td>
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**Botulinum Toxin Types A and B LCD – R10**

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

**Medicare Coverage Database (MCD) Number:** L35172

**LCD Title:** Botulinum Toxin Types A and B

**Effective Date:** February 13, 2017

**Summary of Changes:** The following corrections were made:

- In Revision 7, G93.4 is an invalid code and was corrected to G83.4 - Cauda equina syndrome.
- Corrected CPT® 49499 to 43499 – unlisted procedure, esophagus and clarified ICD-10 code K22.0 - Achalasia of cardia may be billed with other appropriate CPT® codes in the Group 1 Medical Necessity ICD-10 Codes Asterisk Explanation section of the policy.

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

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

**Botulinum Toxin Types A and B LCD – R11**

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

**Medicare Coverage Database (MCD) Number:** L35172

**LCD Title:** Botulinum Toxin Types A and B

**Effective Date:** October 1, 2017

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

New/Revised ICD-10 codes:

- I63211: Cerebral infarction due to unspecified occlusion or stenosis of right vertebral artery
- I63212: Cerebral infarction due to unspecified occlusion or stenosis of left vertebral artery
- I63322: Cerebral infarction due to thrombosis of left anterior cerebral artery
- I63323: Cerebral infarction due to thrombosis of bilateral anterior cerebral arteries
- I63333: Cerebral infarction to thrombosis of bilateral posterior cerebral arteries
- I63513: Cerebral infarction due to unspecified occlusion or stenosis of bilateral middle cerebral arteries
- I63523: Cerebral infarction due to unspecified occlusion or stenosis of bilateral anterior cerebral arteries
- I63533: Cerebral infarction due to unspecified occlusion or stenosis of bilateral posterior cerebral arteries

View the locally hosted Noridian Active LCD PDF.

- Go to [https://med.noridianmedicare.com/web/jfa/policies/lcd/active](https://med.noridianmedicare.com/web/jfa/policies/lcd/active)
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
  - Locate and select above listed LCD title.
B-type Natriuretic Peptide (BNP) Testing LCD – R5

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

Medicare Coverage Database (MCD) Number: L35526

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

Effective Date: October 1, 2017

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

New ICD-10 codes

- I50.810: Right heart failure, unspecified.
- I50.811: Acute right heart failure
- I50.812: Chronic right heart failure
- I50.813: Acute on chronic right heart failure
- I50.814: Right heart failure due to left heart failure.
- I50.82: Biventricular heart failure
- I50.83: High output heart failure
- I50.84: End state heart failure
- I50.89: Other heart failure
- R06.03: Acute Respiratory distress

Revised ICD-10 codes

- I50.1: Left ventricular failure

View the locally hosted Noridian Active LCD PDF.

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

Cataract Surgery in Adults Final LCD – Effective October 10, 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: L37027

LCD Title: Cataract Surgery in Adults

Effective Date: October 10, 2017

Summary of LCD: Specialized Ophthalmic Testing guidelines have been added along with guidelines for Complex Cataract Surgery (CPT code 66982). Additions to Associated Information and Utilization Requirements have also been added.

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).
MEDICAL POLICIES

• 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.

Chest X-Ray 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: DL37549

LCD Title: Chest X-Ray

Comment period: October 5, 2017 – December 12, 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

Chest X-Ray LCD – R7
The following JF Local Coverage Determination (LCD) has been revised under contractor numbers 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT), 03601 (WY).

Medicare Coverage Database (MCD) Number: L34097

LCD Title: Chest X-Ray

Effective Date: October 1, 2017

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

New ICD-10 codes:

• G12.23: Primary lateral sclerosis
• G12.24: Familial motor neuron disease
• G12.25: Progressive spinal muscle atrophy
• R06.03: Acute respiratory distress
• C96.20: Malignant mast cell neoplasm, unspecified
• C96.21: Aggressive systemic mastocytosis
• C96.22: Mast cell sarcoma
• C96.29: Other malignant mast cell neoplasm
• D47.02: Systemic mastocytosis
• D47.09: Other mast cell neoplasms of uncertain behavior
• E85.81: Light chain (AL) amyloidosis
• E85.82: Wild-type transthyretin-related (ATTR) amyloidosis
• E85.89: Other amyloidosis
• P29.30: Pulmonary hypertension of newborn
• P29.38: Other persistent fetal circulation
• T07.XXXA: Unspecified multiple injuries, initial encounter
• T07.XXXD: Unspecified multiple injuries, subsequent encounter
• T07.XXXS: Unspecified multiple injuries, sequela
• T14.91XA: Suicide attempt, initial encounter
• T14.91XD: Suicide attempt, subsequent encounter
• T14.91XS: Suicide attempt, sequela

Revised ICD-10 codes:

• I50.1: Left ventricular failure revised to Left ventricular failure, unspecified
• I82.811: Embolism and thrombosis of superficial veins of right lower extremities revised to Embolism and thrombosis of superficial veins of right lower extremity
• I82.812: Embolism and thrombosis of superficial veins of left lower extremities revised to Embolism and thrombosis of superficial veins of left lower extremity
• J15.6: Pneumonia due to other aerobic Gram-negative bacteria revised to Pneumonia due to other Gram-negative bacteria
• M33.01: Juvenile dermatopolymyositis with respiratory involvement revised to Juvenile dermatomyositis with respiratory involvement
• M33.02: Juvenile dermatopolymyositis with myopathy revised to Juvenile dermatomyositis with myopathy
• M33.09: Juvenile dermatopolymyositis with other organ involvement revised to Juvenile dermatomyositis with other organ involvement
• M33.11: Other dermatopolymyositis with respiratory involvement revised to Other dermatomyositis with respiratory involvement
• M33.12: Other dermatopolymyositis with myopathy revised to Other dermatomyositis with myopathy
• M33.19: Other dermatopolymyositis with other organ involvement revised to Other dermatomyositis with other organ involvement

Deleted ICD-10 codes:

• C96.2: Malignant mast cell tumor
• D47.0: Histiocytic and mast cell tumors of uncertain behavior
• E85.8: Other amyloidosis
• I27.2: Other secondary pulmonary hypertension
• K91.3: Postprocedural intestinal obstruction
• N63: Unspecified lump in breast
• P29.3: Persistent fetal circulation
• P91.8: Other specified disturbances of cerebral status of newborn
• T07: Unspecified multiple injuries
• T14.91: Suicide attempt

View the locally hosted Noridian Active LCD PDF.

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

• Locate and select above listed LCD title

Coenzyme Q10 (CoQ10) LCD – Effective October 2, 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: L37068
LCD Title: Coenzyme Q10 (CoQ10)
Effective Date: October 2, 2017
Summary of LCD: This is a non-coverage policy for serum or other body fluid testing for levels of Coenzyme Q10 (CoQ10 or Q10), also known as ubiquinone, ubidecarenone, coenzyme Q, for all diseases.

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.

Controlled Substance Monitoring and Drugs of Abuse Testing LCD – R2 and R3
The following JF Local Coverage Determination (LCD) has been revised under contractor numbers 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT), 03601 (WY).

Medicare Coverage Database (MCD) Number: L36707
LCD Title: Controlled Substance Monitoring and Drugs of Abuse Testing
Effective Date: October 1, 2017
Summary of Changes: This LCD has been updated to include ICD-10 codes.
New/Revised ICD-10 codes
• R41.82: Altered mental status, unspecified
• R41.850: Homicidal ideations
• R41.851: Suicidal ideations
• F10.11: Alcohol abuse, in remission
• F11.11: Opioid abuse, in remission
• F12.11: Cannabis abuse, in remission
• F13.11: Sedative, hypnotic or anxiolytic abuse, in remission
• F14.11: Cocaine abuse, in remission
• F15.11: Other stimulant abuse, in remission
• F16.11: Hallucinogen abuse, in remission
• F18.11: Inhalant abuse, in remission
MEDICAL POLICIES

- F19.11: Other psychoactive substance abuse, in remission

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

**Diagnostic and Therapeutic Colonoscopy LCD – R1 and R2**

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

**Medicare Coverage Database (MCD) Number**: L36868

**LCD Title**: Diagnostic and Therapeutic Colonoscopy

**Effective Date**: October 1, 2017

**Summary of Changes**: This LCD has been updated to include new and remove ICD-10 codes and corrected a typographical error.
- New/Revised ICD-10 codes
  - A04.71 - Enterocolitis due to Clostridium difficile, recurrent
  - A04.72 - Enterocolitis due to Clostridium difficile, not specified as recurrent
  - K56.50 - Intestinal adhesions [bands], unspecified as to partial versus complete obstruction
  - K56.51 - Intestinal adhesions [bands], with partial obstruction
  - K56.52 - Intestinal adhesions [bands] with complete obstruction
  - K56.690 - Other partial intestinal obstruction
  - K56.691 - Other complete intestinal obstruction
  - K56.699 - Other intestinal obstruction unspecified as to partial versus complete obstruction
- Deleted ICD-10 codes
  - A04.7 - Enterocolitis due to Clostridium difficile
  - K56.5 - Intestinal adhesions [bands] with obstruction (postprocedural) (postinfection)
  - K56.69 - Other intestinal obstruction

View the locally hosted Noridian Active LCD PDF.
- Go to https://med.noridianmedicare.com/web/jfa/policies/lcd/active
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
  - Locate and select above listed LCD title
Flow Cytometry LCD - R6

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

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

**LCD Title:** Flow Cytometry

**Effective Date:** October 1, 2015

**Summary of Changes:** Corrected C82.11-C85.19 in the previous Revision History to read C85.11-C85.19 – Unspecified B-cell lymphomas were added effective 10/01/2015. The following ICD-10 code ranges were already in the policy prior to the addition of C85.11-C85.19:

- C82.01-C82.09-Follicular Lymphomas, Grade I,
- C82.11-C82.19-Follicular Lymphomas, Grade II,
- C82.31-C82.39-Follicular Lymphomas, Grade IIIa,
- C82.41-C82.49-Follicular Lymphomas, Grade IIIb,
- C82.51-C82.59-Diffuse follicle center lymphomas,
- C82.61-C82.69-Cutaneous follicle center lymphomas,
- C82.81-C82.89-Other types of follicular lymphomas,
- C83.01-C83.09-Small cell B-cell lymphomas,
- C83.11-C83.19-Mantle cell lymphomas,
- C83.31-C83.39-Diffuse large B-cell lymphomas,
- C83.51-C83.59-Lymphoblastic (diffuse) lymphomas,
- C83.71-C83.79-Burkitt lymphomas,
- C83.81-C83.89-Other non-follicular lymphoma,
- C84.01-C84.09-Mycosis fungoides,
- C84.11-C84.19-Sezary diseases,
- C84.41-C84.49-Peripheral T-cell lymphoma,
- C84.61-C84.69-Anaplastic large cell lymphomas, ALK-positive,
- C84.71-C84.79-Anaplastic large cell lymphomas, ALK-negative, and
- C84.71-C84.79-Other mature T/NK-cell lymphomas,

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.
Flow Cytometry LCD – R7
The following JF Local Coverage Determination (LCD) has been revised under contractor numbers 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT), 03601 (WY).

Medicare Coverage Database (MCD) Number: L36094

LCD Title: Flow Cytometry

Effective Date: October 1, 2017

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

• New ICD-10 codes
  • C96.20 Malignant mast cell neoplasm, unspecified
  • C96.21 Aggressive systemic mastocytosis
  • C96.22 Mast cell sarcoma
  • C96.29 Other malignant mast cell neoplasm

• Deleted ICD-10 codes
  • C96.2 Malignant mast cell tumor

View the locally hosted Noridian Active LCD PDF.

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

Frequency of Hemodialysis 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: DL37504

LCD Title: Frequency of Hemodialysis

Comment period: October 5 – December 15, 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:

• policy.a.drafts@noridian.com
• Noridian Medicare JF Part A
  Attention: Draft LCD Comments
  PO Box 6781
  Fargo, ND 58103-6781
Intensity Modulated Radiation Therapy (IMRT) LCD – R7

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

Medicare Coverage Database (MCD) Number: L34080
LCD Title: Intensity Modulated Radiation Therapy (IMRT)
Effective Date: October 1, 2017
Summary of Changes: This LCD has been updated to include and/or remove ICD-10 codes.

New/Revised ICD-10 codes:
- C78.01 – Secondary malignant neoplasm of right lung
- C78.02 – Secondary malignant neoplasm of left lung
- C96.20 – Malignant mast cell neoplasm, unspecified
- C96.21 – Aggressive systemic mastocytosis
- C96.22 – Mast cell sarcoma
- C96.29 – Other malignant mast cell neoplasm
  - C77.0 was included in Group I and in Group II. ICD-10 code is removed from Group II and does not require a secondary diagnosis.

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

Lumbar Epidural Injections LCD - R4

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

Medicare Coverage Database (MCD) Number: L34980
LCD Title: Lumbar Epidural Injections
Effective Date: October 1, 2017
Summary of Changes: This LCD has been updated to include ICD-10 codes.
New ICD-10 codes:
- M48.062: Spinal stenosis, lumbar region with neurogenic claudication
Deleted codes:
- M48.06: Spinal stenosis, lumbar region

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

Measurement of Salivary Hormones LCD - R1
The following JF Local Coverage Determination (LCD) has been revised under contractor numbers 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT), 03601 (WY).

Medicare Coverage Database (MCD) Number: L36857

LCD Title: Measurement of Salivary Hormones

Effective Date: October 1, 2017

Summary of Changes: This LCD has been updated to include ICD-10 code.

New/Revised ICD-10 codes:
• E27.8: Other Specified disorders of adrenal gland

View the locally hosted Noridian Active LCD PDF.

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

MolDX: APC and MUTYH Gene Testing LCD – R1
The following JF Local Coverage Determination (LCD) has been revised under contractor numbers 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT), 03601 (WY).

Medicare Coverage Database (MCD) Number: L36884

LCD Title: MolDX: APC and MUTYH Gene Testing

Effective Date: May 15, 2017

Summary of Changes: LCD is revised to add ICD-10 code D12.0, effective 5/12/17 and to add the following required fields: Summary of the Evidence, Analysis of Evidence and Bibliography.

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

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

MolDX: DecisionDx-UM (Uveal Melanoma) Final LCD – Effective September 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: L37072

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

Effective Date: September 22, 2017

Summary of LCD: This policy provides limited coverage for the DecisionDx-UM (Castle Bioscience, Inc.)
test for the management of newly diagnosed uveal melanoma. This test is intended for the determination of metastatic risk, and to guide surveillance and referral to medical oncology (preferably an oncologist with expertise in melanoma) in patients who have a confirmed diagnosis of uveal melanoma (UM) and no evidence of metastatic disease.

The Noridian current article, DecisionDx-UM™ Billing Guidelines will be retired September 21, 2017 when the LCD becomes final September 22, 2017.

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

- Go to https://med.noridianmedicare.com/web/jfa/policies/lcd/future
  - 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: Percepta Bronchial Genomic Classifier LCD – R1**

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

**Medicare Coverage Database (MCD) Number:** L36891

**LCD Title:** MolDX: Percepta© Bronchial Genomic Classifier

**Effective Date:** August 25, 2017

**Summary of Changes:** LCD is revised to remove CDD from the title and to add newly required fields for Summary of Evidence, Analysis of Evidence and Bibliography.

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

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

**MolDX: Prolaris Prostate Cancer Genomic Assay for Men with Favorable Intermediate Risk Disease Final LCD - Effective September 25, 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:** L37082

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

**Effective Date:** September 25, 2017

**Summary of LCD:** This LCD provides limited coverage for the Prolaris™ prostate cancer assay (Myriad, Salt Lake City, UT) to help determine which patients with favorable intermediate risk, needle biopsy proven prostate cancer, can be conservatively managed rather than treated with definitive surgery or radiation therapy. For coverage requirements for patients with very low or low risk disease, please refer to Noridian’s MolDX-CDD: Prolaris™ Prostate Cancer Genomic Assay LCD, L36350.
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: PTCH1 Gene Testing Billing and Coding Guidelines**

The MolDX: PTCH1 Gene Testing Billing and Coding Guidelines coverage article has been revised and published for notice under contract numbers: 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601 (WY) in the CMS Medicare Coverage Database (MCD).

**Summary of Article:** To provide billing and coverage criteria for the MolDX: PTCH1 Gene Testing.

**Effective Date:** October 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](https://med.noridianmedicare.com/web/jfa/policies/lcd/future) webpage to:

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

**MolDX: Vita Risk Pharmacogenetic Test for Dry Age-related Macular Degeneration (AMD) LCD Retirement – Effective August 8, 2017**

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

**Medicare Coverage Database Number:** DL37064

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

**Effective Date:** August 8, 2017

This LCD was presented for notice and comment and will not be finalized. The MolDX Contractor is retiring the LCD to allow for additional data and comments that require analysis and review. It will be viewable in the Medicare Coverage Database under Draft LCDs for 6 months from the date of retirement.
MEDICAL POLICIES

MolDX: Xpresys Lung Final LCD – Effective September 29, 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: L37062

LCD Title: MolDX: Xpresys Lung

Effective Date: September 29, 2017

Summary of LCD: This is a limited coverage policy for patients with a newly identified solitary lung nodule when clinical risk of cancer cannot be ruled out by clinical findings. The intended use of the test is to assist physicians in the management of lung nodules by identifying those lung nodules with a high probability of being benign, allowing patients to be candidates for monitoring using non-invasive CT surveillance instead of invasive procedures.

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.

MRI and CT Scans of the Head, Brain, and Neck LCD – R6

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

Medicare Coverage Database (MCD) Number: L35175

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

Effective Date: Multiple Dates

Summary of Changes: This LCD has been updated to add the following ICD-10 codes effective dates of service (DOS) 10/01/2016 and include new, revised and removed ICD-10 codes effective dates of service (DOS) 10/01/2017.

Added ICD-10 codes

• S02.40AA - Malar fracture, right side, initial encounter for closed fracture
• S02.40AB - Malar fracture, right side, initial encounter for open fracture
• S02.40AD - Malar fracture, right side, subsequent encounter for fracture with routine healing
• S02.40AG - Malar fracture, right side, subsequent encounter for fracture with delayed healing
• S02.40AK - Malar fracture, right side, subsequent encounter for fracture with nonunion
• S02.40AS - Malar fracture, right side, sequela
• S02.40BA - Malar fracture, left side, initial encounter for closed fracture
• S02.40BB - Malar fracture, left side, initial encounter for open fracture
• S02.40BD - Malar fracture, left side, subsequent encounter for fracture with routine healing
• S02.40BG - Malar fracture, left side, subsequent encounter for fracture with delayed healing
• S02.40BK - Malar fracture, left side, subsequent encounter for fracture with nonunion
• S02.40BS - Malar fracture, left side, sequela
• S02.40CA - Maxillary fracture, right side, initial encounter for closed fracture
• S02.40CB - Maxillary fracture, right side, initial encounter for open fracture
• S02.40CD - Maxillary fracture, right side, subsequent encounter for fracture with routine healing
• S02.40CG - Maxillary fracture, right side, subsequent encounter for fracture with delayed healing
• S02.40CK - Maxillary fracture, right side, subsequent encounter for fracture with nonunion
• S02.40CS - Maxillary fracture, right side, sequela
• S02.40DA - Maxillary fracture, left side, initial encounter for closed fracture
• S02.40DB - Maxillary fracture, left side, initial encounter for open fracture
• S02.40DD - Maxillary fracture, left side, subsequent encounter for fracture with routine healing
• S02.40DG - Maxillary fracture, left side, subsequent encounter for fracture with delayed healing
• S02.40DK - Maxillary fracture, left side, subsequent encounter for fracture with nonunion
• S02.40DS - Maxillary fracture, left side, sequela
• S02.40EA - Zygomatic fracture, right side, initial encounter for closed fracture
• S02.40EB - Zygomatic fracture, right side, initial encounter for open fracture
• S02.40ED - Zygomatic fracture, right side, subsequent encounter for fracture with routine healing
• S02.40EG - Zygomatic fracture, right side, subsequent encounter for fracture with delayed healing
• S02.40EK - Zygomatic fracture, right side, subsequent encounter for fracture with nonunion
• S02.40ES - Zygomatic fracture, right side, sequela
• S02.40FA - Zygomatic fracture, left side, initial encounter for closed fracture
• S02.40FB - Zygomatic fracture, left side, initial encounter for open fracture
• S02.40FD - Zygomatic fracture, left side, subsequent encounter for fracture with routine healing
• S02.40FG - Zygomatic fracture, left side, subsequent encounter for fracture with delayed healing
• S02.40FK - Zygomatic fracture, left side, subsequent encounter for fracture with nonunion
• S02.40FS - Zygomatic fracture, left side, sequela

New ICD-10 codes

• C9621 Aggressive systemic mastocytosis
• C9622 Mast cell sarcoma
• C9629 Other malignant mast cell neoplasm
• D47.02 - Systemic mastocytosis
• H54.0X33 - Blindness right eye category 3, blindness left eye category 3
• H54.0X34 - Blindness right eye category 3, blindness left eye category 4
• H54.0X35 - Blindness right eye category 3, blindness left eye category 5
• H54.0X43 - Blindness right eye category 4, blindness left eye category 3
• H540X44 - Blindness right eye category 4, blindness left eye category 4
• H540X45 - Blindness right eye category 4, blindness left eye category 5
• H540X53 - Blindness right eye category 5, blindness left eye category 3
• H540X54 - Blindness right eye category 5, blindness left eye category 4
• H540X55 - Blindness right eye category 5, blindness left eye category 5
• H541131 - Blindness right eye category 3, low vision left eye category 1
• H541132 - Blindness right eye category 3, low vision left eye category 2
• H541141 - Blindness right eye category 4, low vision left eye category 1
• H541142 - Blindness right eye category 4, low vision left eye category 2
• H541151 - Blindness right eye category 5, low vision left eye category 1
• H541152 - Blindness right eye category 5, low vision left eye category 2
• H541213 - Low vision right eye category 1, blindness left eye category 3
• H541214 - Low vision right eye category 1, blindness left eye category 4
• H541215 - Low vision right eye category 1, blindness left eye category 5
• H541223 - Low vision right eye category 2, blindness left eye category 3
• H541224 - Low vision right eye category 2, blindness left eye category 4
• H541225 - Low vision right eye category 2, blindness left eye category 5
• H542X11 - Low vision right eye category 1, low vision left eye category 1
• H542X12 - Low vision right eye category 1, low vision left eye category 2
• H542X21 - Low vision right eye category 2, low vision left eye category 1
• H542X22 - Low vision right eye category 2, low vision left eye category 2
• H54413A - Blindness right eye category 3, normal vision left eye
• H54414A - Blindness right eye category 4, normal vision left eye
• H54415A - Blindness right eye category 5, normal vision left eye
• H5442A3 - Blindness left eye category 3, normal vision right eye
• H5442A4 - Blindness left eye category 4, normal vision right eye
• H5442A5 - Blindness left eye category 5, normal vision right eye
• H54511A - Low vision right eye category 1, normal vision left eye
• H54512A - Low vision right eye category 2, normal vision left eye
• H5452A1 - Low vision left eye category 1, normal vision right eye
• H5452A2 - Low vision left eye category 2, normal vision right eye

**Revised ICD-10 Codes along with the 7th characters D-subsequent encounter and S-sequela where applicable**

• I63.211- Cerebral infarction due to unspecified occlusion or stenosis of right vertebral artery
• I63.212- Cerebral infarction due to unspecified occlusion or stenosis of left vertebral artery
• I63.22- Cerebral infarction due to unspecified occlusion or stenosis of basilar artery
• S04.031A- Injury of optic tract and pathways, right side, initial encounter
• S04.032A- Injury of optic tract and pathways, left side, initial encounter
• S04.039A- Injury of optic tract and pathways, unspecified side, initial encounter
• S04.041A- Injury of visual cortex, right side, initial encounter
• S04.042A- Injury of visual cortex, left side, initial encounter
• S04.049A- Injury of visual cortex, unspecified side, initial encounter

**Deleted ICD-10 codes**

• C962 - Malignant mast cell tumor
• D47.0 - Histiocytic and mast cell tumors of uncertain behavior
- E85.8 - Other amyloidosis
- H54.0 - Blindness, both eyes
- H54.11 - Blindness, right eye, low vision left eye
- H54.12 - Blindness, left eye, low vision right eye
- H54.2 - Low vision, both eyes
- H54.41 - Blindness, right eye, normal vision left eye
- H54.42 - Blindness, left eye, normal vision right eye
- H54.51 - Low vision, right eye, normal vision left eye
- H54.52 - Low vision, left eye, normal vision right eye
- S06.1X7D - Traumatic cerebral edema with loss of consciousness of any duration with death due to brain injury prior to regaining consciousness, subsequent encounter
- S06.1X7S - Traumatic cerebral edema with loss of consciousness of any duration with death due to brain injury prior to regaining consciousness, sequela
- S06.1X8D - Traumatic cerebral edema with loss of consciousness of any duration with death due to other cause prior to regaining consciousness, subsequent encounter
- S06.1X8S - Traumatic cerebral edema with loss of consciousness of any duration with death due to other cause prior to regaining consciousness, sequela
- S06.2X7D - Diffuse traumatic brain injury with loss of consciousness of any duration with death due to brain injury prior to regaining consciousness, subsequent encounter
- S06.2X7S - Diffuse traumatic brain injury with loss of consciousness of any duration with death due to brain injury prior to regaining consciousness, sequela
- S06.2X8D - Diffuse traumatic brain injury with loss of consciousness of any duration with death due to other cause prior to regaining consciousness, subsequent encounter
- S06.2X8S - Diffuse traumatic brain injury with loss of consciousness of any duration with death due to other cause prior to regaining consciousness, sequela
- S06.307D - Unspecified focal traumatic brain injury with loss of consciousness of any duration with death due to brain injury prior to regaining consciousness, subsequent encounter
- S06.307S - Unspecified focal traumatic brain injury with loss of consciousness of any duration with death due to brain injury prior to regaining consciousness, sequela
- S06.308D - Unspecified focal traumatic brain injury with loss of consciousness of any duration with death due to other cause prior to regaining consciousness, subsequent encounter
- S06.308S - Unspecified focal traumatic brain injury with loss of consciousness of any duration with death due to other cause prior to regaining consciousness, sequela
- S06.317D - Contusion and laceration of right cerebrum with loss of consciousness of any duration with death due to brain injury prior to regaining consciousness, subsequent encounter
- S06.317S - Contusion and laceration of right cerebrum with loss of consciousness of any duration with death due to brain injury prior to regaining consciousness, sequela
- S06.318D - Contusion and laceration of right cerebrum with loss of consciousness of any duration with death due to other cause prior to regaining consciousness, subsequent encounter
- S06.318S - Contusion and laceration of right cerebrum with loss of consciousness of any duration with death due to other cause prior to regaining consciousness, sequela
- S06.327D - Contusion and laceration of left cerebrum with loss of consciousness of any duration with death due to brain injury prior to regaining consciousness, subsequent encounter
- S06.327S - Contusion and laceration of left cerebrum with loss of consciousness of any duration with death due to brain injury prior to regaining consciousness, sequela
- S06.328D - Contusion and laceration of left cerebrum with loss of consciousness of any duration with death due to other cause prior to regaining consciousness, subsequent encounter
- S06.328S - Contusion and laceration of left cerebrum with loss of consciousness of any duration with death due to other cause prior to regaining consciousness, sequela
• S06.328D - Contusion and laceration of left cerebrum with loss of consciousness of any duration with death due to other cause prior to regaining consciousness, subsequent encounter
• S06.328S - Contusion and laceration of left cerebrum with loss of consciousness of any duration with death due to other cause prior to regaining consciousness, sequela
• S06.337D - Contusion and laceration of cerebrum, unspecified, with loss of consciousness of any duration with death due to brain injury prior to regaining consciousness, subsequent encounter
• S06.337S - Contusion and laceration of cerebrum, unspecified, with loss of consciousness of any duration with death due to brain injury prior to regaining consciousness, sequela
• S06.338D - Contusion and laceration of cerebrum, unspecified, with loss of consciousness of any duration with death due to other cause prior to regaining consciousness, subsequent encounter
• S06.338S - Contusion and laceration of cerebrum, unspecified, with loss of consciousness of any duration with death due to other cause prior to regaining consciousness, sequela
• S06.347D - Traumatic hemorrhage of right cerebrum with loss of consciousness of any duration with death due to brain injury prior to regaining consciousness, subsequent encounter
• S06.347S - Traumatic hemorrhage of right cerebrum with loss of consciousness of any duration with death due to brain injury prior to regaining consciousness, sequela
• S06.348D - Traumatic hemorrhage of right cerebrum with loss of consciousness of any duration with death due to other cause prior to regaining consciousness, subsequent encounter
• S06.348S - Traumatic hemorrhage of right cerebrum with loss of consciousness of any duration with death due to other cause prior to regaining consciousness, sequela
• S06.357D - Traumatic hemorrhage of left cerebrum with loss of consciousness of any duration with death due to brain injury prior to regaining consciousness, subsequent encounter
• S06.357S - Traumatic hemorrhage of left cerebrum with loss of consciousness of any duration with death due to brain injury prior to regaining consciousness, sequela
• S06.358D - Traumatic hemorrhage of left cerebrum with loss of consciousness of any duration with death due to other cause prior to regaining consciousness, subsequent encounter
• S06.358S - Traumatic hemorrhage of left cerebrum with loss of consciousness of any duration with death due to other cause prior to regaining consciousness, sequela
• S06.367D - Traumatic hemorrhage of cerebrum, unspecified, with loss of consciousness of any duration with death due to brain injury prior to regaining consciousness, subsequent encounter
• S06.367S - Traumatic hemorrhage of cerebrum, unspecified, with loss of consciousness of any duration with death due to brain injury prior to regaining consciousness, sequela
• S06.368D - Traumatic hemorrhage of cerebrum, unspecified, with loss of consciousness of any duration with death due to other cause prior to regaining consciousness, subsequent encounter
• S06.368S - Traumatic hemorrhage of cerebrum, unspecified, with loss of consciousness of any duration with death due to other cause prior to regaining consciousness, sequela
• S06.377D - Contusion, laceration, and hemorrhage of cerebellum with loss of consciousness of any duration with death due to brain injury prior to regaining consciousness, subsequent encounter
• S06.377S - Contusion, laceration, and hemorrhage of cerebellum with loss of consciousness of any duration with death due to brain injury prior to regaining consciousness, sequela
• S06.378D - Contusion, laceration, and hemorrhage of cerebellum with loss of consciousness of any duration with death due to other cause prior to regaining consciousness, subsequent encounter
• S06.378S - Contusion, laceration, and hemorrhage of cerebellum with loss of consciousness of any duration with death due to other cause prior to regaining consciousness, sequela
• S06.387D - Contusion, laceration, and hemorrhage of brainstem with loss of consciousness of any duration with death due to brain injury prior to regaining consciousness, subsequent encounter
• S06.387S - Contusion, laceration, and hemorrhage of brainstem with loss of consciousness of any duration with death due to brain injury prior to regaining consciousness, sequela

• S06.388D - Contusion, laceration, and hemorrhage of brainstem with loss of consciousness of any duration with death due to other cause prior to regaining consciousness, subsequent encounter

• S06.388S - Contusion, laceration, and hemorrhage of brainstem with loss of consciousness of any duration with death due to other cause prior to regaining consciousness,

• S06.4X7D - Epidural hemorrhage with loss of consciousness of any duration with death due to brain injury prior to regaining consciousness, subsequent encounter This is in the Draft LCD only

• S06.4X7S - Epidural hemorrhage with loss of consciousness of any duration with death due to brain injury prior to regaining consciousness, sequela

• S06.4X8D - Epidural hemorrhage with loss of consciousness of any duration with death due to other causes prior to regaining consciousness, subsequent encounter This is in the Draft LCD only

• S06.4X8S - Epidural hemorrhage with loss of consciousness of any duration with death due to other causes prior to regaining consciousness, sequela

• S06.5X7D - Traumatic subdural hemorrhage with loss of consciousness of any duration with death due to brain injury before regaining consciousness, subsequent encounter

• S06.5X7S - Traumatic subdural hemorrhage with loss of consciousness of any duration with death due to brain injury before regaining consciousness, sequela

• S06.5X8D - Traumatic subdural hemorrhage with loss of consciousness of any duration with death due to other cause before regaining consciousness, subsequent encounter

• S06.5X8S - Traumatic subdural hemorrhage with loss of consciousness of any duration with death due to other cause before regaining consciousness, sequela

• S06.6X7D - Traumatic subarachnoid hemorrhage with loss of consciousness of any duration with death due to brain injury prior to regaining consciousness, subsequent encounter

• S06.6X7S - Traumatic subarachnoid hemorrhage with loss of consciousness of any duration with death due to brain injury prior to regaining consciousness, sequela

• S06.6X8D - Traumatic subarachnoid hemorrhage with loss of consciousness of any duration with death due to other cause prior to regaining consciousness, subsequent encounter

• S06.6X8S - Traumatic subarachnoid hemorrhage with loss of consciousness of any duration with death due to other cause prior to regaining consciousness, sequela

• S06.817D - Injury of right internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness of any duration with death due to brain injury prior to regaining consciousness, subsequent encounter

• S06.817S - Injury of right internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness of any duration with death due to brain injury prior to regaining consciousness, sequela

• S06.818D - Injury of right internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness of any duration with death due to other cause prior to regaining consciousness, subsequent encounter

• S06.818S - Injury of right internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness of any duration with death due to other cause prior to regaining consciousness, sequela

• S06.827D - Injury of left internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness of any duration with death due to brain injury prior to regaining consciousness, subsequent encounter

• S06.827S - Injury of left internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness of any duration with death due to brain injury prior to regaining consciousness, sequela

• S06.828D - Injury of left internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness of any duration with death due to other cause prior to regaining consciousness, subsequent encounter

• S06.828S - Injury of left internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness of any duration with death due to other cause prior to regaining consciousness, sequela
Nerve Blockade for Treatment of Chronic Pain and Neuropathy LCD – R10

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

Medicare Coverage Database (MCD) Number: L35457

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

Effective Date: October 1, 2017

Summary of Changes: This LCD has been updated to include new and removed ICD-10 codes.

- New ICD-10 codes
  - M48.062 - Spinal stenosis, lumbar region with neurogenic claudication
- Deleted ICD-10 codes
  - M48.06 - Spinal stenosis, lumbar region

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Plastic Surgery Final LCD – Effective October 10, 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:** L37020

**LCD Title:** Plastic Surgery

**Effective Date:** October 10, 2017

**Summary of LCD:** Further guidelines were added to Abdominal Lipectomy/Panniculectomy and use of N65.1 under Group 4. The following codes were added:

Group 2
- L03.311: Cellulitis of the abdominal wall.

Group 3
- N65.0: Deformity of reconstructed breast.
- T85.79XA: Infection and inflammatory reaction due to other internal prosthetic devices, implants and grafts, initial encounter.
- T85.79XD: Infection and inflammatory reaction due to other internal prosthetic devices, implants and grafts, subsequent encounter.
- T85.79XS: Infection and inflammatory reaction due to other internal prosthetic devices, implants and grafts, sequela.
- Z42.1: Encounter for breast reconstruction following mastectomy.

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

- Go to [https://med.noridianmedicare.com/web/jfa/policies/lcd/future](https://med.noridianmedicare.com/web/jfa/policies/lcd/future)
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  - On the “Future LCDs” page, select the coordinating state and locate the above listed CMS MCD number or LCD title.
  - This link will redirect you to the state specific Future Effective LCD on the CMS website.

Polysomnography and Other Sleep Studies LCD - R3

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

**Medicare Coverage Database (MCD) Number:** L34040

**LCD Title:** Polysomnography and Other Sleep Studies

**Effective Date:** October 1, 2017

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

**New ICD-10 codes**
- F51.3: Sleepwalking [somnambulism]
- F51.4: Sleep terrors [night terrors]

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**Spinal Cord Stimulators for Chronic Pain LCD – R3**

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

**Medicare Coverage Database (MCD) Number:** L36204  
**LCD Title:** Spinal Cord Stimulators for Chronic Pain  
**Effective Date:** Multiple Effective Dates

**Summary of Changes:** This LCD has been updated to delete CPT codes effective 06/01/2016 and include new and removed ICD-10 codes effective 10/01/2017. The deleted CPT procedure codes may be used for services unrelated to this LCD and are not subject to the DX criteria in the LCD.

**Deleted CPT Codes:**

- 63661 – Removal of spinal neurostimulator electrode percutaneous arry(s), including fluoroscopy, when performed  
- 63662 – Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed  
- 63688 – Revision or removal of implanted spinal neurostimulator pulse generator or receiver  
- 95970 – Electronic analysis of implanted neurostimulator pulse generator system (EG, Rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple or complex brain, spinal cord, or peripheral (IE, Cranial never, peripheral nerve, sacral nerve, neuromuscular) neurostimulator pulse generator/transmitter, without reprogramming  
- 95971 – Electronic analysis of implanted neurostimulator pulse generator system (EG, Rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); Simple spinal cord, or peripheral (IE, peripheral nerve, sacral nerve, neuromuscular) (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming  
- 95972 – Electronic analysis of implanted neurostimulator pulse generator system (EG, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex spinal cord, or peripheral (IE, peripheral nerve, sacral nerve, neuromuscular) (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming

**New ICD-10 codes:**

- M48.062 - Spinal stenosis, lumbar region with neurogenic claudication

**Deleted ICD-10 codes:**

- M48.06 - Spinal stenosis, lumbar region

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Treatment of Males with Low Testosterone LCD – R3

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

**Medicare Coverage Database (MCD) Number:** L36569

**LCD Title:** Treatment of Males with Low Testosterone

**Effective Date:** October 1, 2017

**Summary of Changes:** This LCD has been updated to include ICD-10 code.

- New/Revised ICD-10 codes
  - D44.3: Neoplasm of uncertain behavior of pituitary gland

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Treatment of Ulcers & Symptomatic Hyperkeratoses 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:** L34199

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

**Effective Date:** October 1, 2017

**Summary of Changes:** This LCD has been updated to delete CPT codes and include new ICD-10 codes. The deleted CPT procedure codes may be used for services unrelated to this LCD and are not subject to the diagnosis criteria in the LCD.

- Deleted CPT Codes:
  - 10060 - Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single
  - 10061 - Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); complicated or multiple

- New ICD-10 codes
  - L97.115 - Non-pressure chronic ulcer of right thigh with muscle involvement without evidence of necrosis
  - L97.116 - Non-pressure chronic ulcer of right thigh with bone involvement without evidence of necrosis
  - L97.118 - Non-pressure chronic ulcer of right thigh with other specified severity
  - L97.125 - Non-pressure chronic ulcer of left thigh with muscle involvement without evidence of necrosis
  - L97.126 - Non-pressure chronic ulcer of left thigh with bone involvement without evidence of necrosis
  - L97.128 - Non-pressure chronic ulcer of left thigh with other specified severity
  - L97.215 - Non-pressure chronic ulcer of right calf with muscle involvement without evidence of necrosis
• L97.216 - Non-pressure chronic ulcer of right calf with bone involvement without evidence of necrosis
• L97.218 - Non-pressure chronic ulcer of right calf with other specified severity
• L97.225 - Non-pressure chronic ulcer of left calf with muscle involvement without evidence of necrosis
• L97.226 - Non-pressure chronic ulcer of left calf with bone involvement without evidence of necrosis
• L97.228 - Non-pressure chronic ulcer of left calf with other specified severity
• L97.316 - Non-pressure chronic ulcer of right ankle with bone involvement without evidence of necrosis
• L97.318 - Non-pressure chronic ulcer of right ankle with other specified severity
• L97.325 - Non-pressure chronic ulcer of left ankle with muscle involvement without evidence of necrosis
• L97.326 - Non-pressure chronic ulcer of left ankle with bone involvement without evidence of necrosis
• L97.328 - Non-pressure chronic ulcer of left ankle with other specified severity
• L97.415 - Non-pressure chronic ulcer of right heel and midfoot with muscle involvement without evidence of necrosis
• L97.416 - Non-pressure chronic ulcer of right heel and midfoot with bone involvement without evidence of necrosis
• L97.418 - Non-pressure chronic ulcer of right heel and midfoot with other specified severity
• L97.425 - Non-pressure chronic ulcer of left heel and midfoot with muscle involvement without evidence of necrosis
• L97.426 - Non-pressure chronic ulcer of left heel and midfoot with bone involvement without evidence of necrosis
• L97.428 - Non-pressure chronic ulcer of left heel and midfoot with other specified severity
• L97.516 - Non-pressure chronic ulcer of other part of right foot with bone involvement without evidence of necrosis
• L97.518 - Non-pressure chronic ulcer of other part of right foot with other specified severity
• L97.525 - Non-pressure chronic ulcer of other part of left foot with muscle involvement without evidence of necrosis
• L97.526 - Non-pressure chronic ulcer of other part of left foot with bone involvement without evidence of necrosis
• L97.528 - Non-pressure chronic ulcer of other part of left foot with other specified severity
• L97.815 - Non-pressure chronic ulcer of other part of right lower leg with muscle involvement without evidence of necrosis
• L97.816 - Non-pressure chronic ulcer of other part of right lower leg with bone involvement without evidence of necrosis
• L97.818 - Non-pressure chronic ulcer of other part of right lower leg with other specified severity
• L97.825 - Non-pressure chronic ulcer of other part of left lower leg with muscle involvement without evidence of necrosis
• L97.826 - Non-pressure chronic ulcer of other part of left lower leg with bone involvement without evidence of necrosis
• L97.828 - Non-pressure chronic ulcer of other part of left lower leg with other specified severity
• L97.911 - Non-pressure chronic ulcer of unspecified part of right lower leg limited to breakdown of skin
• L97.912 - Non-pressure chronic ulcer of unspecified part of right lower leg with fat layer exposed
• L97.913 - Non-pressure chronic ulcer of unspecified part of right lower leg with necrosis of muscle
• L97.914 - Non-pressure chronic ulcer of unspecified part of right lower leg with necrosis of bone
• L97.915 - Non-pressure chronic ulcer of unspecified part of right lower leg with muscle involvement without evidence of necrosis
• L97.916 - Non-pressure chronic ulcer of unspecified part of right lower leg with bone involvement without evidence of necrosis
• L97.918 - Non-pressure chronic ulcer of unspecified part of right lower leg with other specified severity
• L97.921 - Non-pressure chronic ulcer of unspecified part of left lower leg limited to breakdown of skin
• L97.922 - Non-pressure chronic ulcer of unspecified part of left lower leg with fat layer exposed
• L97.923 - Non-pressure chronic ulcer of unspecified part of left lower leg with necrosis of muscle
• L97.924 - Non-pressure chronic ulcer of unspecified part of left lower leg with necrosis of bone
• L97.925 - Non-pressure chronic ulcer of unspecified part of left lower leg with muscle involvement without evidence of necrosis
• L97.926 - Non-pressure chronic ulcer of unspecified part of left lower leg with bone involvement without evidence of necrosis
• L97.928 - Non-pressure chronic ulcer of unspecified part of left lower leg with other specified severity
• L98.415 - Non-pressure chronic ulcer of buttock with muscle involvement without evidence of necrosis
• L98.416 - Non-pressure chronic ulcer of buttock with bone involvement without evidence of necrosis
• L98.418 - Non-pressure chronic ulcer of buttock with other specified severity
• L98.425 - Non-pressure chronic ulcer of back with muscle involvement without evidence of necrosis
• L98.426 - Non-pressure chronic ulcer of back with bone involvement without evidence of necrosis
• L98.428 - Non-pressure chronic ulcer of back with other specified severity
• L98.495 - Non-pressure chronic ulcer of other sites with muscle involvement without evidence of necrosis
• L98.496 - Non-pressure chronic ulcer of other sites with bone involvement without evidence of necrosis
• L98.498 - Non-pressure chronic ulcer of other sites with other specified severity

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Treatment of Varicose Veins of the Lower Extremities 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: L34010
LCD Title: Treatment of Varicose Veins of the Lower Extremities
Effective Date: October 1, 2017
Summary of Changes: This LCD has been updated to include ICD-10 codes.

New ICD-10 codes:
• I87.301: Chronic venous hypertension (idiopathic) without complications of right lower extremity
• I87.302: Chronic venous hypertension (idiopathic) without complications of left lower extremity
• I87.303: Chronic venous hypertension (idiopathic) without complications of bilateral lower extremity
• I87.391: Chronic venous hypertension (idiopathic) with other complications of right lower extremity
• I87.392: Chronic venous hypertension (idiopathic) with other complications of left lower extremity
• I87.393: Chronic venous hypertension (idiopathic) with other complications of bilateral lower extremity
• I87.8: Other specified disorders of veins
• Revised ICD-10 codes
• I83.811: Varicose veins of right lower extremities with pain revised to Varicose veins of right lower extremity with pain
• I83.812: Varicose veins of left lower extremities with pain revised to Varicose veins of left lower extremity with pain
• I83.891: Varicose veins of right lower extremities with other complications revised to Varicose veins of right lower extremity with other complications
• I83.892: Varicose veins of left lower extremity with other complications revised to Varicose veins of left lower extremity with other complications

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Trigger Point Injections LCD– R1
The following JF Local Coverage Determination (LCD) has been revised under contractor numbers 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT), 03601 (WY).

Medicare Coverage Database (MCD) Number: L36859
LCD Title: Trigger Point Injections
Effective Date: October 1, 2017
Summary of Changes: This LCD has been updated to include ICD-10 codes.

• New ICD-10 codes
  • M53.83: Other specified dorsopathies, cervicothoracic region
  • M58.84: Other specified dorsopathies, thoracic region
Urolift Coverage Article Retirement – Effective September 1, 2017

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

Medicare Coverage Database Number: A54044

Article Title: Urolift

Effective Date: September 1, 2017

Summary: Coverage articles may be retired due to lack of evidence of current problems or CMS may have issued guidance regarding national coverage. This article is being retired as CMS has set MUE edits that we feel address the issues for which the article was used and therein the article is no longer necessary. The Noridian guidance in the retired article may still be helpful in assessing medical necessity. Where providers have adjusted their billing and coding practices to correspond to the guidance in a coverage article, they will want to be very careful in departing from these practices just because the article is retired. Provider offices remain responsible for correct performance, coding, billing, and medical necessity under Medicare. This responsibility for correct claims submission is unchanged whether or not there is a coverage article in place.

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

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

On the “Medicare Coverage Articles” page, select the state of interest in the table under “Retired Articles.”

• This link will redirect you to the CMS website.

Locate the above-listed CMS Medicare Coverage Database (MCD) number and article title and select the title of interest.
**Leadless Pacemakers – NCD 20.8.4**

**MLN Matters Number:** MM10117  
**Related Change Request (CR) Number:** 10117  
**Related CR Release Date:** July 28, 2017  
**Effective Date:** January 18, 2017  
**Related CR Transmittal Number:** R201NCD and R3815C  
**Implementation Date:** August 29, 2017 for local MAC system edits and January 2, 2018 for shared system edits

**PROVIDER TYPES AFFECTED**

This MLN Matters Article is intended for physicians and other providers who submit claims to Medicare Administrative Contractors (MACs) for leadless pacemaker services provided to Medicare beneficiaries.

**PROVIDER ACTION NEEDED**

Change Request (CR) 10117 informs MACs that effective January 18, 2017, the Centers for Medicare & Medicaid Services (CMS) covers leadless pacemakers through Coverage with Evidence Development (CED) when procedures are performed in CMS-approved CED studies. Please make your billing staffs are aware of this determination.

**BACKGROUND**

The leadless pacemaker eliminates the need for a device pocket and insertion of a pacing lead which are integral elements of traditional pacing systems. The removal of these elements eliminates an important source of complications associated with traditional pacing systems while providing similar benefits. Leadless pacemakers are delivered via catheter to the heart, and function similarly to other transvenous single-chamber ventricular pacemakers. Prior to January 18, 2017, there was currently no National Coverage Determination (NCD) in effect.

On January 18, 2017, CMS issued an NCD to cover leadless pacemakers through CED. CMS covers leadless pacemakers when procedures are performed in studies approved by the Food and Drug Administration (FDA). CMS also covers, in prospective longitudinal studies, leadless pacemakers that are used in accordance with the FDA-approved label for devices that have either:

- An associated ongoing FDA-approved post-approval study; or
- Completed an FDA post-approval study.

For such coverage, Medicare will allow payment for claims for dates of service on or after January 18, 2017 for leadless pacemakers through CED when billed with the following CPT codes:

- **0387T** – Transcatheter insertion or replacement 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 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.

Effective for dates of service on or after January 18, 2017, MACs will allow the following ICD-10 diagnosis codes on claims for leadless pacemakers:

- **Z00.6** – Encounter for examination for normal comparison and control in clinical research program.

Effective for dates of service on or after January 18, 2017, contractors shall return claims as unprocessable with the listed procedure codes billed without ICD-10 Z00.6 and use the following messages:

- **CARC 16** - Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. 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.

- RARC M76-Missing/incomplete/invalid diagnosis or condition

Effective for claims with dates of service on or after January 18, 2017, modifier Q0 – Investigational clinical service provided in a clinical research study that is an approved clinical research study, must also be included.

Effective for dates of service on or after January 18, 2017, MACs will return claims with the procedure codes listed billed without modifier Q0 and use the following messages:

- CARC 4: “The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.”
- RARC N572: This procedure not payable unless appropriate non-payable reporting.

- Group Code – Contractual Obligation (CO).

Remember to include the 8-digit clinical trial identifier on the claim. Effective for claims with dates of service on or after January 18, 2017, MACs will return claims as unprocessable that are billed with the Q0 modifier and do not contain the 8-digit clinical trial identifier in item 23 of the CMS-1500 form or the electronic equivalent. Use the following messages:

- CARC 16: “Claim/service lacks information which is needed for adjudication. 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.)”
- RARC MA50: Missing/incomplete/invalid Investigational Device Exemption number or Clinical Trial number.

- Group Code – Contractual Obligation (CO).

Effective for dates of service in or after January 18, 2017, MACs shall only pay claims for leadless pacemakers when services are provided in one of the following Places of Service (POS):

- POS 06 – Indian Health Service Provider Based Facility
- POS 21 – Inpatient Hospital
- POS 22 – On Campus-Outpatient Hospital
- POS 26 – Military Treatment Facility

Where the proper POS code is not included and the claim is rejected/denied, the following messaging should be used:

- CARC 58: Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. 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.hhs.gov/mcd/search.asp. If you do have web access, you may contact the contractor to request a copy of the NCD.

- Group Code – Contractual Obligation (CO)

MACs will not search their files for claims for leadless pacemakers with dates of service between January 18, 2017, and the implementation date of CR10117, but may adjust claims that you bring to their attention.

All clinical research study protocols must address pre-specified research questions, adhere to standards of scientific integrity and be reviewed and approved by CMS. Approved studies will be posted to the CMS website at http://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/index.html. The process for submitting a clinical research study to Medicare is outlined in the NCD.
Leadless pacemakers are non-covered outside of CMS-approved studies.

Note: This revision to the Medicare NCD Manual is a National Coverage Determination (NCD). NCDs are binding on all carriers, fiscal intermediaries, and MACs with the Federal government that review and/or adjudicate claims, determinations, and/or decisions, quality improvement organizations, qualified independent MACs, 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)(A)(i) of the Social Security Act).

ADDITIONAL INFORMATION

MLN Connects – July 6, 2017
MLN Connects® for Thursday, July 6, 2017
View this edition as a PDF

News & Announcements

• ESRD: Proposed 2018 Policy and Payment Rate Changes
• ESRD QIP: Prepare for the PY 2018 Preview Period
• QPP: New Resources to Help Clinicians Participate in MIPS
• QPP: New Webpage for Clinicians in Small, Rural, or Underserved Areas
• Open Payments Program Posts 2016 Financial Data

Provider Compliance

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

Upcoming Events

• ESRD QIP: Reviewing Your Facility’s PY 2018 Performance Data Call — July 10
• Creating and Verifying Your National Provider Identifier Call — July 12
• Assessing Your Ability to Support Patient Self-Management Webinar — July 19
• ESRD QIP: Proposed Rule for Payment Year 2021 Listening Session — July 26

Medicare Learning Network Publications & Multimedia

• Modernized National Plan and Provider Enumeration System MLN Matters Article — New
• Infection Control: Hand Hygiene Video — New
• PECOS for Provider and Supplier Organizations Booklet — Reminder
• Medicare Vision Services Fact Sheet — Reminder
• Mass Immunizers and Roster Billing Booklet — Reminder

MLN Connects – July 13, 2017
MLN Connects® for Thursday, July 13, 2017
View this edition as a PDF

News & Announcements

• New Medicare Cards with New Numbers: 3 Changes You May Need to Make
• QRDA III Implementation Guide Available
• Quality Payment Program: View Recent Webinar Recordings
• Hospital Discharge Notices
• IPPS Hospitals: FY 2014 S-10 Revisions
• Recognizing National HIV Testing Day

Provider Compliance

• OIG Video: Reporting Fraud to the Office of the Inspector General

Claims, Pricers & Codes

• ICD-10-CM Errata Available

Upcoming Events

• Revised Interpretive Guidance for Nursing Homes and New Survey Process Call — July 25
• ESRD QIP: Proposed Rule for Payment Year 2021 Listening Session — July 26
MLN Connects Special Edition – July 13, 2017

In This Edition:

- Hospital Outpatient, ASC: CMS Proposes 2018 Policy and Rate Changes
- Physician Fee Schedule: CMS Proposes 2018 Payment and Policy Updates

Hospital Outpatient, ASC: CMS Proposes 2018 Policy and Rate Changes

Proposed rule and Request for Information promote improvements to quality, accessibility, and affordability of care.

On July 13, CMS issued a proposed rule that updates payment rates and policy changes in the Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System. The proposed rule is one of several for 2018 that reflect a broader strategy to relieve regulatory burdens for providers; support the patient-doctor relationship in healthcare; and promote transparency, flexibility, and innovation in the delivery of care.

The OPPS and ASC payment system are updated annually to include changes to payment policies, payment rates, and quality provisions for those Medicare patients who receive care at hospital outpatient departments or receive care at surgical centers. Among the provisions in this rule, CMS is proposing to change the payment rate for certain Medicare Part B drugs purchased by hospitals through the 340B program. The proposed rule also includes a provision that would alleviate some of the burdens rural hospitals experience in recruiting physicians by placing a two-year moratorium on the direct supervision requirement currently in place at rural hospitals and critical access hospitals. In addition, CMS is releasing within the proposed rule a Request for Information to welcome continued feedback on flexibilities and efficiencies in the Medicare program.

For More Information:

- Proposed Rule
- Fact Sheet

See the full text of this excerpted Press Release (issued July 13).

Physician Fee Schedule: CMS Proposes 2018 Payment and Policy Updates

Proposed rule & Request for Information provide flexibility, support strong patient-doctor relationships.

On July 13, CMS issued a proposed rule that would update Medicare payment and policies for doctors and other clinicians who treat Medicare patients in CY 2018. The proposed rule is one of several Medicare payment rules for CY 2018 that reflect a broader strategy to relieve regulatory burdens for providers; support the patient-doctor relationship in healthcare; and promote transparency, flexibility, and innovation in the delivery of care.
The Physician Fee Schedule is updated annually to include changes to payment policies, payment rates, and quality provisions for services furnished to Medicare beneficiaries. This proposed rule would provide greater potential for payment system modernization and seeks public comment on reducing administrative burdens for providing patient care, including visits, care management, and telehealth services. The rule takes steps to better align incentives and provide clinicians with a smoother transition to the new Merit-based Incentive Payment System under the Quality Payment Program. The rule encourages fairer competition between hospitals and physician practices by promoting greater payment alignment, and it would improve the payment for office-based behavioral health services that are often the therapy and counseling services used to treat opioid addiction and other substance use disorders. In addition, the proposed rule makes additional proposals to implement the Center for Medicare and Medicaid Innovation’s Medicare Diabetes Prevention Program expanded model starting in 2018.

For More Information:
- Proposed Rule
- Fact Sheet

See the full text of this excerpted Press Release (issued July 13).

MLN Connects – July 20, 2017

MLN Connects® for Thursday, July 20, 2017

View this edition as a PDF

News & Announcements
- Home Health Agency CoP Final Rule: Effective Date Extended to January 13, 2018
- Hospice Quality Reporting Program: Non-Compliance Letters
- IRF Quality Reporting Program: Non-Compliance Letters
- LTCH Quality Reporting Program: Non-Compliance Letters
- SNF Quality Reporting Program: Non-Compliance Letters
- IRF, LTCH, and SNF Quality Reporting Program Data due August 15
- New PEPPER Available for Home Health Agencies and Partial Hospitalization Programs
- Hospitals: 2018 QRDA Category I Implementation Guide
- Health Care Fraud Takedown: Charges Against Individuals Responsible for $1.3 Billion in Fraud

Provider Compliance
- Billing For Stem Cell Transplants

Claims, Pricers & Codes
- Clinicians: Medicare Part B Crossover Claims Issue Tied to Error Code H31312

Upcoming Events
- Revised Interpretive Guidance for Nursing Homes and New Survey Process Call — July 25
- ESRD QIP: Proposed Rule for Payment Year 2021 Listening Session — July 26
- New Proposals for RHCs and FQHCs on Care Management Services and ACO Assignments - Listening Session — August 1
- Medicare Diabetes Prevention Program Model Expansion Listening Session — August 16
- IMPACT Act: Drug Regimen Review Measure Overview for the Home Health Quality Reporting Program Call — August 17
- LTCH Quality Reporting Program Refresher Training Webinar — August 22
Medicare Learning Network Publications & Multimedia

- Quality Payment Program Listening Session: Audio Recording and Transcript — New
- Medicare Basics: Parts A and B Claims Overview Video — Reminder
- Chronic Care Management Services Fact Sheet — Reminder

MLN Connects – July 27, 2017

MLN Connects® for Thursday, July 27, 2017

News & Announcements

- Home Health Agencies: CMS Proposes 2018 and 2019 Payment Changes
- New Medicare Card (formerly called SSNRI)
- Quality Payment Program: Explanation of Special Status Calculation
- Updated CMS Measures Inventory Posted
- World Hepatitis Day: Medicare Coverage for Viral Hepatitis
- Anniversary of the American Disabilities Act

Provider Compliance

- Hospital Discharge Day Management Services CMS Provider Minute Video

Claims, Pricers & Codes

- 2018 ICD-10-CM POA Exempt Codes Available

Upcoming Events

- New Proposals for RHCs and FQHCs on Care Management Services and ACO Assignments Listening Session — August 1
- Medicare Diabetes Prevention Program Model Expansion Listening Session — August 16
- IMPACT Act: Drug Regimen Review Measure Overview for the Home Health QRP Call — August 17
- LTCH Quality Reporting Program Refresher Training Webinar — August 22
- CMS National Provider Enrollment Conference — September 6 and 7

Medicare Learning Network Publications & Multimedia

- Quality Payment Program 2017 MIPS: Improvement Activities Performance Category Web-Based Training Course — New
- Provider/Supplier Enrollment Call: Audio Recording and Transcript — New
- Medicare Part B Immunization Billing Educational Tool — Reminder
CMS Finalizes 2018 Payment and Policy Updates for Medicare Hospital Admissions

On August 2, CMS issued the FY 2018 Medicare Inpatient Prospective Payment System and Long-Term Care Hospital Prospective Payment System final rule, which updates 2018 Medicare payment and policies when patients are discharged from hospitals. The final rule relieves regulatory burdens for providers, supports the patient-doctor relationship in healthcare, and promotes transparency, flexibility, and innovation in the delivery of care for Medicare patients.

“This final rule will help provide flexibility for acute and long-term care hospitals as they care for Medicare’s sickest patients,” said CMS Administrator Seema Verma. “Burden reduction and payment rate increases for acute care hospitals and long-term care hospitals will help ensure those suffering from severe injuries and illnesses have access to the care they need.”

Due to the combination of payment rate increases and other policies and payment adjustments, particularly in changes in uncompensated care payments, acute care hospitals will see a total increase in Medicare spending on inpatient hospital payments of $2.4 billion in FY 2018. Based in part on the changes included in the final rule, overall payments to long-term care hospitals will decrease by $110 million in FY 2018.

In addition to the payment and policy updates for Medicare hospital admissions, the final rule addresses changes to how the public is notified of Medicare terminations of certain providers and implements the statutory extension of the Rural Community Hospital Demonstration.

For More Information:
- Final Rule
- Fact Sheet

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

Inpatient Psychiatric Facilities: FY 2018 Medicare Payment and Policy Updates

On August 2, CMS issued a notice with comment period updating FY 2018 Medicare payment policies and rates for the Inpatient Psychiatric Facilities (IPF) Prospective Payment System. CMS estimates IPF payments to increase by 0.99 percent or $45 million in FY 2018. This amount reflects a 2.6 percent IPF market basket update less the productivity adjustment of 0.6 percentage point and less the 0.75 percentage point reduction required by law, for a net market basket update of 1.25 percent. Additionally, estimated payments to IPFs are reduced by 0.26 percentage point due to updating the outlier fixed-dollar loss threshold amount. CMS is also updating the IPF wage index for FY 2018.

CMS is soliciting comments on improvements that can be made to the healthcare delivery system that would reduce unnecessary burden for clinicians, providers such as IPFs, and patients and their families.

For more information, view the notice with comment period. See the full text of this excerpted Fact Sheet (issued August 2).

CMS Updates Medicare Payment Rates, Quality Reporting Requirements

CMS issued three final rules outlining 2018 Medicare payment rates for skilled nursing facilities, hospice, and inpatient rehabilitation facilities. The final rules are effective for FY 2018 and reflect a broader Administration strategy to streamline administrative requirements for providers; support the patient-doctor relationship in healthcare; and promote transparency, flexibility, and innovation in the delivery of care.

“These announcements take important steps to support innovation in the delivery of care in order to promote a Medicare program that is responsive to patients’ unique needs and ensure that patients have access to high-quality skilled nursing, hospice, and inpatient rehabilitative care,” said CMS Administrator Seema Verma. “These rules update quality reporting requirements and allow providers to spend less
time and fewer resources on cumbersome paperwork, so they can increase their focus on the needs of Medicare patients.”

Final Rules:

- Hospice: Fact Sheet and Final Rule
- IRF: Fact Sheet and Final Rule
- SNF: Fact Sheet and Final Rule

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

**MLN Connects – August 3, 2017**

MLN Connects® for Thursday, August 03, 2017

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**News & Announcements**

- CMS Updates Medicare Payment Rates, Quality Reporting Requirements
- Hospice Benefit: FY 2018 Updates to the Wage Index and Payment Rates
- IRFs: Final FY 2018 Payment and Policy Changes
- SNFs: Final FY 2018 Payment and Policy Changes
- SNF Quality Reporting Program: Reconsideration Period Ends August 13
- Antipsychotic Drug use in Nursing Homes: Trend Update
- Vaccines are Not Just for Kids

**Provider Compliance**

- Reporting Changes in Ownership

**Claims, Pricers & Codes**

- ICD-10 GEMS for 2018 Available

**Upcoming Events**

- SNF Quality Reporting Program: Review and Correct Reports Refresher Training Webinar — August 7
- Medicare Diabetes Prevention Program Model Expansion Listening Session — August 16
- IMPACT Act: Drug Regimen Review Measure Overview for the Home Health QRP Call — August 17
- CMS National Provider Enrollment Conference — September 6 and 7
- Nursing Home Facility Assessment Tool and State Operations Manual Revisions Call — September 7
- Comparative Billing Report on IPPE/AWV Webinar — September 13

**Medicare Learning Network Publications & Multimedia**

- Medicare Part B Immunization Billing Educational Tool — Revised
- The ABCs of the Annual Wellness Visit Educational Tool — Reminder
MLN Connects – August 10, 2017

MLN Connects® for Thursday, August 10, 2017
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News & Announcements

• New Medicare Card: Webpage Updates
• IRF Quality Reporting Program: Reconsideration Period Ends August 17
• LTCH Quality Reporting Program: Reconsideration Period Ends August 17
• Hospice Quality Reporting Program: Reconsideration Period Ends August 17
• EHR Incentive Program Hardship Exception Application Due by October 1
• Hospitals: Submit Meaningful Use Data to the HQR via the QualityNet Secure Portal in 2018
• Chronic Care Management: New Connected Care Videos
• Medicare Fee-For-Service Beneficiary Selection of a Primary Clinician
• Home Health Quality Reporting Program: OASIS-C2 2018 Guidance Manual Available
• Quality Payment Program Hardship Exception Application for 2017 Transition Year Open
• Quality Payment Program: Explanation of Special Status Calculation — Correction

Provider Compliance

• Home Health Care: Proper Certification Required

Claims, Pricers & Codes

• July 2017 OPPS Pricer File
• Part B Billing for Certain New Biosimilar Biological Products before the Modifier is Implemented

Upcoming Events

• IRF Quality Reporting Program Refresher Training Webinar — August 15
• Medicare Diabetes Prevention Program Model Expansion Listening Session — August 16
• Quality Payment Program Year 2 NPRM Virtual Office Hours Session — August 16
• IMPACT Act: Drug Regimen Review Measure Overview for the Home Health QRP Call — August 17
• LTCH Quality Reporting Program Refresher Training Webinar — August 22
• Nursing Home Facility Assessment Tool and State Operations Manual Revisions Call — September 7

Medicare Learning Network Publications & Multimedia

• August 2017 Catalog Available
• Quality Payment Program 2017: MIPS Quality Performance Category Web-Based Training Course — New
• Long-Term Care Call: Audio Recording and Transcript — New
• ESRD Listening Session: Audio Recording and Transcript — New
• Medicare Secondary Payer Web-Based Training Course — Revised
• Medicare Secondary Payer Booklet — Revised
MLN Connects – August 17, 2017
MLN Connects® for Thursday, August 17, 2017
View this edition as a PDF

News & Announcements
- CMS Releases Hospice Compare Website to Improve Consumer Experiences, Empower Patients
- Proposed Changes to Comprehensive Care for Joint Replacement Model, Cancellation of Other Models
- CMS Releases Updated Data on Medicare Hospice Utilization and Payment
- SNF Quality Reporting Program Web-based Training Module Available
- Beneficiary Notices: Large Print Forms Available

Provider Compliance
- Inpatient Skilled Nursing Facility Denials

Claims, Pricers & Codes
- 2018 ICD-10-CM Coding Guidelines and Conversion Table Available

Upcoming Events
- IMPACT Act: Medicare Spending Per Beneficiary Measures Call — September 6
- Nursing Home Facility Assessment Tool and State Operations Manual Revisions Call — September 7

Medicare Learning Network Publications & Multimedia
- Care Management Listening Session: Audio Recording and Transcript — New
- Medicare Parts A & B Appeals Process Booklet— Revised
- DMEPOS Information for Pharmacies Fact Sheet – Revised
- DMEPOS Accreditation Fact Sheet – Revised

MLN Connects – August 24, 2017
MLN Connects® for Thursday, August 24, 2017
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News & Announcements
- CMS Launches Jimmo Settlement Agreement Webpage
- Provider Compliance
- CMS Provider Minute: Preventive Services Video

Upcoming Events
- IMPACT Act: Medicare Spending Per Beneficiary Measures Call — September 6
- Nursing Home Facility Assessment Tool and State Operations Manual Revisions Call — September 7
- Qualified Medicare Beneficiary Program Billing Rules Call — September 19
- Reporting Hospice Quality Data: Tips for Compliance Call — September 20
- PQRS: Feedback Reports and Informal Review Process for PY 2016 Results Call — September 26
- Physician Compare Call — September 28
- Comparative Billing Report on Modifier 25 Dermatology Webinar — October 11

Medicare Learning Network Publications & Multimedia
- Mass Immunizers and Roster Billing Booklet — Revised
MLN Connects – August 31, 2017

MLN Connects® for Thursday, August 31, 2017

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News & Announcements

• New PEPPER Available for Short-term Acute Care Hospitals
• Hospice Compare Update Document Available
• Participate in Quality Payment Program Website Testing
• Departmental Appeals Board: Submit Feedback
• Correction to QRDA III Implementation Guide for Eligible Clinicians and Eligible Professionals

Provider Compliance

• Billing For Stem Cell Transplants

Upcoming Events

• IMPACT Act: Medicare Spending Per Beneficiary Measures Call — September 6
• Nursing Home Facility Assessment Tool and State Operations Manual Revisions Call — September 7
• Qualified Medicare Beneficiary Program Billing Requirements Call — September 19
• Reporting Hospice Quality Data: Tips for Compliance Call — September 20
• PQRS: Feedback Reports and Informal Review Process for PY 2016 Results Call — September 26
• Physician Compare Call — September 28

Medicare Learning Network Publications & Multimedia

• IMPACT Act Call: Audio Recording and Transcript — New
• A Physician’s Guide to Medicare Part D Medication Therapy Management Programs MLN Matters Article — Revised
• Preventive Services Poster Educational Tool — Revised
• Medicare Costs at a Glance: 2017 Educational Tool — Reminder
• Suite of Products & Resources for Rural Health Providers Educational Tool — Reminder
• Inpatient Rehabilitation Facility Prospective Payment System Fact Sheet — Reminder
• Physician Fee Schedule Fact Sheet — Reminder
• Telehealth Services Fact Sheet — Reminder
• Transitional Care Management Services Fact Sheet — Reminder
• Federally Qualified Health Center Fact Sheet — Reminder
• Rural Health Clinic Fact Sheet — Reminder
• Medicare Home Health Benefit Booklet — Reminder
• Critical Access Hospital Booklet — Reminder
MLN Connects Special Edition – August 31, 2017

- CMS Helping Texas and Louisiana with Hurricane Harvey Recovery
- Hurricane Harvey and Medicare Disaster Related Texas Claims MLN Matters Article — New
- Tropical Storm Harvey and Medicare Disaster Related Louisiana Claims MLN Matters Article — New

CMS Helping Texas and Louisiana with Hurricane Harvey Recovery

On August 30, 2017, the Centers for Medicare and Medicaid Services (CMS) Administrator Seema Verma announced the efforts that are underway to support Texas and Louisiana in response to Hurricane Harvey. Earlier this week, Health and Human Services Secretary Tom Price, M.D., declared public health emergencies in both States. Actions include temporarily waiving or modifying certain Medicare, Medicaid and Children’s Health Insurance Program (CHIP) requirements to provide immediate relief to those affected by the hurricane and resulting floods.

“In light of the natural disaster still unfolding in Texas and Louisiana, CMS is committed to acting as quickly and effectively as possible so the States can continue to ensure the vital health care needs of our most vulnerable beneficiaries are not interrupted,” said CMS Administrator Seema Verma. “CMS is in constant communication with officials in Texas and Louisiana to be sure we are doing all we can to support those in the path of this historic and devastating storm.”

CMS and the U.S. Department of Health and Human Services (HHS) are working in close coordination with the Kidney Community Emergency Response (K CER) Network and the States of Texas and Louisiana to ensure that beneficiaries have access to facilities to provide their treatments. As the CMS response continues, other efforts include, supporting Texas and Louisiana in arranging Special Purpose Renal Dialysis Facilities, transporting patients to facilities and arranging for new facilities to open in order to serve beneficiaries without interruption. In Texas, CMS is coordinating and transporting the workforce on the ground that cares for renal patients to ensure there are enough facilities to serve beneficiaries in need of dialysis. The agency is accepting requests from end stage renal disease suppliers to become a temporary Special Purpose Renal Dialysis Facility (SP RDF).

Since the public health emergencies were declared, CMS has offered immediate administrative relief actions to Texas and Louisiana including issuing several general waivers of certain requirements for specific types of providers in impacted counties and geographical areas. These waivers work to prevent gaps in access to care for beneficiaries.

Skilled Nursing Facilities (SNF): CMS waives requirements for a 3-day prior hospitalization before admission in order to receive Medicare SNF services and provides temporary emergency coverage of services in SNFs without a qualifying hospital stay for people who are evacuated, transferred, or otherwise dislocated due to Hurricane Harvey. Certain people with Medicare benefits who recently exhausted their SNF benefits are authorized for renewed coverage without first having to start a new benefit period.

Home Health Agencies: This CMS waiver provides relief to Home Health Agencies on the timeframes related to completion of OASIS (assessment data) Transmission.

Critical Access Hospitals (CAH): CMS waives the requirements limiting the number of patient beds to 25, and allows for length of stays beyond the capped 96-hour time period.

With the public health emergency in effect, CMS can also waive or modify certain Medicare provisions for providers, including certain deadlines, conditions of participation and certification requirements. Providers can now submit waiver requests to the state survey agency or the CMS regional office and they will be evaluated to ensure that they meet the requirements set out under the law. To help clarify billing instructions, CMS has issued technical direction to the Medicare Administrative Contractors regarding the waivers and has reminded area Medicare Advantage plans regarding their responsibilities to relax certain requirements during a disaster or emergency.

CMS will continue to work with the States of Texas and Louisiana. The agency continues to update our emergency page (www.cms.gov/emergency) with important information for state and local officials, providers, healthcare facilities and the public.

To read previous updates regarding HHS activities related to Hurricane Harvey, please visit https://www.hhs.gov/about/news.
To learn more about HHS resources related to Hurricane Harvey, please visit [https://www.hhs.gov/hurricane-harvey](https://www.hhs.gov/hurricane-harvey).

**Hurricane Harvey and Medicare Disaster Related Texas Claims MLN Matters Article — New**

The President declared a state of emergency for Texas and the HHS Secretary declared a Public Health Emergency for Texas which allows for CMS programmatic waivers based on Section 1135 of the Social Security Act. An MLN Matters Special Edition Article on Hurricane Harvey and Medicare Disaster Related Texas Claims is available. Learn about blanket waivers CMS issued in the impacted counties and geographical areas in Texas. These waivers will prevent gaps in coverage for beneficiaries impacted by the emergency.

Check the Hurricanes webpage for current information on temporary emergency policies and waivers. Additional waiver requests are being reviewed, and the webpage will be updated as decisions are made.

**Tropical Storm Harvey and Medicare Disaster Related Louisiana Claims MLN Matters Article — New**

The President declared a state of emergency for Louisiana and the HHS Secretary declared a Public Health Emergency for Louisiana which allows for CMS programmatic waivers based on Section 1135 of the Social Security Act. An MLN Matters Special Edition Article on Tropical Storm Harvey and Medicare Disaster Related Louisiana Claims is available. Learn about blanket waivers CMS issued in the impacted counties and geographical areas in Louisiana. These waivers will prevent gaps in coverage for beneficiaries impacted by the emergency.

Check the Hurricanes webpage for current information on temporary emergency policies and waivers. Additional waiver requests are being reviewed, and the webpage will be updated as decisions are made.

**MLN Connects Special Edition – September 1, 2017**

- Hurricane Harvey and Medicare Disaster Related Texas Claims MLN Matters Article — Updated
- Tropical Storm Harvey and Medicare Disaster Related Louisiana Claims MLN Matters Article — Updated

**Hurricane Harvey and Medicare Disaster Related Texas Claims MLN Matters Article - Updated**

The MLN Matters Special Edition Article on Hurricane Harvey and Medicare Disaster Related Texas Claims has been updated. The article was revised to include additional waiver information for Medicare-dependent small, rural hospitals and for low-volume hospitals. Information regarding administrative relief related to timely filing of appeals was also added. All other information remained the same.

**Tropical Storm Harvey and Medicare Disaster Related Louisiana Claims MLN Matters Article — Updated**

The MLN Matters Special Edition Article on Tropical Storm Harvey and Medicare Disaster Related Louisiana Claims has been updated. The article was revised to include additional waiver information for Medicare-dependent small, rural hospitals and for low-volume hospitals. Information regarding administrative relief related to timely filing of appeals was also added. All other information remained the same.

**MLN Connects Special Edition – September 5, 2017**

- Hurricane Harvey and Medicare Disaster Related Texas Claims MLN Matters Article — Updated
- Tropical Storm Harvey and Medicare Disaster Related Louisiana Claims MLN Matters Article — Updated

**Hurricane Harvey and Medicare Disaster Related Texas Claims MLN Matters Article — Updated**

The MLN Matters Special Edition Article on Hurricane Harvey and Medicare Disaster Related Texas Claims has been updated. The article was revised to include additional waiver information about housing acute care patients in excluded distinct part units and lifting the temporary enrollment moratoria on Part B non-emergency ambulance suppliers in Texas. Information regarding the Facilities Quality Reporting was also added. All other information remains the same.

**Tropical Storm Harvey and Medicare Disaster Related Louisiana Claims MLN Matters Article — Updated**
The MLN Matters Special Edition Article on *Tropical Storm Harvey and Medicare Disaster Related Louisiana Claims* has been updated. The article was revised to include additional waiver information about housing acute care patients in excluded distinct part units. Information regarding the Facilities Quality Reporting was also added. All other information remains the same.

**MLN Connects – September 7, 2017**

**MLN Connects® for Thursday, September 7, 2017**

*View this edition as a PDF*

**News & Announcements**

- Hospice Provider Preview Reports Available through September 28
- IRF and LTCH Provider Preview Reports: Review by September 30
- IRF and LTCH Compare Quarterly Refresh
- Mapping Medicare Disparities Tool: 2017 Enhancements Released
- 2015 Inpatient and Outpatient Hospital Utilization and Payment Data Available
- Healthy Aging® Month: Discuss Preventive Services with your Patients

**Provider Compliance**

- Lumbar Spinal Fusion CMS Provider Minute Video — Reminder

**Claims, Pricers & Codes**

- October 2017 Average Sales Price Files Available

**Upcoming Events**

- Overview of MIPS for Small, Rural, and Underserved Practices Webinar — September 8
- New Medicare Card Project: Clearinghouses and Vendors Special Open Door Forum — September 12
- Qualified Medicare Beneficiary Program Billing Requirements Call — September 19
- Reporting Hospice Quality Data: Tips for Compliance Call — September 20
- PQRS: Feedback Reports and Informal Review Process for PY 2016 Results Call — September 26
- Physician Compare Call — September 28

**Medicare Learning Network Publications & Multimedia**

- Medicare Diabetes Prevention Program: Audio Recording and Transcript — New
MLN Connects Special Edition – September 7, 2017

- Hurricane Harvey and Medicare Disaster Related Texas Claims MLN Matters Article — Updated
- Tropical Storm Harvey and Medicare Disaster Related Louisiana Claims MLN Matters Article — Updated

Hurricane Harvey and Medicare Disaster Related Texas Claims MLN Matters Article — Updated

The MLN Matters Special Edition Article on Hurricane Harvey and Medicare Disaster Related Texas Claims has been updated. This article was revised to include additional waiver information about emergency durable medical equipment, prosthetics, orthotics, and supplies for Medicare beneficiaries impacted by Hurricane Harvey. All other information remains the same.

Tropical Storm Harvey and Medicare Disaster Related Louisiana Claims MLN Matters Article — Updated

The MLN Matters Special Edition Article on Tropical Storm Harvey and Medicare Disaster Related Louisiana Claims has been updated. This article was revised to include additional waiver information about emergency durable medical equipment, prosthetics, orthotics, and supplies for Medicare beneficiaries impacted by Hurricane Harvey. All other information remains the same.

MLN Connects Special Edition – September 11, 2017

Hurricane Irma and Medicare Disaster Related South Carolina and Georgia Claims MLN Matters Article — New

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

Check the Hurricanes webpage for current information on temporary emergency policies and waivers.

MLN Connects Special Edition – September 11, 2017

Hurricane Irma and Medicare Disaster Related United States Virgin Islands, Commonwealth of Puerto Rico and State of Florida Claims MLN Matters Article — New

The President declared a state of emergency for the United States Virgin Islands, Commonwealth of Puerto Rico and State of Florida and the HHS Secretary declared a Public Health Emergency which allows for CMS programmatic waivers based on Section 1135 of the Social Security Act. An MLN Matters Special Edition Article on Hurricane Irma and Medicare Disaster Related United States Virgin Islands, Commonwealth of Puerto Rico and State of Florida Claims is available. Learn about blanket waivers CMS issued for the impacted counties and geographical areas. These waivers will prevent gaps in access to care for beneficiaries impacted by the emergency.

Check the Hurricanes webpage for current information on temporary emergency policies and waivers. Additional waiver requests are being reviewed, and the webpage will be updated as decisions are made.
MLN Connects – September 14, 2017

MLN Connects® for Thursday, September 14, 2017

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News & Announcements

• Quality Payment Program: New Resources Available
• September is Prostate Cancer Awareness Month

Provider Compliance

• Billing for Ambulance Transports — Reminder

Upcoming Events

• Qualified Medicare Beneficiary Program Billing Requirements Call — September 19
• Reporting Hospice Quality Data: Tips for Compliance Call — September 20
• PQRS: Feedback Reports and Informal Review Process for PY 2016 Results Call — September 26
• Physician Compare Call — September 28

Medicare Learning Network Publications & Multimedia

• Office of Inspector General Reports Highlight Hospital Billing Issues MLN Matters® Article — New
• PECOS for DMEPOS Suppliers Booklet — Reminder
• Medicare Enrollment Resources Educational Tool — Reminder

MLN Connects – September 21, 2017

MLN Connects® for Thursday, September 21, 2017

View this edition as a PDF

News & Announcements

• Transition to New Medicare Numbers and Cards
• 2016 PQRS Feedback Reports and Annual QRURs Available
• Hospice Provider Preview Reports Available through September 28
• IRF and LTCH Provider Preview Reports: Review by September 30
• CMS Innovation Center New Direction RFI: Submit Comments by November 20
• DME Appeals Demonstration: Respond to Reopening Document Request Letters
• Chronic Care Management: Connected Care Videos
• Quality Payment Program: Hardship Exception Application for 2017 Transition Year Available
• Hospital Quality Reporting Programs: eCQM Value Set Addendum Available

Provider Compliance

• Medicare Hospital Claims: Avoid Coding Errors

Upcoming Events

• PQRS: Feedback Reports and Informal Review Process for PY 2016 Results Call — September 26
• Physician Compare Call — September 28
• IMPACT Act and Improving Care Coordination: Special Open Door Forum — September 28
• SNF QRP: Claims-Based Measures Confidential Feedback Report Webinar — September 28
• Home Health Agencies: Quality of Patient Care Star Rating Algorithm Call — October 10
• 2016 Annual QRURs Webcast — October 19
Medicare Learning Network Publications & Multimedia

- IMPACT Act Call: Audio Recording and Transcript — New
- Hurricane Harvey and Medicare Disaster Related Texas Claims MLN Matters Article — Updated
- Tropical Storm Harvey and Medicare Disaster Related Louisiana Claims MLN Matters Article — Updated
- Hurricane Irma and Medicare Disaster Related United States Virgin Islands, Commonwealth of Puerto Rico and State of Florida Claims MLN Matters Article — Updated
- Hurricane Irma and Medicare Disaster Related South Carolina and Georgia Claims MLN Matters Article — Updated
- Prohibition on Billing Dually Eligible Individuals Enrolled in the QMB Program MLN Matters Article — Revised
- Global Surgery Fact Sheet — Revised

MLN Connects Special Edition – September 21, 2017

Hurricane Maria and Medicare Disaster Related United States Virgin Islands and Commonwealth of Puerto Rico Claims MLN Matters Article — New

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

Check the Hurricanes webpage for current information on temporary emergency policies and waivers.

MLN Connects – September 28, 2017

MLN Connects® for Thursday, September 28, 2017

News & Announcements

- Medicare Clinical Laboratory Fee Schedule: Preliminary CY 2018 Payment Rates
- 2016 PQRS Feedback Reports and Annual QRURs Updates
- Quality Payment Program: New Resources Available
- Quality Payment Program: View Recordings of Recent Webinars
- MIPS Eligible Measure Applicability: New Resources Available
- National Cholesterol Education Month and World Heart Day

Provider Compliance

- Psychiatry and Psychotherapy CMS Provider Minute Video — Reminder

Claims, Pricers & Codes

- Clinicians: Medicare Part B Crossover Claims Issue Tied to Error Code H51082

Upcoming Events

- Home Health Agencies: Quality of Patient Care Star Rating Algorithm Call — October 10
- 2016 Annual QRURs Webcast — October 19

Medicare Learning Network Publications & Multimedia

- 2017-2018 Influenza Resources for Health Care Professionals MLN Matters® Article — New
MLN CONNECTS

- Billing in Medicare Secondary Payer Liability Insurance Situations MLN Matters Article — New
- Accepting Payment from Patients with Set-Aside Arrangements MLN Matters Article — New
- Clarification of Billing and Payment Policies for Negative Pressure Wound Therapy Using a Disposable Device MLN Matters Article — New
- Transition to New Medicare Numbers and Cards Fact Sheet — New
- Nursing Home Call: Audio Recording and Transcript — New
- SNF Consolidated Billing Web-Based Training Course — Reminder
- Remittance Advice Resources and FAQs Fact Sheet — Reminder
- Medicare Enrollment Guidelines for Ordering/Referring Providers Booklet — Reminder
Noridian Medicare Portal (NMP) Offers Cost Report Submission

Effective September 5, 2017, Medicare Part A provider facilities can now save time and money by uploading cost reports and supporting documentation using NMP. This new feature requires the Provider Administrator from each facility to grant access to the End Users for the Provider Audit function.

Benefits your facility can experience by using this new function are:

- Quick and easy submission of all cost report paper work
- Electronic confirmation of cost report packet submission
- Teaching hospitals can upload IRIS files
- Monitor the status of cost report from started to upload completed
- Reduce risk of late cost report submission
- Passwords are no longer needed for file submission since the portal is secure
- Reduce overnight priority mail or postage costs

For additional information and how to use this new feature, view the Provider Audit section of the Noridian Medicare Portal End User Manual on the Noridian website.
I/OCE Specifications Version 18.3 – October 2017

MLN Matters Number: MM10230
Related Change Request (CR) Number: 10230
Related CR Release Date: August 25, 2017
Effective Date: October 1, 2017
Related CR Transmittal Number: R3852CP
Implementation Date: October 2, 2017

PROVIDER TYPE AFFECTED
This MLN Matters Article is intended for physicians, providers and suppliers billing Medicare Administrative Contractors (MACs), including the Home Health and Hospice MACs, for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED
Change Request (CR) 10230 provides the Integrated Outpatient Code Editor (I/OCE) instructions and specifications that will be used under the Outpatient Prospective Payment System (OPPS) and Non-OPPS for hospital outpatient departments, community mental health centers, all non-OPPS providers, and for limited services when provided in a Home Health Agency (HHA) not under the Home Health PPS or to a hospice patient for the treatment of a non-terminal illness. This update relates to Chapter 4, Section 40.1 of the “Medicare Claims Processing Manual” (Pub. 100-04). Make sure your billing staffs are aware of these updates.

BACKGROUND
CR10230 informs MACs, as well as the Fiscal Intermediary Shared System (FISS) maintainer that the I/OCE is being updated for October 1, 2017. The I/OCE routes all institutional outpatient claims (which includes non-OPPS hospital claims) through a single integrated OCE.

The I/OCE specifications will be posted at http://www.cms.gov/OutpatientCodeEdit/.

The following table summarizes the modifications of the I/OCE for the October 2017 v18.3 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.

Note: Some I/OCE modifications in the update may be retroactively added to prior releases. If so, the retroactive date appears in the “Effective Date” column.

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Edits Affected</th>
<th>Modification</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/1/2017</td>
<td>1, 2, 3, 5, 86</td>
<td>Updated diagnosis code editing for validity, age, gender and manifestation based on the FY 2018 ICD-10-CM code revisions to the Medicare Code Editor (MCE).</td>
</tr>
<tr>
<td>10/1/2017</td>
<td>29</td>
<td>Updated the mental health diagnosis list based on the FY 2018 ICD-10-CM code revisions.</td>
</tr>
<tr>
<td>10/1/2017</td>
<td>95</td>
<td>Modify the effective date for edit 95 to 10/1/2017.</td>
</tr>
<tr>
<td>4/1/2017</td>
<td>30, 95</td>
<td>Update the list of add-on procedure codes that are not counted towards the daily and weekly requirements for number of Partial Hospitalization Program (PHP) services. Procedure codes 90833, 90836 and 90838 are removed from the list; 90785 remains (see special processing logic, Appendix C-a flowchart and Appendix O of CR10230).</td>
</tr>
<tr>
<td>7/1/2017</td>
<td>22</td>
<td>Add ZC (Merck/ Samsung Bioepis) to the list of valid modifiers.</td>
</tr>
<tr>
<td>7/1/2017</td>
<td>94</td>
<td>Add modifier ZC as a biosimilar manufacturer modifier applicable for HCPCS Q5102.</td>
</tr>
<tr>
<td>Date of Change</td>
<td>Description</td>
<td></td>
</tr>
<tr>
<td>----------------</td>
<td>-------------</td>
<td></td>
</tr>
<tr>
<td>10/1/2016</td>
<td>99 Add HCPCS J2505 (Injection, pegfilgrastim 6mg) to the list of HCPCS excepted from requiring an OPPS procedure on the same claim (see special processing logic).</td>
<td></td>
</tr>
<tr>
<td>7/1/2017</td>
<td>41, 65 Add new revenue code 1006 to the list of valid revenue codes and to the list of revenue codes not recognized by Medicare.</td>
<td></td>
</tr>
<tr>
<td>10/1/2017</td>
<td>Update the following lists for the release (see quarterly data files): Edit 99 exclusion list (add new codes to exception Comprehensive Ambulatory Payment Classification (APC) ranking Comprehensive APC Code Pairs (correction to two APC Pairs missing complexity-adjusted APC assignment retroactive for 2016 service dates) New data file report for Comprehensive APCs (includes list of procedures, rank and flag for eligibility of complexity-adjusted APC) Device-procedure list (edit 92) Terminated device-procedures for device credit (Device offset amount corrections; updated code Non-standard CT Scan (updated code list)</td>
<td></td>
</tr>
<tr>
<td>5/25/2017</td>
<td>68 Implement NCD mid-quarter effective editing for procedure code 93668.</td>
<td></td>
</tr>
<tr>
<td>4/3/2017</td>
<td>68 Implement NCD mid-quarter effective editing for HCPCS A4575 and E0446.</td>
<td></td>
</tr>
<tr>
<td>10/1/2017</td>
<td>Make all HCPCS/APC/SI changes as specified by CMS (quarterly data files).</td>
<td></td>
</tr>
<tr>
<td>10/1/2017</td>
<td>20, 40 Implement version 23.3 of the NCCI (as modified for applicable outpatient institutional providers).</td>
<td></td>
</tr>
</tbody>
</table>

**ADDITIONAL INFORMATION**


**DOCUMENT HISTORY**

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>August 29, 2017</td>
<td>Initial article released</td>
</tr>
</tbody>
</table>
Hospital OPPS October 2017 Update – Revised

MLN Matters Number: MM10236 Revised
Related Change Request (CR) Number: 10236
Related CR Release Date: September 15, 2017
Effective Date: October 1, 2017
Related CR Transmittal Number: R3864CP
Implementation Date: October 2, 2017

The article was revised on September 15, 2017, to reflect an updated Change Request (CR) that updated the policy section (added Transurethral Waterjet Prostate Ablation Procedure) that also includes information on the revised OPPS status indicator and APC for CPT code 0421T. It also corrected an error to the OPPS status indicator for Q5102 in Table 5. In addition, a new Table 7 was added. All other information remains the same.

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
Change Request (CR) 10236 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
This Recurring Update Notification describes changes to and billing instructions for various payment policies implemented in the October 2017 OPPS update. The October 2017 Integrated Outpatient Code Editor (I/OCE) will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in CR 10236. This Recurring Update Notification applies to Chapter 4, section 10.9.

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

Proprietary Laboratory Analyses (PLA) CPT Codes 0006U through 0017U Effective August 1, 2017

The American Medical Association CPT Editorial Panel established 12 new PLA CPT codes, specifically, CPT codes 0006U through 0017U effective August 1, 2017. Because the codes will be effective August 1, 2017, they were not included in the July 2017 OPPS Update and are instead being including in the October 2017 Update with an effective date of August 1, 2017.

Table 1 lists the long descriptors and status indicators for CPT codes 0006U through 0017U.

Table 1 – Proprietary Laboratory Analyses (PLA) CPT Codes Effective August 1, 2017

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Long Descriptor</th>
<th>OPPS SI</th>
<th>OPPS APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>0006U</td>
<td>Prescription drug monitoring, 120 or more drugs and substances, definitive tandem mass spectrometry with chromatography, urine, qualitative report of presence (including quantitative levels, when detected) or absence of each drug or substance with description and severity of potential interactions, with identified substances, per date of service</td>
<td>Q4</td>
<td>N/A</td>
</tr>
<tr>
<td>0007U</td>
<td>Drug test(s), presumptive, with definitive confirmation of positive results, any number of drug classes, urine, includes specimen verification including DNA authentication in comparison to buccal DNA, per date of service</td>
<td>Q4</td>
<td>N/A</td>
</tr>
</tbody>
</table>
0008U Helicobacter pylori detection and antibiotic resistance, DNA, 16S and 23S rRNA, gyrA, ppb1, rdxA and rpoB, next generation sequencing, formalin-fixed paraffin embedded or fresh tissue, predictive, reported as positive or negative for resistance to clarithromycin, fluoroquinolones, metronidazole, amoxicillin, tetracycline and rifabutin A N/A

0009U Oncology (breast cancer), ERBB2 (HER2) copy number by FISH, tumor cells from formalin fixed paraffin embedded tissue isolated using image-based dielectrophoresis (DEP) sorting, reported as ERBB2 gene amplified or non-amplified Q4 N/A

0010U Infectious disease (bacterial), strain typing by whole genome sequencing, phylogenetic-based report of strain relatedness, per submitted isolate A N/A

0011U Prescription drug monitoring, evaluation of drugs present by LCMS/MS, using oral fluid, reported as a comparison to an estimated steady-state range, per date of service including all drug compounds and metabolites Q4 N/A

0012U Germline disorders, gene rearrangement detection by whole genome next-generation sequencing, DNA, whole blood, report of specific gene rearrangement(s) A N/A

0013U Oncology (solid organ neoplasia), gene rearrangement detection by whole genome next-generation sequencing, DNA, fresh or frozen tissue or cells, report of specific gene rearrangement(s) A N/A

0014U Hematology (hematolymphoid neoplasia), gene rearrangement detection by whole genome next-generation sequencing, DNA, whole blood or bone marrow, report of specific gene rearrangement(s) A N/A

0015U Drug metabolism (adverse drug reactions), DNA, 22 drug metabolism and transporter genes, real-time PCR, blood or buccal swab, genotype and metabolizer status for therapeutic decision support Q4 N/A

0016U Oncology (hematolymphoid neoplasia), RNA, BCR/ABL1 major and minor breakpoint fusion transcripts, quantitative PCR amplification, blood or bone marrow, report of fusion not detected or detected with quantitation A N/A

0017U Oncology (hematolymphoid neoplasia), JAK2 mutation, DNA, PCR amplification of exons 12-14 and sequence analysis, blood or bone marrow, report of JAK2 mutation not detected or detected A N/A

CPT codes 0006U through 0017U have been added to the October 2017 I/OCE with an effective date of August 1, 2017. These codes, along with their short descriptors and status indicators, are also listed in the October 2017 OPPS Addendum B.

Billing for Peripheral Artery Disease (PAD) Rehabilitation

Effective May 25, 2017, the Centers for Medicare & Medicaid Services (CMS) will pay for supervised exercised therapy (SET) for beneficiaries with intermittent claudication for the treatment of symptomatic peripheral artery disease. To implement this National Coverage Determination (NCD), CMS will pay separately for CPT code 93668 under the hospital OPPS.

For purposes of Medicare coverage, services must meet all of the following eligibility criteria:

- Consist of sessions lasting 30-60 minutes comprising a therapeutic exercise-training
- program for PAT in patients with claudication
- Be conducted in a hospital outpatient setting, or a physician’s office
- Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD
- Be under the direct supervision of a physician (as defined in 1861(r)(1)), physician assistant, or nurse practitioner/clinical nurse specialist (as identified in 1861(aa)(5)) who must be trained in both basic and advanced life support techniques.
Beneficiaries must have a face-to-face visit with the physician responsible for PAD treatment to obtain the referral for SET. At this visit, the beneficiary must receive information regarding cardiovascular disease and PAD risk factor reduction, which could include education, counseling, behavioral interventions, and outcome assessments.

- MACs have the discretion to cover SET beyond 36 sessions over 12 weeks and may cover an additional 36 sessions over an extended period of time. A second referral is required for these additional sessions.
- SET is non-covered for beneficiaries with absolute contraindications to exercise as determined by their primary physician.


Table 2 lists the long descriptor, status indicator, and APC assignment for CPT code 93668. The payment amount for CPT code 93668 is available in the October 2017 OPPS Addendum B.

### Table 2 – Peripheral Artery Disease (PAD) Rehabilitation

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Long Descriptor</th>
<th>OPPS SI</th>
<th>OPPS APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>93668</td>
<td>Peripheral arterial disease (PAD) rehabilitation, per session</td>
<td>$</td>
<td>5733</td>
</tr>
</tbody>
</table>

### New Procedures Requiring the Insertion of a Device

Since January 1, 2017, all new procedures requiring the insertion of an implantable medical device will be assigned a default device offset percentage of at least 41%, and thereby assigned device intensive status, until claims data is available. In certain rare instances, CMS may temporarily assign a higher offset percentage if warranted by additional information. In accordance with current Medicare policy, the following code requiring the insertion of a device (listed in Table 3) will be assigned device intensive status effective October 1, 2017. CMS notes that although HCPCS code C9747, was effective under the OPPS as of July 1, 2017, its device intensive designation is not effective until October 1, 2017.

### Table 3 – New Procedures Requiring the Insertion of a Device

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
<th>Effective Date</th>
<th>October 2017 OPPS SI</th>
<th>October 2017 OPPS APC</th>
<th>CY 2017 OPPS Payment Rate</th>
<th>CY 2017 Device Offset</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9747</td>
<td>Ablation of prostate, transrectal, high intensity focused ultrasound (HIFU), including imaging guidance</td>
<td>10-01-2017</td>
<td>J1</td>
<td>5376</td>
<td>$7,452.66</td>
<td>$3,055.60</td>
</tr>
</tbody>
</table>

### Drugs, Biologicals, and Radiopharmaceuticals

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

Payment for separately payable non pass-through drugs, biologicals and therapeutic radiopharmaceuticals (status indicator “K”) 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 addition, a single payment of ASP + 6 percent for pass-through drugs, biologicals and radiopharmaceuticals (status indicator “G”) 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 ASP submissions become available. Updated payment rates effective October 1, 2017 and drug price restatements are available in the October 2017 update of the OPPS Addendum A and Addendum B at [http://www.cms.gov/HospitalOutpatientPPS/](http://www.cms.gov/HospitalOutpatientPPS/).
b. Drugs and Biologicals Based on ASP Methodology with Restated Payment Rates

Some drugs and biologicals paid based on the ASP methodology will have payment rates that are corrected retroactively. These retroactive corrections typically occur on a quarterly basis. The list of drugs and biologicals with corrected payments rates will be accessible on the first date of the quarter at https://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/HospitalOutpatientPPS/OPPS-Restated-Payment-Rates.html.

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

c. Drugs and Biologicals with OPPS Pass-Through Status Effective October 1, 2017

Four drugs and biologicals have been granted OPPS pass-through status effective October 1, 2017. These items, along with their descriptors and APC assignments, are identified in Table 4.

Table 4 – Drugs and Biologicals with OPPS Pass-Through Status Effective October 1, 2017

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Description</th>
<th>Long Description</th>
<th>Oct 2017 OPPS SI</th>
<th>Oct 2017 OPPS APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9491</td>
<td>Injection, avelumab</td>
<td>Injection, avelumab, 10 mg</td>
<td>G</td>
<td>9491</td>
</tr>
<tr>
<td>C9492</td>
<td>Injection, durvalumab</td>
<td>Injection, durvalumab, 10 mg</td>
<td>G</td>
<td>9492</td>
</tr>
<tr>
<td>C9493</td>
<td>Injection, edaravone</td>
<td>Injection, edaravone, 1 mg</td>
<td>G</td>
<td>9493</td>
</tr>
<tr>
<td>C9494</td>
<td>Injection, ocrelizumab</td>
<td>Injection, ocrelizumab, 1 mg</td>
<td>G</td>
<td>9494</td>
</tr>
</tbody>
</table>

d. New Modifier for Biosimilar Biological Product

Q5102 can be reported with either the existing modifier ZB or new modifier ZC effective July 1, 2017, see table 5. CMS is also instructing MACs that the ZC modifier will become effective, that is, valid for claims submitted beginning October 1, 2017, and applies retroactively to dates of service on or after July 24, 2017.

Table 5 – Biosimilar Biological Product Payment and Required Modifiers

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>SI</th>
<th>APC</th>
<th>HCPCS Code Effective Date</th>
<th>Modifier</th>
<th>Modifier Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5102</td>
<td>Injection, infliximab biosimilar</td>
<td>Injection, infliximab Biosimilar, 10 mg</td>
<td>G</td>
<td>1847</td>
<td>04/05/2016</td>
<td>ZB – Pfizer/ Hospira</td>
<td>04/01/2016</td>
</tr>
<tr>
<td>Q5102</td>
<td>Injection, infliximab biosimilar</td>
<td>Injection, Infliximab Biosimilar, 10 mg</td>
<td>G</td>
<td>1847</td>
<td>04/05/2016</td>
<td>ZC – Merck/ Samsung Bioepis</td>
<td>07/01/2017</td>
</tr>
</tbody>
</table>

e. New Flu Vaccine

The existing influenza vaccine CPT code 90674 (Cciiv4 vaccine, no preservative, 0.5 ml, intramuscular) with trade name Flucelvax Quadrivalent was effective January 1, 2017 and is a preservative-free and antibiotic-free vaccine. A new preservative, antibiotic-free influenza vaccine CPT code with the same trade name, Flucelvax Quadrivalent, will be effective on January 1, 2018. For the period between August 1, 2017 and December 31, 2017, Flucelvax Quadrivalent Preservative can be reported as Q2039. The permanent CPT code for the Flucelvax Quadrivalent preservative influenza vaccine will be released on a later date, see Table 6.
Table 6 – Billing for Preservative and Preservative-Free Flucelvax Quadrivalent Influenza Vaccine

<table>
<thead>
<tr>
<th>Vaccine Type</th>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>OPSS SI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flucelvax Quadrivalent Preservative-Free and</td>
<td>90674</td>
<td>Cciiv4 vaccine, no preservative, 0.5 ml, intramuscular</td>
<td>Influenza virus vaccine, quadrivalent (ccIV4), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use</td>
<td>L</td>
</tr>
<tr>
<td>Antibiotic-Free Flu Vaccine</td>
<td>Q2039</td>
<td>Cciiv4 vaccine, nos, intramuscular</td>
<td>Influenza virus vaccine, not otherwise specified</td>
<td>L</td>
</tr>
</tbody>
</table>

**Upper Eyelid Blepharoplasty and Blepharoptosis Repair**

As indicated in Chapter VIII of the CY 2017 National Correct Coding Initiative (NCCI) Policy Manual for Medicare Services, CMS payment policy does not allow separate payments for a blepharoptosis procedure (CPT code 67901-67908) and a blepharoplasty procedure (CPT codes 15822-15823) on the ipsilateral upper eyelid. Under this policy, any removal of upper eyelid skin in the context of an upper eyelid blepharoptosis surgery was considered a part of the blepharoptosis surgery. This instruction was clarified in the July 2016 Hospital OPPS Update Change Request (Transmittal 3557, Change Request 9658 dated July 1, 2016) and the July 2016 OPPS MLN Matters Article MM9658, available at [https://www.cms.gov/Outreach-andEducation/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9658.pdf](https://www.cms.gov/Outreach-andEducation/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9658.pdf).

However, effective October 1, 2017, CMS is revising this policy to allow either cosmetic or medically necessary blepharoplasty to be performed in conjunction with a medically necessary upper eyelid blepharoptosis surgery. Specifically, physicians may receive payment for a medically necessary upper eyelid blepharoptosis from Medicare even when performed with (non-covered) cosmetic blepharoplasty on the same eye during the same visit. Since cosmetic procedures are not covered by Medicare, advance beneficiary notice of noncoverage (ABN) instructions would apply for cosmetic blepharoplasty. However, medically necessary blepharoplasty will continue to be bundled into the payment for blepharoptosis when performed with and as a part of a blepharoptosis surgery.

Other aspects of the July 2016 OPPS Update CR and MLN guidance on upper eyelid blepharoplasty and blepharoptosis remain unchanged. Specifically, CMS notes that Medicare does not allow separate payment for the following:

- Operating on the left and right eyes on different days when the standard of care is bilateral eyelid surgery
- Charging the beneficiary an additional amount for removing orbital fat when a blepharoplasty or a blepharoptosis repair is performed
- Performing a blepharoplasty on a different date of service than the blepharoptosis procedure for the purpose of unbundling the blepharoplasty
- Performing blepharoplasty as a staged procedure, either by one or more surgeons (note that under certain circumstances a blepharoptosis procedure could be a staged procedure)
- Billing for two procedures when two surgeons divide the work of a blepharoplasty performed with a blepharoptosis repair
- Using modifier 59 to unbundle the blepharoplasty from the ptosis repair on the claim form; this applies to both physicians and facilities.
- Treating medically necessary surgery as cosmetic for the purpose of charging the beneficiary for a cosmetic surgery
- In the rare event that a blepharoplasty is performed on one eye and a blepharoptosis repair is performed on the other eye, the services must each be billed with the appropriate RT or LT modifier.

**Transurethral Waterjet Prostate Ablation Procedure**

On June 5, 2017, the Investigational Device Exemption (IDE) study associated with the “Waterjet Ablation Therapy for Endoscopic Resection of Prostate Tissue II” met CMS’s
standards for coverage. The procedure associated with this study is currently described by CPT code 0421T. Based on the recent Medicare coverage of the IDE study, CMS is revising the OPPS status indicator (SI) for CPT code 0421T from “E1” (Not paid by Medicare when submitted on outpatient claims (any outpatient bill type)) to “J1” (Hospital Part B services paid through a comprehensive APC) and assigning the code to APC 5374 (Level 4 Urology and Related Services).

The SI and APC revision will be added to the January 2018 IOCE release with an effective date of June 5, 2017, which is the date of the Medicare approval for coverage of the IDE study.

Table 7 (below) lists the long descriptor, status indicator, and APC assignment for CPT code 0421T. The October 2017 national payment rate for APC 5374 is $2,542.56. However, as previously stated, payment for claims involving CPT code 0421T will not begin to be processed until January 1, 2018.

For more information on this approved Medicare IDE study, refer to study title “Waterjet Ablation Therapy for Endoscopic Resection of Prostate Tissue II” which can be found on the CMS IDE Studies website at: https://www.cms.gov/Medicare/Coverage/IDE/Approved-IDE-Studies.html.

For more information on Medicare’s coverage related to IDE studies, refer to this CMS website: https://www.cms.gov/Medicare/Coverage/IDE/index.html.

Table 7 – Transurethral Waterjet Prostate Ablation Procedure

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Long Description</th>
<th>OPPS SI</th>
<th>OPPS APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>0421T</td>
<td>Transurethral waterjet ablation of prostate, including control of postoperative bleeding, including ultrasound guidance, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included when performed)</td>
<td>J1</td>
<td>5374</td>
</tr>
</tbody>
</table>

Coverage Determinations

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

ADDITIONAL INFORMATION


DOCUMENT HISTORY

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<tr>
<td>September 15, 2017</td>
<td>The article was revised to reflect an updated Change Request (CR) that updated the policy section (added Transurethral Waterjet Prostate Ablation Procedure) that also includes information on the revised OPPS status indicator and APC for CPT code 0421T. It also corrected an error to the OPPS status indicator for Q5102 in Table 5. In addition, a new Table 7 was added.</td>
</tr>
<tr>
<td>August 29, 2017</td>
<td>Initial article released.</td>
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PROVIDER BASED FACILITIES

Provider-Based Determination - Revised

MLN Matters Number: MM10095 Revised
Related Change Request (CR) Number: CR10095
Related CR Release Date: August 4, 2017
Effective Date: November 6, 2017
Related CR Transmittal Number: R1891OTN
Implementation Date: November 6, 2017

This article was revised on September 7, 2017, to delete information regarding certain checklists received. All other information remains the same.

PROVIDER TYPES AFFECTED
This MLN Matters® Article is intended for providers submitting institutional claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

WHAT YOU NEED TO KNOW
Change Request (CR) 10095 advises MACs to use a uniform electronic Provider-Based (PB) checklist to perform uniform reviews of PB applications.

BACKGROUND
Prior to September 2014, the Centers for Medicare & Medicaid Services (CMS) had been receiving discrete, PB checklists from each of the MACs and found that each one was significantly different from the next. CR 10095 instructs MACs to use the comprehensive electronic PB checklist when reviewing PB attestations. CR 10095 does not make any policy revisions to the review of PB applications.

ADDITIONAL INFORMATION
Claim Status Category and Claim Status Codes Update

MLN Matters Number: MM10132  
Related Change Request (CR) Number: 10132  
Related CR Release Date: August 18, 2018  
Effective Date: January 1, 2018  
Related CR Transmittal Number: R3839CP  
Implementation Date: January 2, 2018

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

PROVIDER ACTION NEEDED
Change Request (CR) 10132 updates, as needed, the Claim Status and Claim Status Category Codes used for the Accredited Standards Committee (ASC) X12 276/277, Health Care Claim Status Request and Response and ASC X12 277 Health Care Claim Acknowledgment transactions. Make sure your billing staffs are aware of these updates.

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

The National Code Maintenance Committee meets at the beginning of each ASC X12 trimester meeting, held each year in January or February, June, and in September or October. At these meetings, the Committee 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.


All code changes approved during the September/October 2017 Committee meeting shall be posted on the above websites on or about November 1, 2017.

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

These code changes are 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 CR10132. References in CR10132 to “277 responses,” and “claim status responses,” encompass both the ASC X12 277 Health Care Claim Status Response and the ASC X12 277 Healthcare Claim Acknowledgment transactions.

ADDITIONAL INFORMATION
Revision to Publication 100-06, Medicare Overpayment Manual, Chapter 3, Section 200 – Limitation on Recoupment – Revised

MLN Matters® Number: MM9815
Related Change Request (CR) #: CR 9815
Related CR Release Date: September 14, 2017
Effective Date: April 2, 2018
Related CR Transmittal #: R293FM
Implementation Date: April 2, 2018

This article was revised on September 15, 2017, to reflect an updated Change Request that corrected format errors in the manual instructions. In the article, the CR release date, transmittal number, and 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 provided to Medicare beneficiaries.

Provider Action Needed
Change Request (CR) 9815 updates the Centers for Medicare & Medicaid Services (CMS) “Medicare Financial Management Manual,” Chapter 3, Sections 200-200.2.1, Limitation on Recoupment Overpayments. CR9815 is the first of four CRs that are forthcoming and incorporated into this manual. Make sure your billing staffs are aware of these updates that relate to the limitation on recovery of certain overpayments.

Background
Section 1893(f)(2)(a) of the Social Security Act and the provision in the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) prohibits recouping Medicare overpayments from a provider or supplier that seeks a reconsideration from a Qualified Independent Contractor (QIC). This provision changed how interest is to be paid to a provider or supplier whose overpayment is reversed at subsequent administrative or judicial levels of appeal. The final rule defines the overpayments to which the limitation applies, how the limitation works in concert with the appeals process, and the change in our obligation to pay interest to a provider or supplier whose appeal is successful at levels above the QIC. This section also limits recoupment of Medicare overpayments when a provider or supplier seeks a redetermination until a redetermination decision is rendered.

The MAC will cease recoupment or not begin recoupment when the MAC receives a valid redetermination or reconsideration request timely on an overpayment subject to these limitations. The provider has until the appeal deadline to file an appeal (refer to the “Medicare Claims Processing Manual,” Chapter 29 at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c29.pdf). If a provider wants to delay recoupment, it must submit the redetermination appeal request within 30 days of the demand letter date. To continue the delayed recoupment, the provider will have 60 days from the redetermination decision to submit a reconsideration request. If the request is received before the appeal deadline but after recoupment has started, the MAC will stop the recoupment. The MAC shall not refund any monies collected back to the provider, unless otherwise directed by the Centers for Medicare & Medicaid Services (CMS). The MAC will be accountable to ensure the debts continue to age and accrue interest until the debt is paid in full.

After the first two levels of appeal are completed, the MAC shall resume recoupment and normal debt collection processes. Whether or not the provider subsequently appeals the overpayment to the Administrative Law Judge (ALJ), or subsequent levels (Department Appeals Board (DAB), or Federal court), the MAC shall initiate recoupment at 100% until the debt is satisfied in full, unless an Extended Repayment Schedule (ERS) is established. If the debt was referred to Treasury and the provider files for an appeal, the MAC shall recall the debt from Treasury while in an appeal status. If the appeal decision is unfavorable to the provider, any outstanding debt will be referred back to Treasury, unless an approved Extended Repayment Schedule (ERS) is established or the provider pays the debt in full.
Additional Information


Document History

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

MLN Matters Number: MM10140
Related Change Request (CR) Number: CR10140
Related CR Release Date: August 18, 2017
Effective Date: January 1, 2018
Related CR Transmittal Number: R3841CP
Implementation Date: January 2, 2018

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

PROVIDER ACTION NEEDED
Change Request (CR) 10140 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 are based on the CORE Code Combination List to be published on or about October 1, 2017.

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 Affordable Care Act. The Health Insurance Portability and Accountability Act (HIPAA) amended the Act by adding Part C—Administrative Simplification—to Title XI of the Social Security Act, requiring the Secretary of DHHS to adopt standards for certain transactions to enable health information to be exchanged more efficiently and to achieve greater uniformity in the transmission of health information. Through the Affordable Care Act, Congress sought to promote implementation of electronic transactions and achieve cost reduction and efficiency improvements by creating more uniformity in the implementation of standard transactions. This was done by mandating the adoption of a set of operating rules for each of the HIPAA transactions. The Affordable Care Act defines operating rules and specifies the role of operating rules in relation to the standards.

CAQH CORE will publish the next version of the Code Combination List on or about October 1, 2017. This update is based on the CARC and RARC updates as posted at the Washington Publishing Company (WPC) website on or about July 1, 2017. This will also include updates based on Market Based Review that CAQH CORE conducts once a year to accommodate code combinations that are currently being used by Health Plans including Medicare as the industry needs them. See http://www.wpc-edi.com/reference or CARC and RARC updates and http://www.caqh.org/CORECodeCombinations.php or CAQH CORE defined code combination updates.
Note: The Affordable Care Act mandate all health plans including Medicare must comply with CORE 360 Uniform Use of CARCs and RARCs (835) rule or CORE developed maximum set of CARC/RARC and CAGC combinations for a minimum set of 4 Business Scenarios. Medicare can use any code combination if the business scenario is not one of the 4 CORE defined business scenarios. With the 4 CORE defined business scenarios, Medicare must use the code combinations from the lists published by CAQH CORE.

ADDITIONAL INFORMATION

SPR Suppression in 45 Days if Also Receiving ERA
MLN Matters Number: MM10151
Related Change Request (CR) Number: 10151
Related CR Release Date: August 4, 2017
Effective Date: January 1, 2018
Related CR Transmittal Number: R18900TN
Implementation Date: January 2, 2018

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

PROVIDER ACTION NEEDED
Change Request (CR) 10151 provides notice that beginning January 2, 2018, Medicare’s Shared System Maintainers (SSMs) must eliminate issuance of Standard Paper Remittance Advice (SPRs) to those providers/suppliers (or a billing agent, clearinghouse, or other entity representing those providers/suppliers) who also have been receiving Electronic Remittance Advice (ERA) transactions for 45 days or more. The shared system changes to suppress the distribution of SPRs were implemented in January 2006 per CR3991 (issued August 12, 2005, Transmittal 645). Make sure your billing staffs are aware of the suppression of the SPR.

BACKGROUND
The SPR is the hard copy version of an ERA. MACs, including Durable Medical Equipment (DME) MACs must be capable of producing SPRs for providers/suppliers who are unable or choose not to receive an ERA. The MACs and the DME MACs suppress distribution of SPRs if an Electronic Data Interchange (EDI) enrolled provider/supplier is also receiving ERAs for more than 31 days for Institutional Health Care Claims (837I) and 45 days for DME and Professional Health Care Claims (837P). Internet-Only-Manuals (IOMs), MLN Matters Article MM4376 provided information to the MACs regarding the receipt of SPR and ERA distribution time lines.

Beginning February 14, 2018, the SSMs shall suppress the delivery of SPR to the MACs EDI enrolled providers/suppliers who are also receiving both the ERA and SPR. In rare situations (such as natural or man-made disasters) exceptions to this policy may be allowed at the discretion of the Centers for Medicare & Medicaid Services (CMS). MACs will not send a SPR/hard copy version to a particular provider/supplier unless this requirement causes hardship and CMS has approved a waiver requested by your MAC.


ADDITIONAL INFORMATION
Payments to SNFs that Do Not Submit Required Quality Data – FY 2018 and After

MLN Matters® Number: MM9944
Related Change Request (CR) #: CR 9944
Related CR Release Date: July 14, 2017
Effective Date: August 14, 2017
Related CR Transmittal #: R67QRI
Implementation Date: August 14, 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.

What You Need to Know
Change Request (CR) 9944 reminds SNFs of payment reductions in Fiscal Year 2018, and each subsequent year, for SNFs that do not submit required quality data to Medicare.

Background
The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) added Section 1899B to the Social Security Act that:
• Imposed new data reporting requirements for certain Post-Acute Care (PAC) providers, including Skilled Nursing Facilities (SNFs)
• Required that the Centers for Medicare & Medicaid Services (CMS) implement a SNF Quality Reporting Program (QRP).

As defined in the Social Security Act (Section 1899B(a)(2)(E)), for Fiscal Years (FYs) beginning on or after the specified application date, the Social Security Act (Section 1888(e)(6)(B)(i)(III)) requires that each SNF submit (in a manner and within the time frames specified by CMS):
• Data on quality measures specified under the Social Security Act (Section 1899B(c)(1))
• Data on resource use and other measures specified under the Social Security Act (Section 1899B(d)(1)).

Note that the SNF QRP applies to freestanding SNFs, SNFs affiliated with acute care facilities, and all non-Critical Access Hospital swing-bed rural hospitals.

Beginning with FY 2018, and each subsequent year, if a SNF does not submit required quality data, their payment rates for the year are reduced by 2 percentage points for that fiscal year. Application of the 2 percentage reduction may result in an update that is less than 0.0 for a fiscal year and in payment rates for a fiscal year being less than such payment rates for the preceding fiscal year. In addition, reporting-based reductions to the market basket increase factor will not be cumulative; they will only apply for the FY involved.

CR9944 revises Chapter 3, Section 80 of the “Medicare Quality Reporting Incentive Programs Manual” to reflect changes to the payment reduction reconsideration process. The revised manual section is included with CR9944.

Your MAC will notify you by letter if your SNF was non-compliant with the QRP requirements and are, therefore, subject to the payment reduction.

Additional Information
SNF CB Enforcement HCPCS Codes October 2017 Update

MLN Matters Number: MM10163
Related Change Request (CR) Number: 10163
Related CR Release Date: August 4, 2017
Effective Date: October 1, 2017
Related CR Transmittal Number: R3825CP
Implementation Date: October 2, 2017

PROVIDER TYPES AFFECTED
This MLN Matters® Article is intended for providers who submit claims to Medicare Administrative Contractors (MACs), including Durable Medical Equipment MACs (DME MACs), for services provided in a Skilled Nursing Facility (SNF) to Medicare beneficiaries.

PROVIDER ACTION NEEDED
Change Request (CR) 10163 provides updates to the lists of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the Consolidated Billing (CB) provision of the SNF Prospective Payment System (PPS). The CR corrects an error impacting certain claims with dates of service on or after January 1, 2015, that Medicare mistakenly denied/rejected prior to implementation of CR10163. Make sure your billing staffs are aware of these changes.

BACKGROUND
CR10163 alerts providers that the Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of HCPCS codes that are excluded from the CB provision of the SNF PPS. Services excluded from SNF PPS and CB may be paid to providers, other than SNFs, for beneficiaries, even when in a SNF stay. Services not appearing on the exclusion lists submitted on claims to MACs will not be paid by Medicare to any providers other than a SNF.

For non-therapy services, SNF CB applies only when the services are furnished to a SNF resident during a covered Part A stay; however, SNF CB applies to physical and occupational therapies and speech-language pathology services whenever they are furnished to a SNF resident, regardless of whether Part A covers the stay. In order to assure proper payment in all settings, Medicare systems must edit for services provided to SNF beneficiaries both included and excluded from SNF CB. The updated lists for institutional and professional billing are available at [http://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/index.html](http://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/index.html).

Certain radiation therapy codes are included as services that are not subject to SNF CB. These codes can be submitted globally (no modifier), professional component only (modifier 26), or technical component only (modifier TC).

When the codes listed below are submitted globally or just for the technical component, the claims are being rejected by Medicare’s Common Working File (CWF). That is to say, they are not allowed to pay separately outside of the consolidated payment that is made to the SNF.

When submitted with the 26 modifier for just the professional component, the claims have been allowed to pay. The following are the allowable HCPCS codes: 77014, 77750, 77761, 77762, 77763, 77776, 77777, 77778, 77785, 77786, 77787, 77789, 77790, 77799, 79005, 79101, and 79445.

This error is occurring because the codes were not added by CMS to the appropriate coding lists with the 2015, 2016, and 2017 SNF CB Annual Updates. CR10163 corrects this error. Therefore, when brought to their attention, your MAC will reprocess claims with dates of service on or after January 1, 2015, that were erroneously denied/rejected.

ADDITIONAL INFORMATION
HCPCS Codes for SNF CB 2018 Annual Update

MLN Matters Number: MM10262
Related Change Request (CR) Number: 10262
Related CR Release Date: September 8, 2017
Effective Date: January 1, 2018
Related CR Transmittal Number: R3857CP
Implementation Date: January 2, 2018

PROVIDER TYPES AFFECTED
This MLN Matters® Article is intended for physicians, other providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs), including Home Health & Hospice (HH&H) MACs and Durable Medical Equipment (DME) MACs, for services provided to Medicare beneficiaries who are in a Part A covered Skilled Nursing Facility (SNF) stay.

PROVIDER ACTION NEEDED
Change Request (CR) 10262 makes changes to Healthcare Common Procedure Coding System (HCPCS) codes and Medicare Physician Fee Schedule designations that will be used to revise Common Working File (CWF) edits to allow A/B MACs to make appropriate payments in accordance with policy for SNF CB in Chapter 6, Section 110.4.1 and Chapter 6, Section 20.6 in the “Medicare Claims Processing Manual.”

BACKGROUND
The Common Working File (CWF) currently has edits in place for claims received for beneficiaries in a Part A covered SNF stay as well as for beneficiaries in a non-covered stay. These edits allow only those services that are excluded from consolidated billing to be separately paid. Barring any delay in the Medicare Physician Fee Schedule, the new code files will be provided to CWF by November 1, 2017.

By the first week in December 2017, new code files will be posted at [http://www.cms.gov/SNFConsolidatedBilling/](http://www.cms.gov/SNFConsolidatedBilling/). The files will be applicable to claims with dates of service on or after January 1, 2018, through December 31, 2018. It is important and necessary for the provider/contractor community to view the “General Explanation of the Major Categories” file located at the bottom of each year’s update in order to understand the Major Categories including additional exclusions not driven by HCPCS codes.

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