# DME Happenings

Jurisdiction D

**June 2018**

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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

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## Jurisdiction D DME MAC Supplier Contacts and Resources

| Department/System | Phone Numbers | Availability |
|---|---|---|
| Interactive Voice Response System (IVR) | 877-320-0390 | 24/7 for Eligibility<br>6 a.m. – 8 p.m. CT for all other inquiries |
| Supplier Contact Center | 877-320-0390 | Monday – Friday<br>8 a.m. – 6 p.m. CT |
| Telephone Reopenings | 877-320-0390 | Monday – Friday<br>8 a.m. – 4:30 p.m. CT |
| Beneficiary Customer Service | 800-633-4227 | 24/7 |
| **Fax Numbers** | | |
| Reopenings/Redeterminations<br>Recovery Auditor Redeterminations | | 701-277-7886 |
| Recoupment<br>• Refunds to Medicare<br>• Immediate Offsets | | 701-277-7894 |
| MSP Refunds | | 701-277-7892 |
| Recovery Auditor Offsets | | 701-277-7896 |
| MR Medical Documentation | | 701-277-7888 |
| **Email Addresses/Websites** | | |
| NHS DME Customer Service | https://med.noridianmedicare.com/web/jddme/contact/email-customer-service | |
| Reopenings/Redeterminations | dmeredeterminations@noridian.com | |
| Noridian JD Website | https://med.noridianmedicare.com/web/jddme | |
| **Mailing Addresses** | | |
| • Claims<br>• Redetermination Requests<br>• Correspondence<br>• ADMC Requests<br>• Medical Review Documentation<br>• Recovery Auditor Overpayments | **Noridian JD DME**<br>Attn: _____<br>PO Box 6727<br>Fargo, ND 58108-6727 | |
| • Benefit Protection<br>• Administrative Simplification Compliance Act Exception Requests (ASCA) | **Noridian JD DME**<br>Attn: _____<br>PO Box 6736<br>Fargo, ND 58108-6736 | |

| | |
|---|---|
| Qualified Independent Contractor (QIC) | **C2C Solutions, Inc.**<br>Attn: DME QIC<br>PO Box 44013<br>Jacksonville, FL 32231-4013 |
| • EFT Forms<br>• Overpayment Redeterminations<br>• Recovery Auditor Redeterminations | **Noridian JD DME**<br>Attn: _____<br>PO Box 6728<br>Fargo, ND 58108-6728 |

**Other DME MACs and Other Resources**

| MAC/Resource | Phone Number | Website |
|---|---|---|
| Noridian: Jurisdiction A | 866-419-9458 | https://med.noridianmedicare.com/web/jadme |
| CGS: Jurisdiction B | 877-299-7900 | www.cgsmedicare.com |
| CGS: Jurisdiction C | 866-238-9650 | www.cgsmedicare.com |
| Pricing, Data Analysis and Coding (PDAC) | 877-735-1326 | www.dmepdac.com |
| National Supplier Clearinghouse | 866-238-9652 | www.palmettogba.com/nsc |
| Common Electronic Data Interchange (CEDI) Help Desk | 866-311-9184 | www.ngscedi.com |
| Centers for Medicare and Medicaid Services (CMS) | | www.cms.gov |

## Beneficiaries Call 1-800-MEDICARE

Suppliers are reminded that when beneficiaries need assistance with Medicare questions or claims that they should be referred to call 1-800-MEDICARE (1-800-633-4227) for assistance. The supplier contact center only handles inquiries from suppliers.

The table below provides an overview of the types of questions that are handled by 1-800-MEDICARE, along with other entities that assist beneficiaries with certain types of inquiries.

| Organization | Phone Number | Types of Inquiries |
|---|---|---|
| 1-800-MEDICARE | 1-800-633-4227 | General Medicare questions, ordering Medicare publications or taking a fraud and abuse complaint from a beneficiary |
| Social Security Administration | 1-800-772-1213 | Changing address, replacement Medicare card and Social Security Benefits |
| RRB - Railroad Retirement Board | 1-800-808-0772 | For Railroad Retirement beneficiaries only - RRB benefits, lost RRB card, address change, enrolling in Medicare |
| Coordination of Benefits | 1-800-999-1118 | Reporting changes in primary insurance information |

Another great resource for beneficiaries is the website, http://www.medicare.gov/, where they can:

- Compare hospitals, nursing homes, home health agencies, and dialysis facilities
- Compare Medicare prescription drug plans
- Compare health plans and Medigap policies
- Complete an online request for a replacement Medicare card

- Find general information about Medicare policies and coverage
- Find doctors or suppliers in their area
- Find Medicare publications
- Register for and access MyMedicare.gov

As a registered user of MyMedicare.gov, beneficiaries can:

- View claim status (excluding Part D claims)
- Order a duplicate Medicare Summary Notice (MSN) or replacement Medicare card
- View eligibility, entitlement and preventive services information
- View enrollment information including prescription drug plans
- View or modify their drug list and pharmacy information
- View address of record with Medicare and Part B deductible status
- Access online forms, publications and messages sent to them by CMS

## Medicare Learning Network Matters Disclaimer Statement

Below is the Centers for Medicare & Medicaid (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 "DME Happenings" Articles

The purpose of "DME Happenings" is to educate Noridian's Durable Medical Equipment supplier community. The educational articles can be advice written by Noridian staff or directives from CMS. Whenever Noridian publishes 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 CMS's website, http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html. CMS Change Requests and the date issued will be referenced within the "Source" portion of applicable articles.

CMS has implemented a series of educational articles within the Medicare Leaning Network (MLN), titled "MLN Matters", which will continue to be published 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.

## CMS Quarterly Provider Updates

The Quarterly Provider Update is a listing of non-regulatory changes to Medicare including Program Memoranda, manual changes, and any other instructions that could affect providers or suppliers. This comprehensive resource is published by CMS on the first business day of each quarter. 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 ad 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.

The Quarterly Provider Update can be accessed at http://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/index.html. Suppliers may also sign up to receive notification when regulations and program instructions are added throughout the quarter on this page.

## Physician Documentation Responsibilities

Suppliers are encouraged to remind physicians of their responsibility in completing and signing the Certificate of Medical Necessity (CMN). It is the physician's and supplier's responsibility to determine the medical need for, and the utilization of, all health care services. The physician and supplier should ensure that information relating to the beneficiary's condition is correct. Suppliers are also encouraged to include language in their cover letters to physicians reminding them of their responsibilities.

**Source**: Internet Only Manual, Publication 100-8, Medicare Program Integrity Manual, Chapter 5, Section 5.3.2

## Automatic Mailing/Delivery of DMEPOS Reminder

Suppliers may not automatically deliver DMEPOS to beneficiaries unless the beneficiary, physician, or designated representative has requested additional supplies/equipment. The reason is to assure that the beneficiary actually needs the DMEPOS.

A beneficiary or their caregiver must specifically request refills of repetitive services and/or supplies before a supplier dispenses them. The supplier must not automatically dispense a quantity of supplies on a predetermined regular basis.

A request for refill is different than a request for a renewal of a prescription. Generally, the beneficiary or caregiver will rarely keep track of the end date of a prescription. Furthermore, the physician is not likely to keep track of this. The supplier is the one who will need to have the order on file and will know when the prescription will run out and a new order is needed. It is reasonable to expect the supplier to contact the physician and ask for a renewal of the order. Again, the supplier must not automatically mail or deliver the DMEPOS to the beneficiary until specifically requested.

**Source**: Internet Only Manual (IOM), Publication 100-4, Medicare Claims Processing Manual, Chapter 20, Section 200

## Refunds to Medicare

When submitting a voluntary refund to Medicare, please include the Overpayment Refund Form found on the Forms page of the Noridian DME website. This form provides Medicare with the necessary information to process the refund properly. This is an interactive form which Noridian has created to make it easy for you to type and print out. We've included a highlight button to ensure you don't miss required fields. When filling out the form, be sure to refer to the Overpayment Refund Form instructions.

Processing of the refund will be delayed if adequate information is not included. Medicare may contact the supplier directly to find out this information before processing the refund. If the specific patient name, Medicare number or claim number information is not provided, no appeal rights can be afforded.

Suppliers are also reminded that "The acceptance of a voluntary refund 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."

**Source:** Transmittal 50, Change Request 3274, dated July 30, 2004

## CMS DIFs and CMNs Updated

The following forms, attached to the applicable Local Coverage Determinations (LCDs), have been updated to include the Medicare ID field:

**DME Information Form (DIF):** Enteral and Parenteral Nutrition, External Infusion Pump

**Certificate of Medical Necessity (CMN):** Osteogenesis Stimulators, Oxygen, Pneumatic Compression Devices, Seat Lift Mechanisms, Transcutaneous Electrical Nerve Stimulators

**Form:** Statement of Certifying Physician for Therapeutic Shoes

## DME MAC Collaboration Unifies Processes for National Consistency

With two DME MACS responsible for the national Medicare supplier workload, the need to collaborate and unilaterally identify and implement operational and process consistencies was critical. This article provides you with information on how the Program Managers and their operational leadership for all four DME MAC jurisdictions, work together to unify processes and that impact DME suppliers and their customers.

View the complete DME MAC Program Manager Collaboration article.

## Enhancements Made to MSP Webpages

The Medicare Secondary Payer (MSP) webpages have been updated to include frequently used tools and resources. Quick link buttons have been added to the top of the MSP pages to provide easy access to these tools. The tools listed below will help suppliers when submitting their MSP claims.

**Decision Tree**

- The MSP Decision Tree assists suppliers in determining "Who is the primary payer?" by answering a series of questions

**Payer Type**

- Allows quick access to the MSP Payer Type page. This will help identify the appropriate MSP type when submitting electronic claims. For suppliers who submit paper claims this page will guide you on the appropriate box to check in Item 10

**Payment Calculator**

- The MSP Payment Calculator determines the line by line claim payment calculations for services that are covered by Medicare as the secondary prayer

Your feedback is important to Noridian. Continue to share your suggestions by completing the Website Satisfaction Survey each time it is presented during website or portal navigation.

## Medically Unlikely Edit (MUE) Lookup Tool

Noridian is excited to announce the creation of a new MUE tool to aid suppliers in billing processes. With the use of the MUE Lookup Tool, suppliers can enter a HCPCS code and the tool will return the frequency limitation established by the medically unlikely edits established by CMS.

The use of this tool does not guarantee successful billing and different circumstances should be taken into consideration when submitting the appropriate units of service on the claim in question. Only bill for the units of service that are supported by both a valid detailed written order and the medical records for that beneficiary. These pieces of documentation along with all other applicable documentation must be available in the event of a claim review to support payment.

Visit the Tools page of the Noridian website to begin using the MUE Lookup Tool today.

## Overpayment Interest Calculators – Now Available

Noridian has a new, easy to use tool that will allow suppliers to calculate the interest rates that have accrued on unpaid overpayments. The Overpayment Interest Calculators will give the amount of interest that could accumulate if the overpayment is not satisfied by the date on the demand letter. These calculators can also determine the amount of interest that accrued for a claim on an aggregated overpayment.

The Interest Accrual on the Overpayment calculator is used to determine the interest that has accumulated on an unpaid overpayment by using the information from the demand letter. The calculator requires:

- Date of Demand Letter
- Overpayment Amount
- Interest Rate
- Date Check is being mailed (allow 5 business days)

The calculator will provide the interest rate per month, by date and total amount due.

The Calculate Monthly Interest calculator is used to find the amount of interest by claim on an aggregated overpayment. The tool will request the overpayment amount and interest rate, and then show the interest per month.

Suppliers can find these new calculators on the Overpayments page on the Noridian Medicare website under "Claims & Appeals".

## Overpayment Resources Available

Are you a supplier who needs to refund monies to Medicare because of the Corporate Integrity Program, an OIG Self Disclosure Protocol, or a Voluntary Refund but are unsure of the steps?

Noridian has created an Overpayment Decision Tree tool that will assist in the next steps of the overpayment process. After answering a series of questions, the decision tree will determine the best option for refunding a Medicare overpayment.

The Medicare Secondary Payer (MSP) and Non-MSP Overpayment Refund forms have been updated and will now accommodate more than one adjustment at a time. This eliminates the need to complete multiple forms to send for refunds. In addition to these forms, a spreadsheet is also available to be submitted for large quantities of claim refunds to Medicare. These spreadsheets can be submitted as a subsequent attachment to the corresponding MSP or Non-MSP Overpayment Refund form.

Visit the Refunds/Overpayments Forms page to access these updated forms.

## Noridian is on YouTube!

Noridian is now on YouTube! Our channel provides education and tutorials on several topics including General DMEPOS Guidelines, Mobility, Orthotics & Prosthetics, Respiratory, Noridian Medicare Portal and more. Subscribe to our YouTube channel to be notified when new videos are added!

## OIG Compliance Resource Page

The Office of Inspector General (OIG) has created a Compliance Resource page. This page provides links to handy resources that can help ensure suppliers are in compliance with Federal health care laws.

Resources included are:

- Toolkits
- Provider compliance resources and training
- Advisory opinions
- Voluntary compliance and exclusions resources
- Special fraud alerts, other guidance and safe harbor regulations
- Resources for health care boards
- Resources for physicians
- Accountable care organizations

## Physicians! Your Medical Records Play a Vital Role in Ordering and Providing DMEPOS to Your Patients - Reminder

Noridian is reminding physicians for any Durable Medical Equipment, Prosthetic, Orthotic and Supply (DMEPOS) item to be covered by Medicare, the patient's medical record must contain sufficient information. This would include the patient's medical condition in order to substantiate the necessity for the type of equipment or supply, quantity and/or frequency of use or replacement, if applicable.

## Q&As Removed from Event Materials – Effective May 1, 2018

In an effort to provide improved education to our suppliers, the Noridian Outreach & Education team will be relocating information previously housed as part of Q&A webinar documents. The Q&A documents will be removed from the Event Materials page beginning May 1, 2018.

The information contained within these documents will be included in other areas of education that we provide, such as, webinars, DME on Demand tutorials and the topic specific webpages located under the Browse by Topic and Browse by DMEPOS Category pages. This is intended to provide consistency in location and content of educational information on our website and provide easier one-stop access to relevant educational material.

## KH Modifier Removed from Capped Rental Items – Revised

**MLN Matters Number: MM10422 Revised**
**Related Change Request (CR) Number: 10422**
**Related CR Release Date: May 17, 2018**
**Effective Date: October 1, 2018**
**Related CR Transmittal Number: R4052CP**
**Implementation Date: October 1, 2018**

This article was revised on May 17, 2018, to reflect an updated Change Request (CR) that updated the Internet Only Manual. The transmittal number, CR release date and link to the transmittal also changed. All other information is unchanged.

**PROVIDER TYPE AFFECTED**

This MLN Matters® Article is intended for suppliers that submit claims to Durable Medical Equipment (DME) Medicare Administrative Contractors (MACs) for capped rental DME or parenteral/enteral items and services provided to Medicare beneficiaries.

### PROVIDER ACTION NEEDED

CR 10422 announces that suppliers no longer need to append the KH rental modifier on purchased capped rental durable medical equipment or parenteral/enteral items and services. Make sure your billing staffs are aware of this requirement.

### ADDITIONAL INFORMATION

The official instruction, CR10422, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4052CP.pdf.

### DOCUMENT HISTORY

| Date of Change | Description |
|---|---|
| May 17, 2018 | This article was revised to reflect an updated CR that updated the Internet Only Manual. The transmittal number, CR release date and link to the transmittal also changed. |
| April 30, 2018 | Initial article released. |

## QMB Indicator Reinstated in Medicare FFS Claims Processing System from CR9911 – Second Revision

**MLN Matters Number: MM10433 Revised**
**Related Change Request (CR) Number: 10433**
**Related CR Release Date: March 6, 2018**
**Effective Date: July 1, 2018**
**Related CR Transmittal Number: R3993CP**
**Implementation Date: For claims processed on or after July 2, 2018**

This article was revised on March 13, 2018, to reflect an updated Change Request (CR). That CR added CARCs 66, 247, and 248 (page 3 below). DME MACs were added to the "Providers Affected" section and the QMB enrollment numbers were also updated on page 2 to reflect 2016 statistics. Pharmacies were also included in the "Background" section. The CR date, transmittal number and link to the transmittal also changed. All other information is unchanged.

### PROVIDER TYPES AFFECTED

This MLN Matters® Article is intended for providers and suppliers who submit claims to Part A/B and DME Medicare Administrative Contractors (MACs).

### WHAT YOU NEED TO KNOW

Effective with CR 10433, the Centers for Medicare & Medicaid Services (CMS) will reintroduce Qualified Medicare Beneficiary (QMB) information in the Medicare Remittance Advice (RA) and Medicare Summary Notice (MSN). CR 9911 modified the Fee-For-Service (FFS) systems to indicate the QMB status and zero cost-sharing liability of beneficiaries on RAs and MSNs for claims processed on or after October 2, 2017. On December 8, 2017, CMS suspended CR 9911 to address unforeseen issues preventing the processing of QMB cost-sharing claims by States and other secondary payers outside of the Coordination of Benefits Agreement (COBA) process. CR 10433 remediates these issues by including revised "Alert" Remittance Advice Remark Codes (RARC) in RAs for QMB claims without adopting other RA changes that impeded claims processing by secondary payers. CR 10433 reinstates all changes to the MSNs under CR 9911. Please make sure your billing staff is aware of these changes.

### BACKGROUND

Federal law bars Medicare providers and suppliers, including pharmacies, 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 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 2016, 7.5 million individuals (more than one out of 8 beneficiaries) were enrolled in the QMB program.

Providers and suppliers, including pharmacies, may bill State Medicaid agencies for Medicare cost-sharing amounts. However, as permitted by Federal law, States may limit Medicare cost-sharing payments, under certain circumstances. Be aware, persons enrolled in the QMB program have no legal liability to pay Medicare providers for Medicare Part A or Part B cost-sharing.

**System Changes to Assist Providers under CR 9911**

To help providers more readily identify the QMB status of their patients, CR 9911 introduced a QMB indicator in the claims processing system for the first time. CR 9911 is part of the CMS ongoing effort to give providers tools to comply with the statutory prohibition on collecting Medicare A/B cost-sharing from QMBs.

Through CR 9911, CMS indicated the QMB status and zero cost-sharing liability of beneficiaries in the RA and MSN for claims processed on or after October 2, 2017. In particular, CR 9911 changed the MSN to include new messages for QMB beneficiaries and reflect $0 cost-sharing liability for the period they are enrolled in QMB. In addition, CMS modified the RA to include new Alert RARCs to notify providers to refrain from collecting Medicare cost-sharing because the patient is a QMB (N781 is associated with deductible amounts and N782 is associated with coinsurance).

Additionally, CR 9911 changed the display of patient responsibility on the RA by replacing Claim Adjustment Group Code "Patient Responsibility" (PR) with Group Code "Other Adjustment" (OA). CMS zeroed out the deductible and coinsurance amounts associated with Claim Adjustment Reason Code (CARC) 1 (deductible) and/or 2 (coinsurance) and used CARC 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 the patient if collected. (Use only with Group code OA).") However, the changes to the display of patient liability in the RAs for QMB claims caused unforeseen issues affecting the processing of QMB cost-sharing claims directly submitted by providers to states and other payers secondary to Medicare. Providers rely on RAs to bill State Medicaid Agencies and other secondary payers outside the Medicare COBA claims crossover process. States and other secondary payers generally require RAs that separately display the Medicare deductible and coinsurance amounts with the Claim Adjustment Group Code "PR" and associated CARC codes and could not process claims involving the RA changes from CR 9911. Barriers to the processing of secondary claims have additional implications for institutional providers that claim bad debt under the Medicare program since they must obtain a Medicaid Remittance Advice to seek reimbursement for unpaid deductibles and coinsurance as a Medicare bad debt for QMBs.

To address these issues, on December 8, 2017, CMS suspended the CR 9911 system changes causing the claims processing systems to suspend the RA and MSN changes for QMB claims under CR 9911.

**Reintroduction of QMB information in the MA and MSN under CR 10433**

Effective with CR 10433, the claims processing systems will reintroduce QMB information in the RA without impeding claims processing by secondary payers.

The RA for QMB claims will retain the display of patient liability amounts needed by secondary payers to process QMB cost-sharing claims.

All Medicare's FFS systems will discontinue the practice of outputting Claim Adjustment Group Code OA with CARC 209 in place of CARCs 1 and 2, as well as CARCs 66, 247, and 248, on the ERAs and on SPRs, as applicable.

The shared systems shall include the revised Alert RARCs N781 and N782 in association with CARCs 1 and or 2 on the RA. These RARCs designate that the beneficiary is enrolled in the QMB program and may not be billed for Medicare cost sharing amounts. Additionally, for QMB claims, the Part A and B shared systems shall include the revised Alert RARC N781 in association with CARC 66 (blood deductible). The revised Alert RARCs are as follows:

- N781 - Alert: Patient is a Medicaid/ Qualified Medicare Beneficiary. Review your records for any wrongfully collected deductible. This amount may be billed to a subsequent payer.
- N782 – Alert: Patient is a Medicaid/ Qualified Medicare Beneficiary. Review your records for any wrongfully collected coinsurance. This amount may be billed to a subsequent payer.

CR 9911 changes to the MSN by including QMB messages and reflecting $0 cost-sharing liability for the period beneficiaries are enrolled in QMB.

### ADDITIONAL INFORMATION

The official instruction, MM10433, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R3993CP.pdf.

### DOCUMENT HISTORY

| Date of Change | Description |
|---|---|
| March 13, 2018 | This article was revised to reflect an updated CR. That CR added CARCs 66, 247, and 248 (page 3 above). DME MACs were added to the "Providers Affected" section and the QMB enrollment numbers were also updated on page 2 to reflect 2016 statistics. Pharmacies were also included in the "Background" section. The CR date, transmittal number and link to the transmittal also changed. All other information is unchanged. |
| February 28, 2018 | This article was revised to correct a date in the "What you Need to Know" Section. The date should have been December 8, 2017." All other information is unchanged. |
| February 2, 2018 | Initial article released. |

## HCPCS Drug/Biological Code Changes - April 2018 Update – Revised

**MLN Matters Number: MM10454 Revised**
**Related Change Request (CR) Number: 10454**
**Related CR Release Date: March 7, 2018**
**Effective Date: April 1, 2018**
**Related CR Transmittal Number: R3997CP**
**Implementation Date: April 2, 2018**

This article was revised on March 8, 2018, to reflect an updated Change Request (CR). That CR provided additional instructions for the MACs, regarding use of the long descriptors. The CR date, transmittal number and link to the transmittal also changed. All other information is unchanged.

### PROVIDER TYPES AFFECTED

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

### WHAT YOU NEED TO KNOW

The HCPCS code set is updated on a quarterly basis. Change Request (CR) 10454 informs MACs of the April 2018 updates of specific biosimilar biological product HCPCS code, modifiers used with these biosimilar biologic products and an autologous cellular immunotherapy treatment. Be sure your staffs are aware of these updates.

### BACKGROUND

CR 10454 describes updates associated with the following biosimilar biological product HCPCS codes and modifiers. The April 2018 HCPCS file includes three new HCPCS codes: Q5103, Q5104, and Q2041 Also, the April 2018 HCPCS file includes a revision to the descriptor for HCPCS code Q5101.

Effective for services as of April 1, 2018, The April 2018 HCPCS file includes these revised/new HCPCS codes:

HCPCS Code: Q5101

- Short Description: Injection, zarxio
- Long Description: Injection, filgrastim-sndz, biosimilar, (zarxio), 1 microgram

HCPCS Code: Q5103

- Short Description: Injection, inflectra
- Long Description: Injection, infliximab-dyyb, biosimilar, (inflectra), 10 mg
- Type of Service (TOS) Code: 1,P
- Medicare Physician Fee Schedule Database (MPFSDB) Status Indicator: E

HCPCS Code: Q5104

- Short Description: Injection, renflexis
- Long Description: Injection, infliximab-abda, biosimilar, (renflexis), 10 mg
- TOS Code: 1, P
- MPFSDB Status Indicator: E

HCPCS Code:Q2041

- Short Description: Axicabtagene ciloleucel car+
- Long Description: Axicabtagene Ciloleucel, up to 200 million autologous Anti-CD19 CAR T Cells, Including leukapheresis and dose preparation procedures, per infusion
- TOS Code: 1
- MPFSDB Status Indicator: E

Effective for claims with dates of service on or after April 1, 2018, HCPCS code Q5102 (which describes both currently available versions of infliximab biosimilars) will be replaced with two codes, Q5103 and Q5104. Thus, Q5102 Injection, infliximab, biosimilar, 10 mg, will be discontinued, effective March 31, 2018.

Also, beginning on April 1, 2018, modifiers that describe the manufacturer of a biosimilar product (for example, ZA, ZB and ZC) will no longer be required on Medicare claims for HCPCS codes for biosimilars. However, please note that HCPCS code Q5102 and the requirement to use biosimilar modifiers remain in effect for dates of service prior to April 1, 2018.

Medicare Part B policy changes for biosimilar biological products were discussed in the Calendar Year (CY) 2018 Physician Fee Schedule (PFS) final rule at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1676-F.html. Effective January 1, 2018, newly approved biosimilar biological products with a common reference product will no longer be grouped into the same billing code. The rule also stated that instructions for new codes for biosimilars that are currently grouped into a common payment code and the use of modifiers would be issued.

**ADDITIONAL INFORMATION**

The official instruction, CR 10454, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R3997CP.pdf.

**DOCUMENT HISTORY**

| Date of Change | Description |
|---|---|
| March 8, 2018 | This article was revised to reflect an updated CR. That CR provided additional instructions for the MACs, regarding use of the long descriptors. The CR date, transmittal number and link to the transmittal also changed. All other information is unchanged |
| February 2, 2018 | Initial article released. |

# Medical Genetics and Genomics – New Physician Specialty Code

MLN Matters Number: MM10457
Related Change Request (CR) Number: 10457
Related CR Release Date: April 27, 2018
Effective Date: October 1, 2018
Related CR Transmittal Number: R304FM and R4039CP
Implementation Date: October 1, 2018

## PROVIDER TYPE AFFECTED

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

## PROVIDER ACTION NEEDED

This article is based on Change Request (CR) 10457 which informs MACs that CMS has established a new physician specialty code for Medical Genetics and Genomics (D3).

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

## BACKGROUND

Physicians self-designate their Medicare physician specialty on the Medicare enrollment application (CMS-855I or CMS-855O) or Internet-based Provider Enrollment, Chain and Ownership System (PECOS) when they enroll in the Medicare program. Medicare physician specialty codes describe the specific/unique types of medicine that physicians (and certain other suppliers) practice. The Centers for Medicare & Medicaid Services (CMS) uses specialty codes for programmatic and claims processing purposes. CMS has established a new physician specialty code for Medical Genetics and Genomics. The new code is D3. MACs will accept and recognize the new code of D3.

## ADDITIONAL INFORMATION

CR10457 revises "The Medicare Financial Management Manual," Chapter 6, and the "Medicare Claims Processing Manual," Chapter 26, to reflect this new specialty code. The revised manual sections are attached to CR10457.

The official instruction, CR10457, issued to your MAC regarding this change via two transmittals. The first updates the "Medicare Financial Management Manual" and it is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R304FM.pdf. The second updates the Medicare Claims Processing Manual and it is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4039CP.pdf.

## DOCUMENT HISTORY

| Date of Change | Description |
|---|---|
| April 27, 2018 | Initial article released. |

# Adjustments to QMB Claims Processed Under CR 9911

**MLN Matters Number: MM10494**

**Related Change Request (CR) Number: CR10494**

**Related CR Release Date: March 16, 2018**

**Effective Date: December 20, 2018, for Part B MAC claims and September 20, 2018, for Part A and DME MAC claims**

**Related CR Transmittal Number: R2042OTN**

**Implementation Date: December 20, 2018, for Part B MAC claims and September 20, 2018, for Part A and DME MAC claims**

## PROVIDER TYPE AFFECTED

This MLN Matters® Article is intended for providers and suppliers submitting claims to Medicare Administrative Contractors (MACs), including Home Health & Hospice MACs and Durable Medical Equipment (DME) MACs, for services provided to Qualified Medicare Beneficiaries (QMB).

## PROVIDER ACTION NEEDED

This article is based on Change Request (CR) 10494 which directs MACs to mass adjust QMB claims impacted by CR9911. (An article related to CR9911 is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm9911.pdf.) Make sure that your billing staff is aware of these upcoming claims adjustments.

## BACKGROUND

CR9911 incorporates claims processing system modifications implemented on October 2, 2017, to generate QMB information in Remittance Advices (RAs) and Medicare Summary Notices. Providers may use RAs to bill State Medicaid Agencies and other secondary payers outside the Coordination of Benefits Agreement (COBA) crossover process, but CR9911 RAs lacked the formatting and specificity that States require to process QMB cost-sharing claims.

To address these issues, on December 8, 2017, the Centers for Medicare & Medicaid Services (CMS) temporarily suspended the CR9911 claims processing system modifications. See "QMB Remittance Advice Issue" at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MM9911Update112017.pdf.

Through CR10433, CMS will reintroduce QMB information in the RA starting July 2018 and modify CR9911 to avoid disrupting claims processing by secondary payers. CR10433 will be effective for claims processed on or after July 2, 2018. A related article is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm10433.pdf.

Under CR10494, MACs will initiate non-monetary mass adjustments for claims impacted by CR 9911 QMB RA changes, which include claims that were paid after October 2, 2017 and up to December 31, 2017, and that have not been voided or replaced. MACs will issue replacement RAs without the CR 9911 changes and re-process QMB cost-sharing claims by secondary payers by December 20, 2018, for Part B/MAC claims and by September 20, 2018, for Part A/MAC and Durable Medical Equipment MAC claims.

Providers may use the new RAs to resubmit State Medicaid QMB cost-sharing claims that States initially failed to pay due to CR 9911 QMB RA changes. To avoid duplicate claims, providers should not resubmit claims that secondary payers successfully processed through direct claims submission or the COBA process.

Note that although mass-adjusted claims may not cross over, this solution targets affected providers who attempted to bill supplemental payers directly using CR9911 QMB RAs because their QMB cost-sharing claims either did not cross over or crossed over to supplemental payers but failed to process. The goal is to produce replacement Medicare RAs that providers can submit to supplemental payers to coordinate benefits as necessary.

Make sure your billing staff is aware of these changes.

### ADDITIONAL INFORMATION

The official instruction, CR10494, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R2042OTN.pdf.

### DOCUMENT HISTORY

| Date of Change | Description |
|---|---|
| March 22, 2018 | Initial article released. |

## DMEPOS Fee Schedule – April 2018 Update

**MLN Matters Number: 10503**
**Related Change Request (CR) Number: CR10503**
**Related CR Release Date: March 21, 2018**
**Effective Date: April 1, 2018**
**Related CR Transmittal Number: R4004CP**
**Implementation Date: April 2, 2018**

### PROVIDER TYPE AFFECTED

This MLN Matters® Article is intended for providers and suppliers submitting claims to Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) items or services paid under the DMEPOS fee schedule.

### PROVIDER ACTION NEEDED

Change Request (CR) 10503 provides the April 2018 Medicare DMEPOS fee schedule quarterly update. It provides specific instructions to your DME MAC for implementing updated Oxygen Volume Adjustments.

When necessary, the DMEPOS fee schedule is updated quarterly, to implement fee schedule amounts for new codes, to correct any fee schedule amounts for existing codes (as applicable) and to apply changes in payment policies. It contains fee schedule amounts for both non-rural and rural areas. Additionally, the parenteral and enteral nutrition (PEN) fee schedule file includes state fee schedule amounts for enteral nutrition items and national fee schedule amounts for parental nutrition items.

There were no Quarter 2, 2018 Rural ZIP code changes, so an April 2018 DMEPOS Rural ZIP code file will not be furnished as part of this update; and there was no change to the PEN fee schedule file for Quarter 2, 2018 so a new PEN fee schedule file will not be furnished as part of this update.

### BACKGROUND

Section 1834(a), (h), and (i) of the Social Security Act (the Act) require payment for Durable Medical Equipment (DME), prosthetic devices, orthotics, prosthetics and surgical dressings be completed on a fee schedule basis. Further, payment on a fee schedule basis is a regulatory requirement at 42 Code of Federal Regulations (CFR) §414.102s, for parenteral and enteral nutrition, splints, casts and Intraocular Lenses (IOLs) inserted in a physician's office.

Additionally, Section 1834(a)(1)(F)(ii) of the Act mandates adjustments to the fee schedule amounts for certain items furnished on or after January 1, 2016, in areas that are not competitive bid areas, based on information from Competitive Bidding Programs (CBPs) for DME. Section 1842(s)(3)(B) of the Act provides authority for making adjustments to the fee schedule amount for enteral nutrients, equipment and supplies (enteral nutrition) based on information from CBPs.

The methodologies for adjusting DMEPOS fee schedule amounts under this authority are established at 42 CFR §414.210(g). The DMEPOS and PEN fee schedule files contain Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the adjustments, as well as codes that are not subject to the fee schedule CBP adjustments.

Additional information on adjustments to the fee schedule amounts based on information from CBPs is available in Transmittal 3551, CR 9642, dated June 23, 2016 and Transmittal 3416, CR 9431, dated November 23, 2015. You can find the MLN Matters articles associated with these Change

Requests at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9642.pdf, and https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9431.pdf, respectively.

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 fee schedules 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 on the CMS Website at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html.

K0903

As part of this update, CR 10503 is adding fee schedule amounts for HCPCS code K0903 (For Diabetics Only, Multiple Density Insert, Made By Direct Carving With CAM Technology From A Rectified CAD Model Created From A Digitized Scan Of The Patient, Total Contact With Patient's Foot, Including Arch, Base Layer Minimum Of 3/16 Inch Material Of Shore A 35 Durometer (Or Higher), Includes Arch Filler And Other Shaping Material, Custom Fabricated, Each), effective for claims with dates of service on or after April 1, 2018. The fees for code K0903 are set based on the fees for code A5513 because inserts carved from a digitized scan of the patient's foot were determined to be comparable to inserts made over a positive model of the patient's foot.

Oxygen Volume Adjustments

As part of the 2017 April Quarterly DMEPOS fee schedule update (Please refer to the associated MLN Matters article at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9988.pdf), the 'QF' modifier (Prescribed amount of oxygen is greater than 4 Liter Per Minute (LPM) and portable oxygen is prescribed) was added to the DMEPOS fee schedule for use with both stationary and portable oxygen when the oxygen flow rate exceeds 4 liters per minute (LPM) and portable oxygen is prescribed.

Section 1834(a)(5)(C) and (D) of the Act requires that when an oxygen flow rate exceeds 4 LPM, the Medicare payment amount be the higher of

- 50 percent of the stationary payment amount (HCPCS codes E0424, E0439, E1390, or E1391); or
- The portable oxygen add-on amount (HCPCS codes E0431, E0433, E0434, E1392 or K0738); and
- Never both.

The stationary oxygen QF modifier fee schedule amounts represent 100 percent of the stationary oxygen fee schedule amount. The portable oxygen 'QF' fee schedule amounts represent the higher of 1) 50 percent of the monthly stationary oxygen payment amount; or 2) The fee schedule amount for the portable oxygen add-on amount. The 'QF' modifier is billed on both the stationary oxygen and portable oxygen code when the prescribed amount of oxygen is greater than 4 LPM, portable oxygen is prescribed, and there is no difference in the prescribed flow rate for nighttime and daytime use.

CR 10503 provides that effective April 1, 2018:

The 'QF' modifier is revised to read as follows:

QF – (PRESCRIBED AMOUNT OF STATIONARY OXYGEN WHILE AT REST EXCEEDS 4 LITERS PER MINUTE (LPM) AND PORTABLE OXYGEN IS ; and

The following new oxygen volume adjustment modifier is added to the HCPCS file:

QB – (PRESCRIBED AMOUNTS OF STATIONARY OXYGEN FOR DAYTIME USE WHILE AT REST AND NIGHTTIME USE DIFFER AND THE AVERAGE OF THE TWO AMOUNTS EXCEEDS 4 LITERS PER MINUTE (LPM) AND PORTABLE OXYGEN IS PRESCRIBED).

Specifically (effective April 1, 2018), the modifier 'QB' should be used in conjunction with claims submitted for stationary oxygen (codes E0424, E0439, E1390, or E1391) and portable oxygen (codes E0431, E0433, E0434, E1392, or K0738) when the prescribed amount of oxygen for daytime and nighttime differ and the average of the two amounts is greater than 4 liters per minute (LPM) and portable oxygen is prescribed.

For more information on April 1, 2018, changes to the pricing modifiers for oxygen flow rate, please refer to MLN Matters Article MM10158, titled 'Revised and New Modifiers for Oxygen Flow Rate."

Please note that the 'QB' modifier is used in billing to denote when: 1) The average prescribed amount of oxygen is greater than 4 LPM; 2) Portable oxygen is prescribed; and 3) There is a difference in the prescribed flow rates for nighttime and for daytime use. In these instances, regulations at 42 CFR 414.226(e)(3)(iii) require that an average of the varying nighttime and daytime flow rates is to be used in determining the volume adjustment. Therefore, the 'QB' modifier is used when the average of the nighttime and daytime flow rates exceed 4 LPM and portable oxygen is prescribed.

In addition, please note that Section 1834(a)(5)(C) and (D) of the Act also applies to the 'QB' modifier. This section of the Act requires that, when the oxygen flow rate exceeds 4 LPM, the Medicare payment amount is to be: 1) The higher of 50 percent of the stationary payment amount (codes E0424, E0439, E1390, or E1391); or 2) The portable oxygen add-on amount (E0431, E0433, E0434, E1392 or K0738); and 3) Never both.

To facilitate this payment calculation, CR 10503 adds the 'QB' modifier (effective April 1, 2018) to the DMEPOS fee schedule file, for both stationary and portable oxygen.

The stationary oxygen 'QB' modifier fee schedule amounts represent 100 percent of the stationary oxygen fee schedule amount. The portable oxygen 'OB' fee schedule amounts represent the higher of 1) 50 percent of the monthly stationary oxygen payment amount or 2) the fee schedule amount for the portable oxygen add-on amount.

### ADDITIONAL INFORMATION

The official instruction, CR 10503, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4004CP.pdf.

### DOCUMENT HISTORY

| Date of Change | Description |
|---|---|
| March 22, 2018 | Initial article released |

## DME Payment Classification for SGD and Accessories – Inexpensive or Routinely Purchased

**MLN Matters Number: MM10604**
**Related Change Request (CR) Number: 10604**
**Related CR Release Date: April 27, 2018**
**Effective Date: October 1, 2018**
**Related CR Transmittal Number: R4027CP**
**Implementation Date: October 1, 2018**

### PROVIDER TYPES AFFECTED

This MLN Matters Article is intended for suppliers of Durable Medical Equipment, Prosthetics, Orthotics and Suppliers (DMEPOS) submitting claims to Medicare Administrative Contractors (MACs) for speech generating devices (SGDs) and accessories provided to Medicare beneficiaries.

### PROVIDER ACTION NEEDED

Change Request (CR) 10604 ensures that the use of SGDs and accessories continue to be classified under the inexpensive or routinely purchased DME payment category. Please make sure your billing staffs are aware of this update, which relates to the Medicare Claims Processing Manual, Chapter 20, sections 30.1 and 130.2. The relevant sections of the manual are included at the end of CR10604.

### BACKGROUND

Effective October 1, 2015, amendments to Section 1834(a)(2)(A) of the Social Security Act (the Act), the "Steve Gleason Enduring Voices Act of 2017," changed the DME payment category for SGDs and

accessories essential for the effective use of the SGD furnished between October 1, 2015 and September 30, 2018, from capped rental to inexpensive or routinely purchased.

CR 10604 provides instructions regarding the recent amendment of Section 1834(a)(2)(A) of the Act under the Bipartisan Budget Act of 2018 (BBA), which makes the inexpensive or routinely purchased payment category permanent for SGDs and SGD accessories by removing the end date, "and before October 1, 2018," from the statute. Because of the amendment under Section 50411 of the BBA of 2018, SGDs and their accessories will continue to be classified as inexpensive or routinely purchased items and subject to the payment rules outlined in Section 1834(a)(2) of the Act on or after October 1, 2018.

Items in this payment category are paid on a purchased new, purchased used, or rental basis. Total payments for items in this payment category (sum of allowed charges for all claims for rental or purchase) may not exceed the fee schedule amount/single payment amount for the purchase of the equipment.

### ADDITIONAL INFORMATION

The official instruction, CR 10604, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4027CP.pdf.

### DOCUMENT HISTORY

| Date of Change | Description |
|---|---|
| May 1, 2018 | Initial article released. |

## ICD-10 and Other Revisions to NCDs

**MLN Matters Number: MM10622**
**Related Change Request (CR) Number: 10622**
**Related CR Release Date: May 4, 2018**
**Effective Date: October 1, 2018**
**Related CR Transmittal Number: R2076OTN**
**Implementation Date: October 1, 2018**

### PROVIDER TYPES AFFECTED

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

### PROVIDER ACTION NEEDED

Change Request (CR) 10622 constitutes a maintenance update of International Code of Diseases, 10th Revision (ICD-10) conversions and other coding updates specific to National Coverage Determinations (NCDs). These NCD coding changes are the result of newly available codes, coding revisions to NCDs released separately, or coding feedback received. Please follow the link below for the NCD spreadsheets included with this CR: https://www.cms.gov/Medicare/Coverage/DeterminationProcess/downloads/CR10622.zip.

### BACKGROUND

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

No policy-related changes are included with these updates. Any policy-related changes to NCDs continue to be implemented via the current, long-standing NCD process.

Coding (as well as payment) is a separate and distinct area 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 one-to-one matches, nor are all ICD-10 codes appearing in a complete General Equivalence Mappings (GEMs) mapping guide or other mapping guides appropriate when reviewed against individual NCD policies. In addition, for those policies that expressly allow MAC discretion, there may be changes to those NCDs based on current review of those NCDs against ICD-10 coding. For these reasons, there may be certain ICD-9 codes that were once considered appropriate prior to ICD-10 implementation that are no longer considered acceptable.

CR10622 makes coding and clarifying adjustments to the following NCDs:

- NCD 110.18 Aprepitant
- NCD 150.3 Bone Mineral Density Studies
- NCD 190.11 Prothrombin Time/International Normalized Ratio (PT/INR)
- NCD 220.6.16 Positron Emission Tomography (PET) for Infection/Inflammation
- NCD 220.6.17 PET for Solid Tumors
- NCD 220.13 Percutaneous Image-Guided Breast Biopsy

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

- Group Code PR (Patient Responsibility) assigning financial responsibility to the beneficiary (if a claim is received with occurrence code 32, or with occurrence code 32 and a GA modifier, indicating a signed Advance Beneficiary Notice (ABN) is on file).
- Group Code CO (Contractual Obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file). For modifier GZ, use CARC 50 and Medicare Summary Notice (MSN) 8.81 per instructions in CR 7228/TR 2148.

### ADDITIONAL INFORMATION

The official instruction, CR 10622, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R2076OTN.pdf.

### DOCUMENT HISTORY

| Date of Change | Description |
|---|---|
| May 9, 2018 | Initial article released. |

## HCPCS Drug/Biological Code Changes - July 2018 Update – Revised

**MLN Matters Number: MM10624 Revised**
**Related Change Request (CR) Number: 10624**
**Related CR Release Date: May 11, 2018**
**Effective Date: July 1, 2018**
**Related CR Transmittal Number: R4048CP**
**Implementation Date: July 2, 2018**

This article was revised on May 14, 2018, to reflect a revised CR issued on May 11. In the article, a sentence is added to show that Part B payment for Q9995 includes the clotting factor furnishing fee. Also, the CR release date, transmittal number, and the Web address of the CR are revised. All other information is the same.

### PROVIDER TYPES AFFECTED

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

## PROVIDER ACTION NEEDED

Change Request (CR) 10624 informs MACs of updated drug/biological HCPCS codes. The HCPCS code set is updated on a quarterly basis. The July 2018 HCPCS file includes 4 new HCPCS codes: Q9991, Q9992, Q9993 and Q9995. Please make sure your billing staffs are aware of these updates.

## BACKGROUND

The July 2018 HCPCS file includes four new HCPCS codes, which are payable by Medicare, effective for claims with dates of service on or after July 1, 2018. Part B payment for HCPCS code Q9995 will include the clotting factor furnishing fee. These codes are:

- Q9991
  - Short Description: Buprenorph xr 100 mg or less
  - Long Description: Injection, buprenorphine extended-release (sublocade), less than or equal to 100 mg
  - Type of Service (TOS) Code: 1
  - Medicare Physician Fee Schedule Data Base (MPFSDB) Status Indicator: E
- Q9992
  - Short Description: Buprenorphine xr over 100 mg
  - Long Description: Injection, buprenorphine extended-release (sublocade), greater than 100 mg
  - TOS Code: 1
  - MPFSDB Status Indicator: E
- Q9993
  - Short Description: Inj., triamcinolone ext rel
  - Long Description: Injection, triamcinolone acetonide, preservative-free, extended-release, microsphere formulation, 1 mg
  - TOS Code: 1,P
  - MPFSDB Status Indicator: E
- Q9995
  - Short Description: Inj. emicizumab-kxwh, 0.5 mg
  - Long Description: Injection, emicizumab-kxwh, 0.5 mg
  - TOS Code: 1
  - MPFSDB Status Indicator: E

## ADDITIONAL INFORMATION

The official instruction, CR 10624, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and- Guidance/Guidance/Transmittals/2018Downloads/R4048CP.pdf.

## DOCUMENT HISTORY

| Date of Change | Description |
|---|---|
| May 14, 2018 | This article was revised to reflect a revised CR issued on May 11. In the article, a sentence is added to show that Part B payment for Q9995 includes the clotting factor furnishing fee. Also, the CR release date, transmittal number, and the Web address of the CR are revised. All other information is the same. |
| April 20, 2018 | Initial article released. |

# ASP Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files – July 2018 Quarterly Update

**MLN Matters Number: MM10667**
**Related Change Request (CR) Number: 10667**
**Related CR Release Date: May 25, 2018**
**Effective Date: July 1, 2018**
**Related CR Transmittal Number: R4061CP**
**Implementation Date: July 2, 2018**

## PROVIDER TYPE AFFECTED

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

## PROVIDER ACTION NEEDED

Change Request (CR) 10667 instructs MACs to download and implement the July 2018 and, if released, the revised April 2018, January 2018, October 2017, and July 2017 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 July 2, 2018, with dates of service July 1, 2018, through September 30, 2018. Make sure that your billing staffs are aware of these changes.

## BACKGROUND

The Average Sales Price (ASP) methodology is based on quarterly data submitted by manufacturers to CMS. CMS supplies MACs with the ASP and Not Otherwise Classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the Outpatient Prospective Payment System (OPPS) are incorporated into the Outpatient Code Editor (OCE) through separate instructions that are 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: July 2018 ASP and ASP NOC -- Effective Dates of Service: July 1, 2018, through September 30, 2018
- File: April 2018 ASP and ASP NOC -- Effective for Dates of Service of April 1, 2018, through June 30, 2018
- File: January 2018 ASP and ASP NOC -- Effective for Dates of Service of January 1, 2018, through March 31, 2018
- File: October 2017 ASP and ASP NOC -- Effective for Dates of Service of October 1, 2017, t hrough December 31, 2017
- File: July 2017 ASP and ASP NOC -- Effective for Dates of Service of July 1, 2017, through September 30, 2017

For any drug or biological not listed in the ASP or NOC drug pricing files, your 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 at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c17.pdf.

For any drug or biological not listed in the ASP or NOC drug pricing files that is billed with the KD modifier, MACs will determine the payment allowance limits in accordance with instructions for pricing and payment changes for infusion drugs furnished through an item of durable medical equipment on or after January 1, 2017, associated with the passage of the 21st Century Cures Act which is available at https://www.gpo.gov/fdsys/pkg/PLAW-114publ255/pdf/PLAW-114publ255.pdf.

## ADDITIONAL INFORMATION

The official instruction, CR 10667, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4061CP.pdf.

**DOCUMENT HISTORY**

| Date of Change | Description |
|---|---|
| May 25, 2018 | Initial article released |

# Prohibition on Billing Dually Eligible Individuals Enrolled in the QMB Program – Eighth Revision

## MLN Matters Number: SE1128 Revised

## Related CR Release Date: March 22, 2018

This article was revised on March 22, 2018 to include updated information about the Remittance Advice (RA) and Medicare Summary Notice (MSN) for all Medicare Fee-For-Service (FFS) QMB claims. It also includes new statistics on the number of beneficiaries enrolled in QMB. All other information remains the same.

**PROVIDER TYPE AFFECTED**

This article pertains to all Medicare providers and suppliers, including pharmacies that serve 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, including pharmacies, 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 Part B deductibles, coinsurance, or copays for any Medicare-covered items and services.

Implement key measures to ensure compliance with QMB billing requirements. Use HIPAA Eligibility Transaction System (HETS) (effective November 2017), CMS' eligibility-verification system, and the provider RA (July 2018) to identify beneficiaries' QMB status and exemption from cost-sharing prior to billing. Starting July 2018, look for QMB alerts messages in the Remittance Advice for FFS claims to verify QMB after claims processing. 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 not charge 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 2016, 7.5 million individuals (more than one out of eight beneficiaries) were enrolled in the QMB program.

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. For more information about bad debt, refer to 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, providers and suppliers continue to improperly bill individuals enrolled in the QMB program. 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 Medicare beneficiaries prior to billing for items and services.

- Use Medicare eligibility data provided to Medicare providers, suppliers, and their authorized billing agents (including clearinghouses and third party vendors) by CMS' HETS (effective November 2017) to verify a beneficiary's QMB status and exemption from cost-sharing charges. Ask your third party eligibility-verification vendors how their products reflect the new QMB information from HETS. For more information on HETS, visit https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/index.html.
- In July 2018, CMS will reintroduce QMB information in the Medicare RA that Original Medicare providers and suppliers can use to identify the QMB status of beneficiaries. Refer to the Additional Information section below for educational materials on recent changes that impact RAs for Medicare FFS QMB claims.
- MA providers and suppliers should also contact the MA plan to learn the best way to identify the QMB status of plan members both before and after claims submission.

2. Providers and suppliers may also verify beneficiaries' QMB status through automated Medicaid eligibility-verification systems in the State in which the person is a resident or by asking beneficiaries for other proof, such as their Medicaid identification card or documentation of their QMB status. 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 individuals enrolled in the QMB program, recall the charges (including referrals to collection agencies) and refund the invalid charges they paid.

3. Determine the billing processes that apply to seeking payment for Medicare cost-sharing from the States in which the beneficiaries you serve reside. 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.

States require all providers, including Medicare providers, to enroll in their Medicaid system for provider claims review, processing, and issuance of the Medicaid RA. Providers should contact the State Medicaid Agency for additional information regarding Medicaid provider enrollment.

**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 not charge individuals enrolled in the QMB program for Medicare cost-sharing.

2. Individuals enrolled in the QMB program keep 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 from a different State than the State where they get care.

3. Note that individuals enrolled in QMB cannot elect to pay Medicare deductibles, coinsurance, and copays. However, a QMB who also receives full Medicaid may have a small Medicaid copay.

**ADDITIONAL INFORMATION**

For more information on this process, refer to Section HI 00801.140 of the Social Security Administration Program Operations Manual System.

Refer to these educational materials for information on recent changes that impact RAs and MSNs for Medicare FFS QMB claims:

- MLN Matters Article MM9911, discusses the claims processing system modifications implemented on October 2, 2017, to generate QMB information in the RAs and MSNs.
- On December 8, 2017, the claims processing system modifications made on October 2, 2017, were temporarily suspended due to unintended issues that affected processing QMB cost-sharing claims by States and other payers secondary to Medicare. For more information, refer to QMB Remittance Advice Issue.
- MLN Matters Article 10494 describes how Medicare Administrative Contractors (MACs) will issue replacement RAs for QMB claims paid on or after October 2, 2017, through December 31, 2017, that have not been voided or replaced. MACs will issue replacement RAs by December 20, 2018, for Part B claims and by September 20, 2018, for Part A/Durable Medical Equipment claims.
- MLN Matters Article MM10433 discusses how CMS will reintroduce QMB information in the RA starting July 2018 and modify to CR 9911 to avoid disrupting claims processing by secondary payers.

For more information about dual eligibles under Medicare and Medicaid, please visit https://www.medicaid.gov/affordable-care-act/dual-eligibles/index.html and https://www.medicaid.gov/medicaid/eligibility/medicaid-enrollees/index.html and refer to Dual Eligible Beneficiaries Under Medicare and Medicaid. For general Medicaid information, please visit http://www.medicaid.gov/index.html.

**DOCUMENT HISTORY**

| Date of Change | Description |
|---|---|
| March 22, 2018 | The article was revised to indicate that CMS will reintroduce QMB information in the Medicare Remittance Advice (RA) and Medicare Summary Notice (MSN) for all claims processed on or after July 2, 2018. CMS initially included QMB information in RAs and MSNs for claims processed on or after October 2, 2017, but suspended those changes on December 8, 2017, to address unforeseen issues preventing the processing of QMB cost-sharing claims by States and other secondary payers outside of the Coordination of Benefits Agreement (COBA) process. All other information remains the same. |
| December 4, 2017 | The article was revised to indicate that on December 8, 2017, CMS will suspend modifications to the Provider Remittance Advice and the Medicare Summary Notice for QMB claims made on October 2, 2017. The article was also revised to show the HETS QMB release was implemented in November 2017. Finally, the article was changed to clarify that QMBs cannot elect to pay Medicare cost-sharing but may need to pay a small Medicaid copay in certain circumstances. All other information remains the same. |
| November 3, 2017 | Article revised to show the HETS QMB release will be in November 2017. All other information remains the same. |

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|---|---|
| October 18, 2017 | The article was revised to indicate that the Provider Remittance Advice and the Medicare Summary Notice for beneficiaries identifies the QMB status of beneficiaries and exemption from cost-sharing for Part A and B claims processed on or after October 2, 2017, and to recommend how providers can use these and other upcoming system changes to promote compliance with QMB billing requirements. All other information remains the same. |
| August 23, 2017 | The article was revised 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. |
| May 12, 2017 | This article was revised on May 12, 2017, to modify language pertaining to billing beneficiaries enrolled in the QMB program. All other information is the same. |
| January 12, 2017 | This article was revised to add a reference to MLN Matters article MM9817, which instructs Medicare Administrative Contractors to issue a compliance letter instructing named providers to refund any erroneous charges and recall any existing billing to QMBs for Medicare cost sharing. |
| February 4, 2016 | The article was revised on February 4, 2016, to include updated information for 2016 and a correction to the second sentence in paragraph 2 under Important Clarifications Concerning QMB Balance Billing Law on page 3. |
| February 1, 2016 | The article was revised to include updated information for 2016 and a clarifying note regarding eligibility criteria in the table on page 4. |
| March 28, 2014 | The article was revised on to change the name of the Coordination of Benefits Contractor (COBC) to BCRC. |

## Specimen Validity Testing Billed in Combination with Drug Testing Proper Coding

### MLN Matters Number: SE18001

### Article Release Date: March 29, 2018

#### PROVIDER TYPES AFFECTED

This MLN Matters Article is intended for laboratories and other providers billing Medicare Administrative Contractors (MACs) for urine drug test services provided to Medicare beneficiaries.

#### PROVIDER ACTION NEEDED

This MLN Matters Special Edition article reminds laboratories and other providers about how to properly bill for specimen validity testing done in conjunction with drug testing. This article contains no policy changes, but serves as a reminder to laboratories and providers of current Medicare requirements. Please make sure your billing staffs are aware of these instructions.

#### BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) is issuing SE18001 to remind laboratories and other providers about the correct coding and instructions for billing specimen validity testing when done as a part of drug testing.

Section 1862(a)(1)(A) of the Social Security Act provides that Medicare payment may not be made for services that are not reasonable and necessary. Clinical laboratory services must be ordered and used by the physician who is treating the beneficiary as described in 42 CFR 410.32(a), or by a qualified nonphysician practitioner, as described in 42 CFR 4310.32(a)(3).

Current coding for testing for drugs of abuse relies on a structure of "screening" (known as "presumptive" testing) and "quantitative" or "definitive" testing that identifies the specific drug and quantity in the patient.

Beginning January 1, 2017, presumptive drug testing may be reported with CPT codes 80305-80307. These codes differ based on the level of complexity of the testing methodology. Only one code from this code range may be reported per date of service.

The descriptors for Presumptive Drug Testing codes are:

**80305:** Drug tests(s), presumptive, any number of drug classes; any number of devices or procedures, (eg, immunoassay) capable of being read by direct optical observation only (eg, dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service.

**80306:** Drug tests(s), presumptive, any number of drug classes; any number of devices or procedures, (eg, immunoassay) read by instrument-assisted direct optical observation (eg, dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service.

**80307:** Drug tests(s), presumptive, any number of drug classes, qualitative, any number of devices or procedures; by instrument chemistry analyzers (eg, utilizing immunoassay [eg, EIA, ELISA, EMIT, FPIA, IA, KIMS, RIA]), chromatography (eg, GC, HPLC), and mass spectrometry either with or without chromatography, (eg, DART, DESI, GC-MS, GC-MS/MS, LC-MS, LC-MS/MS, LDTD, MALDI, TOF) includes sample validation when performed, per date of service.

As mentioned in the National Correct Coding Initiative Policy Manual, Chapter 10, Section E, beginning January 1, 2016, definitive drug testing may be reported with HCPCS codes G0480-G0483. These codes differ based on the number of drug classes including metabolites tested. Only one code from this code range may be reported per date of service.

The descriptors for Definitive Drug Testing codes are:

**G0480:** Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day; 1-7 drug class(es), including metabolite(s) if performed

**G0481:** Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day; 8-14 drug class(es), including metabolite(s) if performed

**G0482:** Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day; 15-21 drug class(es), including metabolite(s) if performed

**G0483:** Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-

matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day; 22 or more drug class(es), including metabolite(s) if performed

In addition, definitive drug testing code G0659 was created to recognize those laboratories that are performing a less sophisticated version of these tests than is usually performed in drug testing laboratories:

**G0659:** Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem), excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase), performed without method or drug-specific calibration, without matrix-matched quality control material, or without use of stable isotope or other universally recognized internal standard(s) for each drug, drug metabolite or drug class per specimen; qualitative or quantitative, all sources, includes specimen validity testing, per day, any number of drug classes

The work performed in this test approximates the work performed in CPT code 80307.

Providers performing validity testing on urine specimens utilized for drug testing shall not separately bill the validity testing. For example, if a laboratory performs a urinary pH, specific gravity, creatinine, nitrates, oxidants, or other tests to confirm that a urine specimen is not adulterated, this testing is not separately billed.

## ADDITIONAL INFORMATION

The National Correct Coding Initiative Policy Manual is available in the Downloads section of https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html.

The Office of the Inspector General (OIG) of the Department of Health and Human Services (HHS) recently completed a report that illustrated improper payments for specimen validity tests as part of urine drug testing. To review that report, visit https://oig.hhs.gov/oas/reports/region9/91602034.pdf.

## DOCUMENT HISTORY

| Date of Change | Description |
|---|---|
| March 29, 2018 | Initial article released. |

## Telephone Reopenings: Resources for Success

This article provides the following information on Telephone Reopenings: contact information, hours of availability, required elements, items allowed through Telephone Reopenings, those that must be submitted as a redetermination, and more.

Per the Internet-Only Manual (IOM) Publication 100-04, Chapter 34, Section 10, reopenings are separate and distinct from the appeals process. Contractors should note that while clerical errors must be processed as reopenings, all decisions on granting reopenings are at the discretion of the contractor.

Section 10.6.2 of the same Publication and Chapter states a reopening must be conducted within one year from the date of the initial determination.

| | |
|---|---|
| **How do I request a Telephone Reopening?** | To request a reopening via telephone, call 1-877-320-0390. |
| **What are the hours for Telephone Reopenings?** | Monday through Friday<br>7 a.m. - 6 p.m. CT<br>Further closing information can be found at https://med.noridianmedicare.com/web/jddme/contact/holiday-schedule. |
| **What information do I need before I can initiate a Telephone Reopening?** | Before a reopening can be completed, the caller must have all of the following information readily available as it will be verified by the Telephone Reopenings representative. If at any time the information provided does not match the information in the claims processing system, the Telephone Reopening cannot be completed.<br>• National Provider Identifier (NPI)<br>• Provider Transaction Access Number (PTAN)<br>• Last five digit of Tax ID Number (TIN)<br>• Supplier name<br>• Beneficiary's Health Insurance Claim Number (HICN)<br>• Beneficiary's first and last name<br>• Date of service (DOS)<br>• Last five of the Claim Control Number (CCN)<br>• Healthcare Common Procedure Coding System (HCPCS) code(s) in question<br>• Corrective action to be taken<br>**Note:** Claims with remark code MA130 can **never** be submitted as a reopening (telephone or written). Claims with remark code MA130 are considered unprocessable and do not have reopening or appeal rights. The claim is missing information that is needed for processing or was invalid and must be resubmitted. |

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| **What may I request as a Telephone Reopening?** | The following is a list of clerical errors and omissions that **may** be completed as a Telephone Reopening. Note: This list is not all-inclusive.<br>• Diagnosis code changes or additions<br>• Date of Service (DOS) changes<br>• HCPCS code changes<br>• Certain modifier changes or additions (not an all-inclusive list)<br>  • KH<br>  • KI<br>  • KJ<br>  • RR<br>  • NU<br>  • AU<br>  • KL<br>  • RT<br>  • LT<br>  • A1 – A9<br>**Note:** If, upon research, any of the above change are determined too complex, the caller will be notified the request needs to be sent in writing as a redetermination with the appropriate supporting documentation. |

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| **What is not accepted as a Telephone Reopening?** | The following will not be accepted as a Telephone Reopening and must be submitted as a redetermination with supporting documentation.<br>• Overutilization denials that require supporting medical records<br>• Certificate of Medical Necessity (CMN) and Durable Medical Equipment Information Form (DIF) issues. Please see the article posted March 21, 2013<br>• Oxygen break in service (BIS) issues<br>• Overpayments or reductions in payment<br>• Medicare Secondary Payer (MSP) issues<br>• Claims denied for timely filing<br>• Reopenings past one year from the initial determination<br>• Complex Medical Reviews or Additional Documentation Requests<br>• Advance Beneficiary Notice of Noncoverage (ABN) issues and other liability issues<br>• Repair and labor claims<br>• Miscellaneous HCPCS codes and all HCPCS codes that require manual pricing<br>• The following modifier changes or additions:<br>  • K0 through K4<br>  • GA<br>  • GY<br>  • GZ<br>  • KX<br>  • EY<br>  • RA<br>  • RB<br>  • RP<br>  • JW<br>  • KK<br>• Certain HCPCS codes (not all-inclusive list)<br>  • A4450 through A4452<br>  • E0194<br>  • E0748<br>  • E1028<br>  • J1559<br>  • J1561<br>  • J1562<br>  • K0108<br>  • K0462 |
| **What do I do when I have a large amount of corrections?** | If a supplier has at least 10 of the same correction, that are able to be completed as a reopening, the supplier should notify a Telephone Reopenings representative. The representative will gather the required information for the supplier to submit a Special Project. |

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| **Where can I find more information on Telephone Reopenings?** | Supplier Manual Chapter 13<br>Reopening Section on the Noridian DME website<br>IOM Publication 100-04, Chapter 34 |
| **Additional assistance available** | Suppliers can email questions and concerns regarding reopenings and redeterminations to dmeredeterminations@noridian.com. Please note, emails containing Protected Health Information (PHI) will be returned as unprocessable. |

## LVA EOI Submissions Extended to June 8, 2018

CMS has extended the deadline to submit Low Volume Appeals (LVA) Expression of Interest (EOI) submissions to June 8, 2018. Appellants with either an odd or an even number NPI that meet the eligibility criteria should submit an EOI between April 12, 2018 and June 8, 2018. Details about the process, including a fillable EOI, are available on the Low Volume Appeals Initiative page on the CMS website.

## CERT Documentation

This article is to remind suppliers they must comply with requests from the Comprehensive Error Rate Testing (CERT) Documentation Contractor for medical records needed for the CERT program. An analysis of the CERT related appeals workload indicates the reason for the appeal is due to "no submission of documentation" and "submitting incorrect documentation."

Suppliers are reminded the CERT program produces national, contractor-specific and service-specific paid claim error rates, as well as a supplier compliance error rate. The paid claim error rate is a measure of the extent to which the Medicare program is paying claims correctly. The supplier compliance error rate is a measure of the extent to which suppliers are submitting claims correctly.

The CERT Documentation Contractor sends written requests for medical records to suppliers that include a checklist of the types of documentation required. The CERT Documentation Contractor will mail these letters to suppliers individually. Suppliers must submit documentation to the CERT Operations Center via fax, the preferred method, or mail at the number/address specified below.

The secure fax number for submitting documentation to the CERT Documentation Contractor is 804-261-8100.

Mail all requested documentation to:

AdvanceMed
CERT Documentation Center
1510 East Parham Road
Henrico, VA 23228

The CID number is the CERT reference number contained in the documentation request letter.

Suppliers may call the CERT Documentation Contractor at 888-779-7477 with questions regarding specific documentation to submit.

Suppliers must submit medical records within 75 days from the receipt date of the initial letter or claims will be denied. The supplier agreement to participate in the Medicare program requires suppliers to submit all information necessary to support the services billed on claims.

Also, Medicare patients have already given authorization to release necessary medical information in order to process claims. Therefore, Medicare suppliers do not need to obtain a patient's authorization to release medical information to the CERT Documentation Contractor.

Suppliers who fail to submit medical documentation will receive claim adjustment denials from Noridian as the services for which there is no documentation are interpreted as services not rendered.

## Ankle-Foot/Knee-Ankle-Foot Orthosis (HCPCS L4360, L4361, L4386 and L4387) Quarterly Results of Targeted Probe and Educate Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a targeted probe and educate reviews of HCPCS code(s) L4360, L4361, L4386 and L4387. The quarterly edit effectiveness results from October 2017 through December 2017 are as follows:

Based on dollars, the overall claim potential improper payment rate is **19%**.

**Top Denial Reasons**

- Detailed Written Order (DWO) is incomplete or missing elements.
- Medical record documentation was not authenticated (handwritten or electronic) by the author.
- Claim is the same or similar to another claim on file.
- Documentation does not include verification that the equipment was lost, stolen or irreparably damaged in a specific incident.

For complete detail see, Ankle-Foot/Knee-Ankle-Foot Orthosis (HCPCS L4360, L4361, L4386 and L4387) Quarterly Results of Targeted Probe and Educate Review.

## Enteral Nutrition (HCPCS B4150, B4152, B4154) Quarterly Results of Targeted Probe and Educate Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a targeted probe and educate reviews of HCPCS code(s) B4150, B4152 and B4154. The quarterly edit effectiveness results from October 2017 through December 2017 are as follows:

Based on dollars, the overall claim potential improper payment rate is 87**%**.

**Top Denial Reasons**

- Refill request was not received.

For complete detail see, Enteral Nutrition (HCPCS B4150, B4152, B4154) Quarterly Results of Targeted Probe and Educate Review.

## External Infusion Pumps (HCPCS E0781, E0784) Quarterly Results of Targeted Probe and Educate Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a targeted probe and educate reviews of HCPCS code(s) E0781 and E0784. The quarterly edit effectiveness results from October 2017 through December 2017 are as follows:

Based on dollars, the overall claim potential improper payment rate is **35%**.

**Top Denial Reasons**

- Documentation does not support coverage criteria.
- Documentation does not support continued coverage.
- Detailed Written Order (DWO) is incomplete or missing elements.
- Medical record documentation was not authenticated (handwritten or electronic) by the author.

For complete detail see, External Infusion Pumps (HCPCS E0781, E0784) Quarterly Results of Targeted Probe and Educate Review.

## Glucose Monitors (HCPCS A4253) Quarterly Results of Targeted Probe and Educate Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a targeted probe and educate review of HCPCS code(s) A4253. The quarterly edit effectiveness results from October 2017 through December 2017 are as follows:

Based on dollars, the overall claim potential improper payment rate is **76%**.

**Top Denial Reasons**

- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- No medical record documentation was received. Refer to Medicare Program Integrity Manual 3.2.3.8.
- Documentation does not support high utilization.
- There is no documentation showing the beneficiary has nearly exhausted their supplies.

For complete detail see, Glucose Monitors (HCPCS A4253) Quarterly Results of Targeted Probe and Educate Review.

## Hospital Beds (HCPCS E0250, E0260) Quarterly Results of Targeted Probe and Educate Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a targeted probe and educate reviews of HCPCS code(s) E0250 and E0260. The quarterly edit effectiveness results from October 2017 through December 2017 are as follows:

Based on dollars, the overall claim potential improper payment rate is 14%.

**Top Denial Reasons**

- Documentation does not support coverage criteria for a fixed height hospital bed.
- Advance Beneficiary Notice of Noncoverage (ABN) was not properly executed.
- Documentation does not support coverage criteria for a semi-electric hospital bed.
- Written Order Prior to Delivery (WOPD) is incomplete or missing elements.

For complete detail see, Hospital Beds (HCPCS E0250, E0260) Quarterly Results of Targeted Probe and Educate Review.

## Immunosuppressive Drugs (HCPCS J7507, J7517, J7518, J7520) Quarterly Results of Targeted Probe and Educate Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a targeted probe and educate reviews of HCPCS code(s) J7507, J7517, J7518 and J7520. The quarterly edit effectiveness results from October 2017 through December 2017 are as follows:

Based on dollars, the overall claim potential improper payment rate is 9%.

**Top Denial Reasons**

- Detailed Written Order (DWO) is incomplete or missing elements.
- Medical record documentation was not authenticated (handwritten or electronic) by the author.
- The time limit for filing a claim expired.
- There is no documentation showing the beneficiary has nearly exhausted their supplies.

For complete detail see, Immunosuppressive Drugs (HCPCS J7507, J7517, J7518, J7520) Quarterly Results of Targeted Probe and Educate Review.

## Knee Orthosis (HCPCS L1810, L1812, L1832, L1833, L1843) Quarterly Results of Targeted Probe and Educate Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a targeted probe and educate reviews of HCPCS code(s) L1810, L1812, L1832, L1833 and L1843. The quarterly edit effectiveness results from October 2017 through December 2017 are as follows:

Based on dollars, the overall claim potential improper payment rate is 77%.

**Top Denial Reasons**

- Documentation does not support coverage criteria.
- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Detailed Written Order (DWO) is incomplete or missing elements.
- Documentation does not support custom fit criteria.

For complete detail see, Knee Orthosis (HCPCS L1810, L1812, L1832, L1833, L1843) Quarterly Results of Targeted Probe and Educate Review.

## Manual Wheelchairs (HCPCS K0001 and K0003) Quarterly Results of Targeted Probe and Educate Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a targeted probe and educate reviews of HCPCS code(s) K0001 and K0003. The quarterly edit effectiveness results from October 2017 through December 2017 are as follows:

Based on dollars, the overall claim potential improper payment rate is 57%.

**Top Denial Reasons**

- Detailed Written Order (DWO) was not received.
- Documentation does not support coverage criteria.
- The documentation does not include a written order prior to delivery for the item(s) specified in the Affordable Care Act 6407. Refer to Social Security Act 1834(a)(11)(B)(i).
- Advance Beneficiary Notice of Noncoverage (ABN) was not properly executed.

For complete detail see, Manual Wheelchairs (HCPCS K0001 and K0003) Quarterly Results of Targeted Probe and Educate Review.

## Nebulizer (HCPCS J7605 and J7626) Quarterly Results of Targeted Probe and Educate Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a targeted probe and educate reviews of HCPCS code(s) J7605 and J7626. The quarterly edit effectiveness results from October 2017 through December 2017 are as follows:

Based on dollars, the overall claim potential improper payment rate is 3%.

**Top Denial Reasons**

- The date of service for item(s) billed has been paid.

For complete detail see, Nebulizer (HCPCS J7605 and J7626) Quarterly Results of Targeted Probe and Educate Review.

## Oxygen and Oxygen Equipment (HCPCS E1390, E0431) Quarterly Results of Targeted Probe and Educate Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a targeted probe and educate reviews of HCPCS code(s) E1390 and E0431. The quarterly edit effectiveness results from October 2017 through December 2017 are as follows:

Based on dollars, the overall claim potential improper payment rate is **32%**.

**Top Denial Reasons**

- Documentation does not support coverage criteria.
- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- The documentation does not include a written order prior to delivery for the item(s) specified in the Affordable Care Act 6407.
- Documentation does not support a qualifying blood gas study.

For complete derail see, Oxygen and Oxygen Equipment (HCPCS E1390, E0431) Quarterly Results of Targeted Probe and Educate Review.

## Positive Airway Pressure (PAP) Devices (HCPC E0601) Quarterly Results of Targeted Probe and Educate Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a targeted probe and educate review of HCPCS code E0601. The quarterly edit effectiveness results from October 2017 through December 2017 are as follows:

Based on dollars, the overall claim potential improper payment rate is **3%**.

**Top Denial Reasons**

- The supplier indicated the item(s) were billed in error. Refer to SDL A55426
- Documentation does not support coverage criteria.

For complete detail see, Positive Airway Pressure (PAP) Devices (HCPC E0601) Quarterly Results of Targeted Probe and Educate Review.

## Pre-Claim Hotline - Now Available

Noridian has rolled out a new Pre-Claim hotline for suppliers regarding Advance Determination of Medicare Coverage (ADMC), Power Mobility Device (PMD) Prior Authorization (PA) Demonstration, Condition of Payment (COP) PA and other mobility related inquiries. The hotline is intended to be used for inquiries that are related to the above-mentioned services prior to billing an item.

Acceptable use of the hotline includes questions a supplier may have during the preparation of an ADMC, PMD PA Demonstration or COP PA submission, questions on a decision that was received or information on coverage criteria.

Suppliers are reminded to utilize the Supplier Contact Center for status inquiries, processing and/or claim information.

Suppliers can find the Pre-Claim Hotline information on the Medical Review webpage on the Noridian Medicare website.

## Spinal Orthoses (HCPCS L0627, L0630, L0631, L0637, L0642, L0643, L0648, L0650) Quarterly Results of Targeted Probe and Educate Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a targeted probe and educate reviews of HCPCS code(s) L0627, L0630, L0631, L0637, L0642, L0643, L0648 and L0650. The quarterly edit effectiveness results from October 2017 through December 2017 are as follows:

Based on dollars, the overall claim potential improper payment rate is **34%**.

**Top Denial Reasons**

- Claim is the same or similar to another claim on file.
- Documentation does not include verification that the equipment was lost, stolen or irreparably damaged in a specific incident.
- Documentation does not support coverage criteria.
- Documentation was not received in response to the Additional Documentation Request (ADR) letter.

For complete detail see, Spinal Orthoses (HCPCS L0627, L0630, L0631, L0637, L0642, L0643, L0648, L0650) Quarterly Results of Targeted Probe and Educate Review.

## Surgical Dressings (HCPCS A6196, A6197) Quarterly Results of Targeted Probe and Educate Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a targeted probe and educate reviews of HCPCS code(s) A6196 and A6197. The quarterly edit effectiveness results from October 2017 through December 2017 are as follows:

Based on dollars, the overall claim potential improper payment rate is **80%**.

**Top Denial Reasons**

- Documentation does not support coverage criteria.
- Detailed Written Order (DWO) was not received.
- Medical record documentation was not authenticated (handwritten or electronic) by the author.
- No medical record documentation was received. Refer to Medicare Program Integrity Manual 3.2.3.8.

For complete detail see, Surgical Dressings (HCPCS A6196, A6197) Quarterly Results of Targeted Probe and Educate Review.

## Therapeutic Shoes (HCPCS A5500) Quarterly Results of Targeted Probe and Educate Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a targeted probe and educate review of HCPCS code(s) A5500. The quarterly edit effectiveness results from October 2017 through December 2017 are as follows:

Based on dollars, the overall claim potential improper payment rate is **13%**.

**Top Denial Reasons**

- Documentation does not support coverage criteria.
- Documentation received is illegible.
- Claim history indicates the beneficiary has already received the items billed.
- Claim was submitted with the incorrect beneficiary information.

For complete detail see, Therapeutic Shoes (HCPCS A5500) Quarterly Results of Targeted Probe and Educate Review.

## Urological Supplies (HCPCS A4351, A4353, A4358) Quarterly Results of Targeted Probe and Educate Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a targeted probe and educate reviews of HCPCS code(s) A4351, A4353 and A4358. The quarterly edit effectiveness results from October 2017 through December 2017 are as follows:

Based on dollars, the overall claim potential improper payment rate is **21%**.

**Top Denial Reasons**

- Detailed Written Order (DWO) is incomplete or missing elements.
- Documentation does not support coverage criteria.
- There is no documentation showing the beneficiary has nearly exhausted their supplies.
- The supplier indicates the item(s) were billed in error. Refer to SDL A55426.

For complete detail see, Urological Supplies (HCPCS A4351, A4353, A4358) Quarterly Results of Targeted Probe and Educate Review.

## Denial Code Resolution Page Now Available

Are you working a denial and want to find out the next steps to resolve the issue? Use the Denial Code Resolution page to view the most common claim submission errors. Search for the Reason Code or Remark Code from your remittance advice for instructions on how to correct the claim and avoid the same denial in the future.

## PWK Coversheet Updated

CMS Change Request (CR) 10124 revises the PWK (paperwork) Fax/Mail/esMD Coversheet to remove HICN and replace it with Medicare ID. All receipts containing the previous form received on or after April 2, 2018 will be returned for correction and resubmission.

The updated coversheets will be screened for completion of all required fields. Forms that are incomplete will also be returned for correction and resubmission.

View the CMS Medicare Learning Network (MLN) Matters (MM)10124 for complete instructions. The updated PWK Coversheet can be found on the Forms page under Medical Review Forms on the Noridian website.

# DMEPOS CBP – July 2018 Quarterly Update

MLN Matters Number: MM10556
Related Change Request (CR) Number: 10556
Related CR Release Date: April 27, 2018
Effective Date: July 1, 2018
Related CR Transmittal Number: R4036CP
Implementation Date: July 2, 2018

## PROVIDER TYPES AFFECTED

This MLN Matters® Article is intended for providers and suppliers submitting claims to Durable Medical Equipment Medicare Administrative Contractors (DME 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) 10556 provides the July 2018 quarterly update for the Medicare DMEPOS fee schedule. The Centers for Medicare & Medicaid Services (CMS) updates the DME Competitive Bidding Program (CBP) files on a quarterly basis in order to implement necessary changes to the Healthcare Common Procedure Coding System (HCPCS), ZIP code, Single payment amount, and Supplier files. These requirements provide specific instruction for implementing the DMEPOS CBP files. Note that quarterly updates are available at http://dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/home.

## BACKGROUND

Congress mandated the DMEPOS CBP through the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA). The statute requires that Medicare replace the current fee schedule payment methodology for selected DMEPOS items with a competitive bid process. The intent is to improve the effectiveness of the Medicare methodology for setting DMEPOS payment amounts, which will reduce beneficiary out-of-pocket expenses and save the Medicare program money while ensuring beneficiary access to quality items and services. Under the program, CMS conducts a competition among suppliers who operate in a particular competitive bidding area. Suppliers are required to submit a bid for selected products. Not all products or items are subject to competitive bidding. Suppliers submit bids electronically through a web-based application process and required documents are mailed. CMS evaluates bids based on the supplier's eligibility, its financial stability, and the bid price. Contracts are awarded to the Medicare suppliers who offer the best price and meet applicable quality and financial standards. Contract suppliers must agree to accept assignment on all claims for bid items and will be paid the bid price amount. The amount is derived from the median of all winning bids for an item.

## ADDITIONAL INFORMATION

The official instruction, CR10556, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and- Guidance/Guidance/Transmittals/2018Downloads/R4036CP.pdf.

## DOCUMENT HISTORY

| Date of Change | Description |
|---|---|
| May 25, 2018 | Initial article released. |

# Medicare FFS Response to the 2018 California Wildfires – Second Revision

## MLN Matters Number: SE17035 Revised

## Article Revised Date: April 2, 2018

This article was revised on April 2, 2018, to advise providers that the public health emergency declaration and Section 1135 waiver authority expired on January 5, 2018. 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, who were affected by the 2017 wildfires in the State of California.

### PROVIDER INFORMATION AVAILABLE

Pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act, President Trump declared that, as a result of the effects of the 2017 Wildfires, a major disaster exists in the State of California.

On October 15, 2017, Acting Secretary Hargan of the Department of Health & Human Services declared that a public health emergency exists in the State of California retroactive to October 8, 2017, and authorized waivers and modifications under §1135 of the Social Security Act.

On October 17, 2017, the Administrator of the Centers for Medicare & Medicaid Services (CMS) authorized waivers under §1812(f) of the Social Security Act for the State of California retroactive to October 8, 2017 for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of wildfires. Providers can request an individual Section 1135 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 Public Health Emergency declaration and Social Security Act waivers including the Section 1135 waiver authority expired on January 5, 2018.

### BACKGROUND

Section 1135 and Section 1812(f) Waivers

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

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 California retroactive to October 8, 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.

The most current information can be found at https://www.cms.gov/About-CMS/Agency-Information/Emergency/Wildfires.html.

Also referenced below are Q&As that are applicable for items and services furnished to Medicare beneficiaries within the State of California. 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.

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 individual 1135 waivers requested by providers for California.

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

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

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

Waiver for California

Under the authority of Section 1135 (or, as noted below, Section 1812(f)), CMS has issued the following waiver in the affected areas of California. Individual facilities do not need to apply for the following approved waiver.

Skilled Nursing Facilities

- 1812(f): This waiver of the requirement for a 3-day prior hospitalization for coverage of a Skilled Nursing Facility stay provides temporary emergency coverage of Skilled Nursing Facility (SNF) services without a qualifying hospital stay, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of the wildfires. 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).
- In addition, the waiver provides temporary emergency coverage of SNF services that are not post-hospital SNF services under the authority in §1812(f) of the Social Security Act (the Act), for those people who are evacuated, transferred, or otherwise dislocated as a result of the effects in the State of California, in October 2017. In addition, this waiver provides authority under §1812(f) of the Act to provide coverage for extended care services which will not require a new spell of illness in order to renew provision of services by a SNF. These temporary emergency policies would apply to the timeframes specified in the waiver(s) issued under §1135 of the Act in connection with the effects of the wildfires in the State of California in October 2017. Accordingly, both the effective date and expiration date for these temporary emergency policies are the same as those specified pursuant to the §1135 waivers. Further, unlike the policies authorized directly under the §1135 waiver authority itself, the two policies described above would not be limited to beneficiaries who have been relocated within areas that have been designated as emergency areas. Instead, the policies would apply to all beneficiaries who were evacuated from an emergency area as a result of the effects of the wildfires in California in October 2017, regardless of where the "host" SNF providing post-disaster care is located.

**Administrative Relief**

Appeal Administrative Relief for Areas Affected by California Wildfires

If you were affected by the California wildfires 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.

**Requesting an 1135 Waiver**

Information for requesting an 1135 waiver can be found at https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Requesting-an-1135-Waiver-Updated-11-16-2016.pdf.

More information is available in the 1135 Waiver Letter, which is posted in the Downloads section at https://www.cms.gov/About-CMS/Agency-Information/Emergency/Wildfires.html.

**Medicare Quality Reporting and Value-based Purchasing Programs**

CMS is granting exceptions under certain Medicare quality reporting and value-based purchasing programs to acute care hospitals, inpatient psychiatric facilities, skilled nursing facilities, home health agencies, hospices, inpatient rehabilitation facilities, long-term care hospitals, renal dialysis facilities, and ambulatory surgical centers located in areas affected by the devastating impacts of the Northern California wildfires since October 8, 2017, in and around counties in Northern California. For complete details of these exceptions, see the document posted at https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Memo- Requirements-Facilities-CA-Wildfires.pdf.

### DOCUMENT HISTORY

| Date of Change | Description |
|---|---|
| April 2, 2018 | The article was revised to advise providers that the public health emergency declaration and Section 1135 waiver authority expired on January 5, 2018. |
| November 1, 2017 | This article was revised to add information regarding the exceptions granted for certain Medicare quality reporting and value-based purchasing programs. |
| October 18, 2017 | Initial article released. |

## Medicare FFS Response to the 2017 Southern California Wildfires - Revised

### MLN Matters Number: SE17037 Revised

### Article Revised Date: April 2, 2018

This article was revised on April 2, 2018, to advise providers that the public health emergency declaration and Section 1135 waiver authority expired on March 3, 2018. 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, who were affected by the December 2017 wildfires in the State of California.

### PROVIDER INFORMATION AVAILABLE

Pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act, President Trump declared that, as a result of the effects of the December 2017 Wildfires, an emergency exists in the State of California.

On December 11, 2017, Acting Secretary Hargan of the Department of Health & Human Services declared that a public health emergency (PHE) exists in the State of California retroactive to December 4, 2017, and authorized waivers and modifications under §1135 of the Social Security Act.

On December 13, 2017, the Administrator of the Centers for Medicare & Medicaid Services (CMS) authorized waivers under §1812(f) of the Social Security Act for the State of California retroactive to December 4, 2017 for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of wildfires. Providers can request an individual Section 1135 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 Public Health Emergency declaration and Social Security Act waivers including the Section 1135 waiver authority expired on March 3, 2018.

### BACKGROUND

Section 1135 and Section 1812(f) Waivers

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

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 California retroactive to December 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.

The most current information is available at https://www.cms.gov/About-CMS/Agency-Information/Emergency/Wildfires.html.

Also referenced below are Q&As that are applicable for items and services furnished to Medicare beneficiaries within the State of California. 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.

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 individual 1135 waivers requested by providers for California.

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

- Q&As applicable without any Section 1135 or other formal waiver are available at https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Consolidated_Medicare_FFS_Emergency_QsAs.pdf
- Q&As applicable only with a Section 1135 waiver or, when applicable, a Section 1812(f) waiver, are available at https://www.cms.gov/About-CMS/Agency- Information/Emergency/Downloads/MedicareFFS-EmergencyQsAs1135Waiver.pdf

**Waiver for California**

Under the authority of Section 1135 (or, as noted below, Section 1812(f)), CMS has issued the following waiver in the affected areas of California. Individual facilities do not need to apply for the following approved waiver.

Skilled Nursing Facilities

- 1812(f): This waiver of the requirement for a 3-day prior hospitalization for coverage of a Skilled Nursing Facility stay provides temporary emergency coverage of Skilled Nursing Facility (SNF) services without a qualifying hospital stay, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of the wildfires. 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).
- In addition, the waiver provides temporary emergency coverage of SNF services that are not post-hospital SNF services under the authority in §1812(f) of the Social Security Act (the Act), for those people who are evacuated, transferred, or otherwise dislocated as a result of the effects in the State of California, in December 2017. In addition, this waiver provides authority under §1812(f) of the Act to provide coverage for extended care services which will not require a new spell of illness in order to renew provision of services by a SNF. These temporary emergency policies would apply to the timeframes specified in the waiver(s) issued under §1135 of the Act in connection with the effects of the wildfires in the State of California in December 2017. Accordingly, both the effective date and expiration date for these temporary emergency policies are the same as those specified pursuant to the §1135 waivers. Further, unlike the policies authorized directly under the §1135 waiver authority itself, the two policies described above would not be limited to beneficiaries who have been relocated within areas that have been designated as emergency areas. Instead, the policies would apply to all beneficiaries who were evacuated from an emergency area as a result of the effects of the wildfires in California in December 2017, regardless of where the "host" SNF providing post-disaster care is located.

**Administrative Relief**

Appeal Administrative Relief for Areas Affected by California Wildfires

If you were affected by the California wildfires and are unable to file a timely appeal, respond to pending requests for documentation, or experience an interruption in the receipt of the Remittance Advice (RA) that lists the initial determination(s), please contact your MAC.

**Requesting an 1135 Waiver**

Information for requesting an 1135 waiver is available at https://www.cms.gov/About- CMS/Agency-Information/Emergency/Downloads/Requesting-an-1135-Waiver-Updated-11-16- 2016.pdf.

More information is available in the 1135 Waiver Letter, which is posted in the Downloads section at https://www.cms.gov/About-CMS/Agency-Information/Emergency/Wildfires.html.

### DOCUMENT HISTORY

| Date of Change | Description |
|---|---|
| April 2, 2018 | The article was revised to advise providers that the public health emergency declaration and Section 1135 waiver authority expired on March 3, 2018. |
| December 18, 2017 | Initial article released |

## Immunosuppressive Drugs – Proof of Delivery Update

Effective April 30, 2018, for claims with date of service on or after August 1, 2016, suppliers have the option to mail immunosuppressive drugs to the beneficiary up to two days prior to the anticipated discharge date from an inpatient stay.

Delivery must be to a valid place of service (e.g., home, custodial facility) and not another facility (e.g., inpatient or skilled nursing) that does not qualify as the beneficiary's home. The supplier must enter the date of discharge as the date of service on the claim.

Please see IOM Pub. 100-04, Chapter 17, Section 80.3.3 for additional billing instructions.

## Dear Physician Letter – Immunosuppressive Drugs – April 2018

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Dear Physician Letter – Immunosuppressive Drugs – April 2018" is now available on our (Noridian) website.

View the complete Dear Physician Letter – Immunosuppressive Drugs – April 2018 webpage.

## Dear Physician Letter - Insulin for Insulin Infusion Pumps - March 2018

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Dear Physician Letter - Insulin for Insulin Infusion Pumps - March 2018" is now available on our (Noridian) website.

View the complete Dear Physician Letter – Insulin for Insulin Infusion Pumps – March 2018 webpage.

## Dear Physician Letter – Knee Orthoses – May 2018

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Dear Physician Letter – Knee Orthoses – May 2018" is now available on our (Noridian) website.

View the complete Dear Physician Letter – Knee Orthoses – May 2018 webpage.

## Billing Instruction – Oxygen CMN Question 5 – Revised

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Billing Instruction – Oxygen CMN Question 5 – Revised" is now available on our (Noridian) website.

View the complete Billing Instruction – Oxygen CMN Question 5 – Revised webpage.

## Billing Instructions – LSO and TLSO

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Billing Instructions – LSO and TLSO" is now available on our (Noridian) website.

View the complete Billing Instructions – LSO and TLSO webpage.

## Billing Reminder – Immunosuppressive Drugs – Delivery to Inpatient Hospitals

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Billing Reminder - Immunosuppressive Drugs - Delivery to Inpatient Hospitals" is now available on our (Noridian) website.

View the complete Billing Reminder – Immunosuppressive Drugs – Delivery to Inpatient Hospitals webpage.

## Continuous Glucose Monitor (CGM) Use – Alternative Testing For Fingerstick Testing Requirements For Insulin Pumps

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Continuous Glucose Monitor (CGM) Use – Alternative Testing For Fingerstick Testing Requirements For Insulin Pumps" is now available on our (Noridian) website.

View the complete Continuous Glucose Monitor (CGM) Use – Alternative Testing For Fingerstick Testing Requirements For Insulin Pumps webpage.

## Correct Coding – Incorrect Use of HCPCS Code K0108 To Bill for an Actuator

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Correct Coding – Incorrect Use of HCPCS Code K0108 To Bill for an Actuator" is now available on our (Noridian) website.

View the complete Correct Coding – Incorrect Use of HCPCS Code K0108 To Bill for an Actuator webpage.

## Correct Coding – Incorrect Use of HCPCS Code K0108 To Bill for Anti-Tip Devices for Manual Wheelchairs

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Correct Coding – Incorrect Use of HCPCS Code K0108 To Bill for Anti-Tip Devices for Manual Wheelchairs" is now available on our (Noridian) website.

View the complete Correct Coding – Incorrect Use of HCPCS Code K0108 To Bill for Anti-Tip Devices for Manual Wheelchairs webpage.

## Correct Coding – Incorrect Use of HCPCS Code K0108 To Bill for Front Riggings: Calf Pad or Calf Support

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Correct Coding – Incorrect Use of HCPCS Code K0108 To Bill for Front Riggings: Calf Pad or Calf Support" is now available on our (Noridian) website.

View the complete Correct Coding – Incorrect Use of HCPCS Code K0108 To Bill for Front Riggings: Calf Pad or Calf Support webpage.

## Correct Coding – Incorrect Use of HCPCS Code K0108 To Bill for Front Riggings: Shoe Holder or Shoe Holder Replacement Straps

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Correct Coding – Incorrect Use of HCPCS Code K0108 To Bill for Front Riggings: Shoe Holder or Shoe Holder Replacement Straps" is now available on our (Noridian) website.

View the complete Correct Coding – Incorrect Use of HCPCS Code K0108 To Bill for Front Riggings: Shoe Holder or Shoe Holder Replacement Straps webpage.

## Correct Coding – Incorrect Use of HCPCS Code K0108 To Bill for Labor Charges

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Correct Coding – Incorrect Use of HCPCS Code K0108 To Bill for Labor Charges" is now available on our (Noridian) website.

View the complete Correct Coding – Incorrect Use of HCPCS Code K0108 To Bill for Labor Charges webpage.

## Correct Coding – Incorrect Use of HCPCS Code K0108 To Bill for a Privacy Flap

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Correct Coding – Incorrect Use of HCPCS Code K0108 To Bill for a Privacy Flap" is now available on our (Noridian) website.

View the complete Correct Coding – Incorrect Use of HCPCS Code K0108 To Bill for a Privacy Flap webpage.

## Correct Coding – Incorrect Use of HCPCS Code K0108 To Bill for Transit System and Associated Bracket

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Correct Coding – Incorrect Use of HCPCS Code K0108 To Bill for Transit System and Associated Bracket" is now available on our (Noridian) website.

View the complete Correct Coding – Incorrect Use of HCPCS Code K0108 To Bill for Transit System and Associated Bracket webpage.

## Correct Coding – Incorrect Use of HCPCS Code K0108 To Bill for a Wheel Lock Brake Extension for Manual Wheelchairs

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Correct Coding – Incorrect Use of HCPCS Code K0108 To Bill for a Wheel Lock Brake Extension for Manual Wheelchairs" is now available on our (Noridian) website.

View the complete Correct Coding – Incorrect Use of HCPCS Code K0108 To Bill for a Wheel Lock Brake Extension for Manual Wheelchairs webpage.

## Correct Coding – Submitting Oxygen Claims with Modifiers KX, GA, GY and GZ

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Correct Coding – Submitting Oxygen Claims with Modifiers KX, GA, GY, and GZ" is now available on our (Noridian) website.

View the complete Correct Coding – Submitting Oxygen Claims with Modifiers KX, GA, GY, and GZ webpage.

## LCD and Policy Article Revisions Summary for April 19, 2018

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "LCD and Policy Article Revisions Summary for April 19, 2018" is now available on our (Noridian) website.

View the complete LCD and Policy Article Revisions Summary for April 19, 2018 webpage.

## LCD and Policy Article Revisions Summary for April 26, 2018

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "LCD and Policy Article Revisions Summary for April 26, 2018" is now available on our (Noridian) website.

View the complete LCD and Policy Article Revisions Summary for April 26, 2018 webpage.

## Policy Article Revisions Summary for April 5, 2018

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Policy Article Revisions Summary for April 5, 2018" is now available on our (Noridian) website.

View the complete Policy Article Revisions Summary for April 5, 2018 webpage.

## Policy Article Revisions Summary for April 12, 2018

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Policy Article Revisions Summary for April 12, 2018" is now available on our (Noridian) website.

View the complete Policy Article Revisions Summary for April 12, 2018 webpage.

## Policy Article Revision Summary for May 3, 2018

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Policy Article Revision Summary for May 3, 2018" is now available on our (Noridian) website.

View the complete Policy Article Revision Summary for May 3, 2018 webpage.

## Medicare Beneficiary Identifier (MBI) Page Updated

Noridian has been diligently working to update the content of the MBI webpage to better serve our providers. Easy access to updated information will help providers with this transition. Information on the below topics can be found on the MBI webpage.

- Transition Period
- MBI Format
- Mailing Schedule
- How to Prepare
- Implementation

## MBI – Get It, Use It

### MLN Matters Number: SE18006
### Article Release Date: May 25, 2018

**PROVIDER TYPE AFFECTED**

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

**PROVIDER ACTION NEEDED**

The Centers for Medicare & Medicaid Services (CMS) is mailing the new Medicare cards with the MBI in phases by geographic location. Here are 3 ways you and your office staff can get MBIs:

1. Ask your Medicare patients

- Ask your Medicare patients for their new Medicare card when they come for care. If they haven't received a new card at the completion of their geographic wave, refer them to 1-800-Medicare (1-800-633-4227).

2. Use the MAC's secure MBI look-up tool

- Once the new Medicare card with the MBI has been mailed to your patient, you can look up MBIs for your Medicare patients when they don't or can't give them. Sign up for the Portal to use the tool. You can use this tool even after the end of the transition period – it doesn't end on December 31, 2019.

3. Check the remittance advice

- Starting in October 2018 through the end of the transition period, Medicare will return the MBI on every remittance advice when you submit claims with valid and active Health Insurance Claim Numbers (HICNs).

You can start using the MBIs even if the other health care providers and hospitals who also treat your patients haven't. When the transition period ends December 31, 2019, providers must use the MBI for most transactions.

**BACKGROUND**

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS to remove Social Security Numbers from all Medicare cards by April 2019. A new, randomly generated Medicare Beneficiary Identifier, or MBI, is replacing the SSN-based HICN. The new MBI is noticeably different than the HICN. Just like with the HICN, the MBI dashes on the card are for illustration purposes, don't include the dashes or spaces on transactions.

The Railroad Retirement Board (RRB) is also mailing new Medicare cards with the MBI. The RRB logo will be in the upper left corner and "Railroad Retirement Board" at the bottom, but you can't tell from looking at the MBI if your patients are eligible for Medicare because they're railroad retirees. You'll be able to identify them by the RRB logo on their card, and we'll return a "Railroad Retirement Medicare Beneficiary" message on the Fee-For-Service (FFS) MBI eligibility transaction response.

You'll use the MBI the same way you use the HICN today. You use the MBI in the same field where you've always put the HICN. This also applies to reporting informational only and no-pay claims. The MBI will replace the HICN on Medicare transactions including Billing, Eligibility Status, and Claim Status. The effective date of the MBI, like the old HICN, is the date each beneficiary was or is eligible for Medicare. Up until December, 31, 2019, you can use either the HICN or the MBI in the same field where you've always put the HICN. After that the remittance advice will tell you if claims are rejected because the MBI wasn't used. Claim Adjustment Reason Code (CARC) 16, "Claim/service lacks information or has submission/billing error(s)." along with Remittance Advice Remark Code (RARC) N382 "Missing/incomplete/invalid patient identifier" will be reflected on the remittance advice.

The beneficiary or authorized representative can request an MBI change. CMS can also initiate a change to an MBI. The best example of when this will occur is if the MBI has been compromised. If an MBI changes the old or new MBI can be used on claims with dates of service before the MBI change date. For span-date claims with a "From Date" before the MBI change date, either the old or new MBI can be used. Only the new MBI can be used on claims with dates of service that are entirely on or after the effective date of the change. FFS eligibility transaction requests that contain a terminated MBI will return eligibility data only for the period where the search request dates overlap the active period for the terminated MBI. FFS eligibility transaction requests with a terminated MBI where the search request dates are after the MBI termination date will not receive eligibility data. Beginning June 2018, FFS eligibility transaction requests which include a terminated MBI and a date search that overlaps the active period for the terminated MBI will also receive the MBI termination date in the eligibility response. The FFS eligibility transaction will return all eligibility data when the new MBI is submitted. At the time the MBI changes, the beneficiary is informed to share the new MBI with health care providers. The new MBI can be obtained from your MAC's secure MBI look-up tool.

**Note that the MBI is confidential like the HICN, and it should be protected as Personally Identifiable Information (PII).**

All HICN-based claims have to be received by the January 1, 2020 - the cut-off date. On January 1, 2020, even for dates of services prior to this date, you must use MBIs for all transactions; there are a few exceptions when you can use either the HICN or MBI:

- Appeals – You can use either the HICN or MBI for claim appeals and related forms.
- Claim status query – You can use HICNs or MBIs to check the status of a claim (276 transactions) if the earliest date of service on the claim is before January 1, 2020. If you are checking the status of a claim with a date of service on or after January 1, 2020, you must use the MBI.
- Span-date claims – You can use the HICN or the MBI for 11X-Inpatient Hospital, 32X-Home Health (home health claims and Request for Anticipated Payments [RAPs]) and 41X-Religious Non-Medical Health Care Institution claims if the "From Date" is before the end of the transition period (December 31, 2019). If a patient starts getting services in an inpatient hospital, home health, or religious non-medical health care institution before December 31, 2019, but stops getting those services after December 31, 2019, you may submit a claim using either the HICN or the MBI, even if you submit it after December 31, 2019. Since you submit home health claims for a 60-day payment episode, you can send in the episode's RAP with either the HICN or the MBI, but after the transition period ends on December 31, 2019, you have to use the MBI when you send in the final claim that goes with it.

The MBI does not change Medicare benefits. Medicare beneficiaries may start using their new Medicare cards and MBIs as soon as they receive them. Thus, providers will need to use MBIs right away - as soon as your patients share them. The effective date of the new cards is the date beneficiaries are eligible for Medicare.

Medicare Advantage and Prescription Drug plans will continue to assign and use their own identifiers on their health insurance cards. For patients in these plans, continue to ask for and use the plans' health insurance cards.

**ADDITIONAL INFORMATION**

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

A fact sheet discussing the transition to the MBI and the new cards is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TransitiontoNewMedicareNumbersandCards-909365.pdf.

**DOCUMENT HISTORY**

| Date of Change | Description |
|---|---|
| May 25, 2018 | Initial article released. |

# MLN Connects – March 1, 2018

MLN Connects® for Thursday, March 1, 2018

View this edition as a PDF

**News & Announcements**

- New Medicare Card: Video for Your Waiting Room
- Patients over Paperwork Newsletter
- CMS Launches Public Reporting of CAHPS® Hospice Survey Results
- Hospice Compare Quarterly Refresh
- Medicare Diabetes Prevention Program: Supplier Enrollment
- Medicare EHR Incentive Program Hospital Attestation: Deadline Extended to March 16
- Draft 2019 QRDA Category I Implementation Guide: Submit Comments by March 21
- MIPS: Apply to Participate in Quality Measures Study by March 23
- MIPS Reporting Deadlines
- MIPS 2018 QCDR Measure Specifications
- MIPS Claims Based Quality Measures Projections and Results Video
- eCQM Annual Update Pre-Publication Document
- What's New with Physician Compare Webinar Materials
- Are You Prepared for a Health Care Emergency?
- March is National Colorectal Cancer Awareness Month

**Provider Compliance**

- Provider Compliance Tips for Laboratory Blood Counts Fact Sheet — New

**Upcoming Events**

- Low Volume Appeals Settlement Option Update Call — March 13
- Open Payments: The Program and Your Role Call — March 14
- Dementia Care: Person-Centered Care Planning and Practice Recommendations Call — March 20
- E/M Services: Documentation Guidelines and Burden Reduction Listening Session — March 21

**Medicare Learning Network Publications & Multimedia**

- Provider Compliance Tips for PAP Devices and Accessories Including CPAP Fact Sheet — New
- Provider Compliance Tips for Oral Anticancer Drugs and Antiemetic Drugs Used in Conjunction Fact Sheet — New
- Provider Compliance Tips for Bariatric Surgery Fact Sheet — New
- Provider Compliance Tips for Diabetic Shoes Fact Sheet — New
- Provider Compliance Tips for Lower Limb Orthoses Fact Sheet — New
- Provider Compliance Tips for Enteral Nutrition Fact Sheet — New
- Provider Compliance Tips for Immunosuppressive Drugs Fact Sheet — New
- Provider Compliance Tips for Ambulance Services Fact Sheet — Revised
- Provider Compliance Tips for Clinic ESRD Services (Part A Non-DRG) Fact Sheet — Revised
- Provider Compliance Tips for CT Scans Fact Sheet — Revised
- Medicare Part D Vaccines and Vaccine Administration Fact Sheet — Revised

- Medicare Part B Immunization Billing Educational Tool — Revised
- Screening Pap Tests and Pelvic Examinations Booklet — Revised
- Medicare Enrollment for Physicians, NPPs, and Other Part B Suppliers Booklet — Revised
- Hospital Outpatient Prospective Payment System Booklet — Revised

## MLN Connects – March 8, 2018

MLN Connects® for Thursday, March 8, 2018

View this edition as a PDF

**News & Announcements**

- MyHealthEData Initiative Puts Patients at the Center of the US Health Care System
- New Medicare Card Transition Begins In Less Than a Month
- MACRA Funding Opportunity: Measure Development for the Quality Payment Program
- IRF and LTCH Compare Refresh
- Quality Payment Program: Submit 2017 Participation Data through March 31
- EHR Incentive Program: Hospitals Submit Proposals for New Measures until June 29
- PEPPER for Short-term Acute Care Hospitals
- DME Supplier Feedback on Telephone Discussion and Reopening Process Demonstration
- EHR Incentive Programs FAQs
- Antipsychotic Drug Use in Nursing Homes: Trend Update
- Help Your Patients Go Further With Food

**Provider Compliance**

- Bill Correctly for Device Replacement Procedures — Reminder

**Claims, Pricers & Codes**

- April 2018 Average Sales Price Files

**Upcoming Events**

- Low Volume Appeals Settlement Option Update Call — March 13
- National Patient Safety Week Panel Discussion — March 13
- Open Payments: The Program and Your Role Call — March 14
- QRDA Category I Implementation Guide for CY 2018 Hospital Quality Reporting Webinar — March 19
- Dementia Care: Person-Centered Care Planning and Practice Recommendations Call — March 20
- E/M Services: Documentation Guidelines and Burden Reduction Listening Session — March 21

**Medicare Learning Network® Publications & Multimedia**

- Provider Compliance Tips for Glucose Monitors Fact Sheet — New
- Provider Compliance Tips for Manual Wheelchairs Fact Sheet — New
- Provider Compliance Tips for Ordering Lower Limb Prostheses Fact Sheet — New
- Provider Compliance Tips for Laboratory Tests – Bacterial Cultures Fact Sheet — New
- Provider Compliance Tips for Wheelchair Options/Accessories Fact Sheet — New
- Provider Compliance Tips for Ostomy Supplies Fact Sheet — New
- Provider Compliance Tips for Ordering Oxygen Supplies and Equipment Fact Sheet — New

- Provider Compliance Tips for Negative Pressure Wound Therapy Fact Sheet — New
- Provider Compliance Tips for Surgical Dressings Fact Sheet — New
- Provider Compliance Tips for Urological Supplies Fact Sheet — New
- Low Volume Appeals Settlement Call: Video Presentation — New
- ESRD QIP Call: Audio Recording and Transcript — New
- Rural Health Clinic Fact Sheet — Revised

## MLN Connects – March 15, 2018

MLN Connects® for Thursday, March 15, 2018

View this edition as a PDF

**News & Announcements**

- MIPS Reporting Deadlines Approaching
- EHR Incentive Program: Hospital Attestation Deadline Changed to March 16
- Hospice Provider Preview Reports: Review Your Data by March 30
- IRF and LTCH Provider Preview Reports: Review Your Data by April 5
- Medicare Pharmaceutical and Technology Ombudsman
- Updated QRDA III Implementation Guide with Advancing Care Information Identifier
- Hospice QRP Timeliness Compliance Threshold Report: Footnote Update
- Influenza Activity Continues: Are Your Patients Protected?

**Provider Compliance**

- Provider Compliance Tips for Hospital Beds and Accessories

**Claims, Pricers & Codes**

- Integrated OCE Files for April 2018

**Upcoming Events**

- New Medicare Card Project Special Open Door Forum — March 20
- Dementia Care: Person-Centered Care Planning and Practice Recommendations Call — March 20
- E/M Services: Documentation Guidelines and Burden Reduction Listening Session — March 21
- Interdisciplinary Team Building, Management, and Communication Webinar — March 21
- Hospice Quality Reporting Program Webinar — March 27
- IMPACT Act and Improving Care Coordination Special Open Door Forum — March 28
- Managing Transitions with Adults with Disabilities Webinar — March 28
- Building Partnerships: Health Plans and Community-based Organizations Webinar — April 4

**Medicare Learning Network® Publications & Multimedia**

- Appropriate Use Criteria for Advanced Diagnostic Imaging: HCPCS Modifier QQ MLN Matters Article — New
- April 2018 I/OCE Specifications Version 19.1 MLN Matters Article — New
- April 2018 Update of the Hospital OPPS MLN Matters Article — New
- Provider Compliance Tips for Enteral Nutrition Fact Sheet — New
- Provider Compliance Tips for Walkers Fact Sheet — New

- Provider Compliance Tips for Home Health Services Fact Sheet — New
- Provider Compliance Tips for Respiratory Assistive Devices Fact Sheet— New
- ICD-10 and Other Coding Revisions to NCDs MLN Matters Article — Revised
- Diagnosis Code Update for Add-on Payments for Blood Clotting Factor Administered to Hemophilia Inpatients MLN Matters Article — Revised
- Supervised Exercise Therapy for Symptomatic PAD MLN Matters Article — Revised
- Quarterly HCPCS Drug/Biological Code Changes MLN Matters Article — Revised
- Provider Compliance Tips for Laboratory Tests: Other Fact Sheet – Revised
- Provider Compliance Tips for Ordering Hospital Outpatient Services Fact Sheet — Revised
- Provider Compliance Tips for Skilled Nursing Facility Services Fact Sheet — Revised
- Provider Compliance Tips for Enteral Nutrition Therapy Pumps Fact Sheet — Revised
- Provider Compliance Tips for IRF Fact Sheet — Revised
- Ambulatory Surgical Center Payment System Fact Sheet — Revised
- Beneficiaries in Custody under a Penal Authority Fact Sheet—Revised
- Medicare Ambulance Transports Booklet — Revised
- Medicare Provider-Supplier Enrollment National Educational Products Listing — Revised
- Global Surgery Booklet — Reminder

## MLN Connects – March 22, 2018

MLN Connects® for Thursday, March 22, 2018

View this edition as a PDF

**News & Announcements**

- Coverage of Next Generation Sequencing Tests Ensures Enhanced Access for Cancer Patients
- IMPACT Act Transfer of Health Measures: Public Comment Period Ends May 3
- Hospice Quality Reporting Program: HART v1.4.0
- Hospital VBP Program FY 2020 Baseline Measures Report

**Provider Compliance**

- Billing for Stem Cell Transplants — Reminder

**Upcoming Events**

- IMPACT Act and Improving Care Coordination Special Open Door Forum — March 28
- Spinal Orthoses Referring Providers Comparative Billing Report Webinar — April 11
- CMS National Provider Enrollment Conference — April 24 and 25

**Medicare Learning Network® Publications & Multimedia**

- April 2018 Update: ASC Payment System MLN Matters Article — New
- Internet Only Manual Update to Correct Errors and Omissions: SNF 2018 MLN Matters Article — New
- SSI/Medicare Beneficiary Data for FY 2016: IPPS Hospitals, IRFs, LTCHs MLN Matters Article — New
- Billing Requirements for OPPS Providers with Multiple Service Locations MLN Matters Article — New
- Reinstating the QMB Indicator in the Medicare FFS Claims Processing System MLN Matters Article — Revised

- Quarterly Update for CLFS and Laboratory Services Subject to Reasonable Charge Payment MLN Matters Article — Revised
- Home Health Prospective Payment System Booklet — Revised
- Federally Qualified Health Center Booklet — Revised
- Medicare Parts A and B Appeals Process Booklet — Reminder
- The Medicare Secondary Payer Provisions Web-Based Training Course — Reminder
- CLIA Program and Medicare Laboratory Services — Reminder

## MLN Connects – March 29, 2018

MLN Connects® for Thursday, March 29, 2018

View this edition as a PDF

**News & Announcements**

- Patients Over Paperwork: Empowering Patients Through Data
- MIPS Data Submission Deadline: March 31
- Transitions from Hospice Care, Followed by Death or Acute Care Draft Measure: Comment Period Ends April 25
- Open Payments Review and Dispute Period: April 1 through May 15
- Qualified Medicare Beneficiary Claims: Replacement RAs
- MACRA Patient Relationship Categories and Codes
- Advanced Diagnostic Laboratory Tests: Applications and Guidance
- HIMSS18 Presentations
- Hospice Quality Reporting Program Video Series: Navigating HQRP Websites
- Hospice Item Set Coding Video Series
- Physician Compare Quality Measure TEP Summary Report
- Administrative Simplification: Reaching Compliance with ASETT Video

**Provider Compliance**

- Provider Compliance Tips for Diabetic Test Strips

**Upcoming Events**

- Comparative Billing Report on Spinal Orthoses Suppliers Webinar — May 2
- LTCH Quality Reporting Program In-Person Training Event — May 8 and 9
- IRF Quality Reporting Program In-Person Training Event — May 9 and 10

**Medicare Learning Network® Publications & Multimedia**

- Claims Processing Actions to Implement Certain Provisions of the Bipartisan Budget Act of 2018 MLN Matters Article — New
- Adjustments to QMB Claims Processed under CR 9911 MLN Matters Article — New
- April Quarterly Update for 2018 DMEPOS Fee Schedule MLN Matters Article — New
- Low Volume Appeals Settlement Call: Audio Recording and Transcript — New
- Open Payments Call: Audio Recording and Transcript — New
- E/M Services Listening Session: Audio Recording and Transcript — New

- Prohibition on Billing Dually Eligible Individuals Enrolled in the QMB Program MLN Matters Article — Revised
- April 2018 I/OCE Specifications Version 19.1 MLN Matters Article — Revised
- April 2018 Update of the Hospital OPPS MLN Matters Article — Revised

## MLN Connects – April 5, 2018

MLN Connects® for Thursday, April 5, 2018

View this edition as a PDF

**News & Announcements**

- New Medicare Card Project – Important Updates
- Bipartisan Budget Act: CMS Reprocessing Impacted Claims
- Reducing Provider Burden: Send us Your Feedback
- MIPS Group Web Interface and CAHPS Survey: Register by June 30
- MIPS APM: Resources for Performance Year 2018
- Medicare Diabetes Prevention Program: New Resources
- Administrative Simplification: Electronic Transactions
- Opioids: CDC Online Training Series
- Opioid Overdoses Treated in Emergency Departments: CDC Vital Signs Report
- Help Prevent Alcohol Misuse or Abuse
- Reduce the Risk of Falls in Elderly Patients

**Provider Compliance**

- Hospice Election Statements Lack Required Information or Have Other Vulnerabilities — Reminder

**Claims, Pricers & Codes**

- HCPCS Code Set Modifications

**Upcoming Events**

- Cultural Competence: Meeting LTSS Needs of Beneficiaries Webinar — April 12
- Safe and Effective Use of Medications in Older Adults Webinar — April 18
- Managing Older Adults with Substance Use Disorders Webinar — May 16

**Medicare Learning Network® Publications & Multimedia**

- Institutional Billing for No Cost Items MLN Matters Article — New
- Proper Coding for Specimen Validity Testing Billed in Combination with Drug Testing MLN Matters Article — New
- SNF ABN MLN Matters Article — New
- SNF Value-Based Purchasing Program Updated MLN Matters Article — New
- Dementia Care Call: Audio Recording and Transcript — New
- Medicare FFS Response to the 2017 California Wildfires MLN Matters Article — Updated
- Medicare FFS Response to the 2017 Southern California Wildfires MLN Matters Article — Updated
- Inpatient Psychiatric Facility PPS Booklet — Revised
- Medicare Enrollment for Providers Who Solely Order, Certify, or Prescribe Booklet — Revised

- 2018 Medicare Part C and Part D Reporting Requirements and Data Validation Web-Based Training Course — Revised
- Medicare Parts A & B Appeals Process Booklet — Reminder
- Looking for Educational Materials?

## MLN Connects – April 12, 2018

MLN Connects® for Thursday, April 12, 2018

View this edition as a PDF

**News & Announcements**

- Help Your Medicare Patients Avoid and Report Scams
- 2018 MIPS Eligibility Tool
- Draft 2019 QRDA Category I Schematron: Submit Comments by April 20
- Home Health Utilization and Payment Data
- National Health Care Decisions Day is April 16

**Provider Compliance**

- Provider Compliance Tips for Oral Anticancer Drugs and Antiemetic Drugs Used in Conjunction

**Upcoming Events**

- Opioids Forum: Strategies and Solutions for Minority Communities — April 25
- Medicare Cost Report e-Filing System Webcast — May 1

**Medicare Learning Network® Publications & Multimedia**

- Increased Ambulance Payment Reduction for Non-Emergency BLS Transports to and from Renal Dialysis Facilities MLN Matters Article — New
- New Waived Tests MLN Matters Article — New
- Supervised Exercise Therapy for Symptomatic PAD MLN Matters Article — Revised
- Modifications to the Implementation of the PWK Segment of the esMD System MLN Matters Article — Revised
- Claims Processing Actions to Implement Certain Provisions of the Bipartisan Budget Act of 2018 MLN Matters Article — Revised
- Revised and New Modifiers for Oxygen Flow Rate MLN Matters Article — Revised
- April 2018 MLN Catalog – Revised
- Medicare Home Health Benefit Booklet — Revised

# MLN Connects – April 19, 2018

MLN Connects® for Thursday, April 19, 2018

View this edition as a PDF

**News & Announcements**

- New Medicare Card: New Numbers Are Confidential
- Market Saturation and Utilization Data Tool
- MIPS Study on Burdens Associated with Reporting Quality Measures: Apply by April 30
- IMPACT Act Transfer of Health Measures: Public Comment Period Ends May 3
- PEPPERs Available for Hospices, SNFs, IRFs, IPFs, CAHs, LTCHs
- National Minority Health Month: Partnering for Health Equity

**Provider Compliance**

- Ophthalmology Services: Questionable Billing and Improper Payments

**Claims, Pricers & Codes**

- April 2018 OPPS Pricer File

**Upcoming Events**

- Medicare Cost Report e-Filing System Webcast — May 1
- LTCH Quality Reporting Program In-Person Training Event — May 8 and 9
- IRF Quality Reporting Program In-Person Training Event — May 9 and 10

**Medicare Learning Network® Publications & Multimedia**

- Quarterly Update to the NCCI PTP Edits, Version 24.2 MLN Matters Article — New
- Change in Type of Service for CPT Code 77067 MLN Matters Article — New
- Ambulance Transportation for SNF Resident in Stay Not Covered by Part A MLN Matters Article — New
- Supervised Exercise Therapy for Symptomatic PAD MLN Matters Article — Revised
- Guidelines for Teaching Physicians, Interns, and Residents Booklet — Revised
- Billing Information for Rural Providers and Suppliers Booklet — Revised
- ICD-10-CM/PCS: The Next Generation of Coding Booklet — Reminder
- General Equivalence Mappings FAQs Booklet — Reminder
- Critical Access Hospital Booklet — Reminder
- Learn About Medicare Policy

## MLN Connects – April 26, 2018

MLN Connects® for Thursday, April 26, 2018

View this edition as a PDF

**News & Announcements**

- New Medicare Card: Help Your Patients
- CMS Changes Name of the EHR Incentive Programs and Advancing Care Information to "Promoting Interoperability"
- Protect Medicare and Medicaid: Report Fraud, Waste, and Abuse
- Hospital Inpatient Quality Reporting Program: Submission Deadline May 15
- IRF, LTCH, and SNF Quality Reporting Programs: Submission Deadline May 15
- Open Payments Review and Dispute Data by May 15
- MACRA Funding Opportunity: Deadline Extended to May 30
- STD Awareness Month: Talk, Test, Treat

**Provider Compliance**

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

**Upcoming Events**

- Medicare Cost Report e-Filing System Webcast — May 1
- CMS Quality Measures: How They Are Used and How You Can Be Involved Webinar — May 2
- Quality Payment Program: Answering Your Frequently Asked Questions Call — May 16
- Settlement Conference Facilitation Expansion Call — May 22

**Medicare Learning Network® Publications & Multimedia**

- Quarterly HCPCS Drug/Biological Code Changes: July 2018 Update MLN Matters Article — New

## MLN Connects – May 3, 2018

MLN Connects® for Thursday, May 3, 2018

View this edition as a PDF

**News & Announcements**

- New Medicare Cards: You Can Use MBIs Right Away
- New Strategy to Fuel Data-driven Patient Care, Transparency
- CMS Encourages Eligible Suppliers to Participate in Expanded Medicare Diabetes Prevention Program Model
- Patients Over Paperwork April Newsletter
- Hospital Quality Reporting Center Spring 2018 Newsletter
- Administrative Simplification: Transactions
- Can't Find An Answer To Your Question?
- Hand Hygiene Day is May 5

**Provider Compliance**

- Provider Compliance Tips for Ordering Lower Limb Orthoses

**Upcoming Events**

- Quality Payment Program: Participation Criteria for Year 2 Webinar — May 9
- eCQI Resource Center Demonstration and Annual Update Webinar — May 10
- Quality Payment Program: Answering Your Frequently Asked Questions Call — May 16
- Settlement Conference Facilitation Expansion Call — May 22
- Comparative Billing Report on Critical Care Services Webinar — June 6

**Medicare Learning Network® Publications & Multimedia**

- New Physician Specialty Code for Medical Genetics and Genomics MLN Matters® Article — New
- Processing Instructions to Update the Identification Code Qualifier Being Used in the NM108 Data Element MLN Matters Article — New
- Revisions to the Telehealth Billing Requirements for Distant Site Services MLN Matters Article — New
- Enhancements to Processing of Hospice Routine Home Care Payments MLN Matters Article — New
- Comprehensive ESRD Care Model Telehealth - Implementation MLN Matters Article — New
- Removal of KH Modifier from Capped Rental Items MLN Matters Article — New
- Acute Care Hospital IPPS Booklet — Revised

## MLN Connects – May 10, 2018

MLN Connects® for Thursday, May 10, 2018

View this edition as a PDF

**News & Announcements**

- First CMS Rural Health Strategy
- Direct Provider Contracting RFI — Submit Comments by May 25
- Provider Documentation Manual: Home Use of Oxygen — Submit Comments on Draft by May 31
- Hospital Compare Preview Reports Available through June 2
- eCQM Annual Update
- Hospital Quality Reporting: 2019 QRDA I Implementation Guide, Schematron, and Sample Files
- 2018 Measure Development Plan Annual Report
- National Women's Health Week Kicks off on Mother's Day

**Provider Compliance**

- Reporting Changes in Ownership — Reminder

**Upcoming Events**

- Quality Payment Program: Answering Your Frequently Asked Questions Call — May 16
- Managing Older Adults with Substance Use Disorders Webinar — May 16
- FY 2019 IPPS Proposed Rule: eCQM Reporting Webinar — May 16
- Settlement Conference Facilitation Expansion Call — May 22
- Qualified Medicare Beneficiary Program Billing Requirements Call — June 6

**Medicare Learning Network® Publications & Multimedia**

- Inexpensive or Routinely Purchased DME Payment Classification for SGD and Accessories MLN Matters Article — New
- Medicare Cost Report E-Filing MLN Matters Article — New
- MCReF System Webcast: Audio Recording and Transcript — New

## MLN Connects – May 17, 2018

MLN Connects® for Thursday, May 17, 2018

View this edition as a PDF

**News & Announcements**

- New Medicare Card: MBI Look-up Tool Clarification and RRB Mailing
- Enhanced "Drug Dashboards" to Increase Transparency on Drug Prices
- CMS Safeguards Patient Access to Certain Medical Equipment and Services in Rural and Other Non-contiguous Communities
- Quality Payment Program: Check 2018 MIPS Clinician Eligibility at the Group Level
- Medicare Diabetes Prevention Program Resources
- Hospital Outpatient Quality Reporting Spring 2018 Newsletter
- Talk to Your Patients about Mental Health

**Provider Compliance**

- Cochlear Devices Replaced Without Cost: Bill Correctly — Reminder

**Upcoming Events**

- Settlement Conference Facilitation Expansion Call — May 22
- Qualified Medicare Beneficiary Program Billing Requirements Call — June 6

**Medicare Learning Network® Publications & Multimedia**

- ICD-10 and Other Coding Revisions to National Coverage Determinations MLN Matters Article — New
- Quarterly Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment MLN Matters Article — New
- Updates to Publication 100-04 to Replace RARC MA61 with N382 MLN Matters Article — New
- IPPS and LTCH PPS Extensions per the ACCESS Act MLN Matters Article — New
- Supervised Exercise Therapy for Symptomatic PAD MLN Matters Article — Revised
- Quarterly HCPCS Drug/Biological Code Changes – July 2018 Update MLN Matters Article — Revised
- Medicare Preventive Services National Educational Products — Revised
- Power Mobility Devices Booklet — Reminder
- Advance Beneficiary Notice of Noncoverage Interactive Tutorial Educational Tool — Reminder
- Medicare Advance Written Notices of Noncoverage Booklet — Reminder
- Long-Term Care Hospital Prospective Payment System Booklet — Reminder
- Medicare Disproportionate Share Hospital Fact Sheet — Reminder
- Hospital-Acquired Conditions and Present on Admission Indicator Reporting Provision Fact Sheet — Reminder

## MLN Connects – May 24, 2018

MLN Connects® for Thursday, May 24, 2018

View this edition as a PDF

**News & Announcements**

- MIPS Promoting Interoperability Performance Category
- Provider Documentation Manual on Home Use of Oxygen: Submit Comments on Draft by May 31
- Proposals for New Measures for Promoting Interoperability Program: Deadline June 29
- Targeted Probe and Educate Video
- Hospice Compare Quarterly Refresh
- CQM Annual Update
- Break Free from Osteoporosis

**Provider Compliance**

- Medicare Hospital Claims: Avoid Coding Errors — Reminder

**Claims, Pricers & Codes**

- FY 2019 ICD-10-PCS Procedure Codes

**Upcoming Events**

- Hospice Quality Reporting Program Data Submission and Reporting Webinar — May 30
- DMEPOS Dietary Related Items, Templates and CDEs Special Open Door Forum — May 31
- Qualified Medicare Beneficiary Program Billing Requirements Call — June 6
- MIPS Promoting Interoperability Performance Category Webinar — June 12

**Medicare Learning Network® Publications & Multimedia**

- RARC, CARC, MREP, and PC Print Update MLN Matters Article — New
- Implement Operating Rules - Phase III ERA EFT: CORE 360 Uniform Use of CARC, RARC and CAGC Rule - Update from CAQH CORE MLN Matters Article — New
- Removal of KH Modifier from Capped Rental Items MLN Matters Article — Revised
- Changes to the ESRD Claim to Accommodate Dialysis Furnished to Beneficiaries with AKI MLN Matters Article — Revised
- World of Medicare Web-Based Training Course — Revised
- Your Office in the World of Medicare Web-Based Training Course — Revised
- Your Institution in the World of Medicare Web-Based Training Course — Revised

## MLN Connects – May 31, 2018

MLN Connects® for Thursday, May 31, 2018

View this edition as a PDF

**News & Announcements**

- New Medicare Card Project — Card Mailing Update
- MIPS: Submit Quality Measures for Consideration by June 1
- 2016 Physician and Other Supplier PUF
- 2016 Referring Provider DMEPOS PUF

**Provider Compliance**

- Provider Minute Video: The Importance of Proper Documentation

**Upcoming Events**

- Qualified Medicare Beneficiary Program Billing Requirements Call — June 6
- Medicare Diabetes Prevention Program: Supplier Enrollment Call — June 20
- IMPACT Act: Frequently Asked Questions Call — June 21

**Medicare Learning Network® Publications & Multimedia**

- New Medicare Beneficiary Identifier: Get It, Use It MLN Matters Article — New
- Quarterly Update to the Medicare Physician Fee Schedule Database MLN Matters Article — New
- Quarterly Update for the DMEPOS CBP MLN Matters Article — New
- Quarterly ASP Part B Drug Pricing Files and Revisions to Prior Files MLN Matters Article — New
- MCReF System Webcast: Video Presentation — New
- Quality Payment Program Call: Audio Recording and Transcript — New
- Diagnosis Code Update for Add-on Payments for Blood Clotting Factor Administered to Hemophilia Inpatients MLN Matters Article — Revised

## NMP Advantages Over the IVR

Although the Interactive Voice Response (IVR) is a great option to access patient, claim, and provider details, the Noridian Medicare Portal (NMP) is a more efficient, no cost, alternative. Check out the NMP advantages over the IVR.

| NMP | IVR |
|---|---|
| Users enter information using computer keyboard | Callers must follow voice prompts and use telephone touch-tone keypad or voice recognition to enter information (factors include accent and mispronunciation) |
| Users able to view information as it is entered (incorrect entries easily/quickly identified) | Callers must wait for an audio response to verify information entered |
| Users able to view immediate inquiry results | Callers must wait for audio response to hear inquiry results |
| Users can download and save viewed information | Callers able to hear inquiry results only |
| Continuous updates with increased access coming soon | No future enhancements planned |

Referring providers to the self-service options is a requirement per CMS Internet Only Manual (IOM), Publication 100-09, Medicare Beneficiary and Provider Communication Manual, Chapter 6, Section 50.1. **"**Providers shall be required to use IVRs to access claim status and beneficiary eligibility information. CSRs shall refer providers back to the IVR if they have questions about claims status or eligibility that can be handled by the IVR … Each MAC has the discretion to also require that providers use the Internet-based provider portal for claim status and eligibility inquiries if the portal has these functionalities."

## NMP Update for DME Vendors and Clearinghouses Only

A change regarding the CEDI Supplier Authorization form will now allow the automatic provisioning of the appropriate Noridian Medicare Portal (NMP) functions per CEDI's approval process for Vendor Administrators and Vendor End Users.

Vendors are still responsible to register for their own individual accounts as directed in the NMP Registration Guide. If you are unsure if this relationship has been acknowledged, please contact your supplier. You may refer to Change Request (CR) 9921 for more details.

## Oxygen Flow Rate Revised and New Modifiers – Revised

**MLN Matters Number: MM10158 Revised**
**Related Change Request (CR) Number: 10158**
**Related CR Release Date: March 30, 2018**
**Effective Date: April 1, 2018**
**Related CR Transmittal Number: R4014CP**
**Implementation Date: April 2, 2018**

This article was revised on April 2, 2018, to reflect the revised CR10158 issued on March 30. In the article, the CR release date, transmittal number, and the Web address of CR10158 are revised. All other information remains the same.

### PROVIDER TYPES AFFECTED

This MLN Matters® Article is intended for providers and suppliers submitting claims to

Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for oxygen services provided to Medicare beneficiaries.

### PROVIDER ACTION NEEDED

Change Request (CR) 10158 revises and introduces new pricing modifiers for oxygen flow rate. Make sure your billing staffs are aware of these changes.

### BACKGROUND

Medicare pays a monthly fee schedule amount for oxygen and oxygen equipment per beneficiary. For stationary oxygen equipment, this monthly fee schedule amount covers the oxygen equipment, contents and supplies and is subject to adjustment depending on the amount of oxygen prescribed (liters per minute (LPM)) and whether or not portable oxygen is also prescribed. The regulations at 42 CFR 414.226(e), and the Medicare Claims Processing Manual, of Chapter 20, Section 30.6.1 include the following payment rules regarding adjustments to the monthly payment amounts for oxygen and oxygen equipment based on the patient's prescribed oxygen flow rate:

1. If the prescribed amount of oxygen is less than 1 LPM, the fee schedule amount for stationary oxygen rental is reduced by 50 percent.

2. The fee schedule amount for stationary oxygen equipment is increased under the following conditions. If both conditions apply, MACs use the higher of either of the following add-ons. Your MAC may not pay both add-ons:

- Volume Adjustment - If the prescribed amount of oxygen for stationary equipment exceeds 4 LPM, the fee schedule amount for stationary oxygen rental is increased by 50 percent. If the prescribed liter flow for stationary oxygen is different than for portable or different for rest and exercise, MACs use the prescribed amount for stationary systems and for patients at rest. If the prescribed liter flow is different for day and night use, MACs use the average of the two rates.
- Portable Add-on - If portable oxygen is prescribed, the fee schedule amount for portable equipment is added to the fee schedule amount for stationary oxygen rental.

The Medicare National Coverage Determinations Manual, Part 4, Chapter 1, Section 240.2.B (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part4.pdf) indicates that a member of the MAC's medical staff should review all claims with oxygen flow rates of more than four liters per minute before payment can be made.

The Medicare Claims Processing Manual, Chapter 20, Section 130.6 describes the claims processing modifiers used to denote these adjustments:

- If the prescribed amount of oxygen is less than 1 LPM, suppliers use the modifier "QE"; Home Health Agencies (HHAs) use revenue code 0602. The monthly payment amount for stationary oxygen is reduced by 50 percent.

- If the prescribed amount of oxygen is greater than 4 LPM, suppliers use the modifier "QG"; HHAs use revenue code 0603. The monthly payment amount for stationary oxygen is increased by 50 percent.
- If the prescribed amount of oxygen exceeds 4LPM and portable oxygen is prescribed, suppliers use the modifier "QF", HHAs use revenue code 0604. The monthly payment for stationary oxygen is increased by the higher of 50 percent of the monthly stationary oxygen payment amount, or the fee schedule amount for the portable oxygen add-on. (A separate monthly payment is not allowed for the portable equipment if the stationary oxygen fee schedule amount is increased by 50 percent.) Effective April 1, 2017, the modifier "QF" must be used with both the stationary and portable oxygen equipment codes.

In addition, CR9848, issued on March 3, 2017, and titled "Payment for Oxygen Volume Adjustments and Portable Oxygen Equipment" (review related article at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM9848.pdf) provided instructions for MACs processing claims for payment of oxygen and oxygen equipment under the Medicare Part B benefit for durable medical equipment.

**KEY POINTS**

To assist in identifying the prescribed flow rate on the claim form, and to ensure appropriate use of modifiers in all cases based on the prescribed flow rate at rest (or at night or based on the average of the rate at rest and at night if applicable) in accordance with Federal regulations, the following three new pricing modifiers are added to the HCPCS file effective April 1, 2018:

- QA - Prescribed amounts of stationary oxygen for daytime use while at rest and nighttime use differ and the average of the two amounts is less than 1 liter per minute (LPM)
- QB - Prescribed amounts of stationary oxygen for daytime used while at rest and nighttime use differ and the average of the two amounts exceeds 4 liters per minute (LPM) and portable oxygen is prescribed
- QR - Prescribed amounts of stationary oxygen for daytime use while at rest and nighttime use differ and the average of the two amounts is greater than 4 liters per minute (LPM)

Additionally, the existing QE, QF, and QG modifiers are revised to clarify that the prescribed flow rate at rest is used in accordance with regulations at 42 CFR 414.226(e)(3). This section instructs that if the prescribed flow rate is different for the patient at rest than for the patient at exercise, the flow rate for the patient at rest is used.

Effective April 1, 2018, these modifiers are revised to read:

- QE - Prescribed amount of stationary oxygen while at rest is less than 1 liter per minute (LPM)
- QF - Prescribed amount of stationary oxygen while at rest exceeds 4 liters per minute (LPM) and portable oxygen is prescribed
- QG - Prescribed amount of stationary oxygen while at rest is greater than 4 liters per minute (LPM)

Beginning April 1, 2018, claims for monthly oxygen volume adjustments must indicate the appropriate HCPCS modifier described below as applicable. Oxygen fee schedule amounts are adjusted as follows:

- If the prescribed amount of oxygen is less than 1 LPM, suppliers use either of the following modifiers with the stationary oxygen HCPCS code:
  - The modifier "QE"; HHAs use revenue code 0602. The monthly payment amount for stationary oxygen is reduced by 50 percent.
  - The modifier "QA"; the monthly payment amount for stationary oxygen is reduced by 50 percent. This modifier is used when the prescribed flow rate is different for nighttime use and daytime use and the average of the two flow rates is used in determining the volume adjustment.
- If the prescribed amount of oxygen is greater than 4 LPM, suppliers use either of the following modifiers with the stationary oxygen HCPCS code:
  - The modifier "QG"; HHAs use revenue code 0603. The monthly payment amount for stationary oxygen is increased by 50 percent.
  - The modifier "QR"; HHAs use revenue code 0603. The monthly payment amount for stationary oxygen is increased by 50 percent.

- If the prescribed amount of oxygen is greater than 4 LPM and portable oxygen is prescribed, suppliers use either of the following modifiers with both the stationary and portable oxygen HCPCS code:
  - The modifier "QF"; HHAs use revenue code 0604. If the prescribed flow rate differs between stationary and portable oxygen equipment, the flow rate for the stationary equipment is used. The monthly payment for stationary oxygen is increased by the higher of 50 percent of the monthly stationary oxygen payment amount, or the fee schedule amount for the portable oxygen add-on. A separate monthly payment is not allowed for the portable equipment if the stationary oxygen fee schedule amount is increased by 50 percent. Effective April 1, 2017, the modifier "QF" must be used with both the stationary and portable oxygen equipment codes.
  - The modifier "QB"; HHAs use revenue code 0604. If the prescribed flow rate differs between stationary and portable oxygen equipment, the flow rate for the stationary equipment is used. The monthly payment for stationary oxygen is increased by the higher of 50 percent of the monthly stationary payment amount, or the fee schedule amount for the portable oxygen add-on. A separate monthly payment is not allowed for the portable equipment if the stationary oxygen fee schedule amount is increased by 50 percent. Effective April 1, 2018, the modifier "QB" must be used with both the stationary and portable oxygen equipment codes. The stationary and portable oxygen equipment QB fee schedule amounts will be added to the DMEPOS fee schedule file effective April 1, 2018.

The stationary oxygen QF and QB fee schedule amounts on the DMEPOS fee schedule file represent 100 percent of the stationary oxygen allowed fee schedule amount. The portable oxygen equipment add-on QF and QB fee schedule amount on the file by state represent the higher of:

- 50 percent of the monthly stationary oxygen payment amount (codes E0424, E0439, E1390 or E1391); or
- The fee schedule amount for the portable oxygen add-on (codes E0431, E0433, E0434, E1392 or K0738).

**ADDITIONAL INFORMATION**

The official instruction, CR10158, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4014CP.pdf.

**DOCUMENT HISTORY**

| Date of Change | Description |
|---|---|
| April 2, 2018 | This article was revised to reflect the revised CR10158 issued on March 30. In the article, the CR release date, transmittal number, and the Web address of CR10158 are revised. All other information remains the same. |
| February 14, 2018 | Initial article released. |

# Implement Operating Rules - Phase III Electronic Remittance Advice (ERA) Electronic Funds Transfer (EFT): CORE 360 Uniform Use of CARC, RARC and CAGC Rule – Update from CAQH CORE

MLN Matters Number: MM10566
Related Change Request (CR) Number: 10566
Related CR Release Date: May 18, 2018
Effective Date: October 1, 2018
Related CR Transmittal Number: R4054CP
Implementation Date: October 1, 2018

## 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 (DME/MACs) for services to Medicare beneficiaries.

## PROVIDER ACTION NEEDED

Change Request (CR) 10566 informs MACs to update their systems based on the CORE 360 Uniform use of Claims Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC) and Claim Adjustment Group Code (CAGC) rule publication. These system updates are based on the Committee on Operating Rules for Information Exchange (CORE) Code Combination List to be published on or about June 4, 2018. CR10566 applies to the Medicare Claims Processing Manual, Chapter 22, Section 80.2. Make sure that your billing staffs are aware of these changes.

## BACKGROUND

The Department of Health and Human Services (DHHS) adopted the Phase III Council for Affordable Quality Healthcare (CAQH) CORE, Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) Operating Rule Set that was implemented on January 1, 2014, under the Affordable Care Act. The Health Insurance Portability and Accountability Act (HIPAA) amended the Act by adding Part C—Administrative Simplification—to Title XI of the Social Security Act, requiring the Secretary of DHHS (the Secretary) to adopt standards for certain transactions to enable health information to be exchanged more efficiently and to achieve greater uniformity in the transmission of health information. Through the Affordable Care Act, Congress sought to promote implementation of electronic transactions and achieve cost reduction and efficiency improvements by creating more uniformity in the implementation of standard transactions. This was done by mandating the adoption of a set of operating rules for each of the HIPAA transactions.

CR10566 deals with the regular update in CAQH CORE defined code combinations per Operating Rule 360 - Uniform Use of CARC and RARC (835) Rule.

CAQH CORE will publish the next version of the Code Combination List on or about June 4, 2018. This update is based on the CARC and RARC updates as posted at the Washington Publishing Company (WPC) website on or about March 1, 2018. This will also include updates based on market based review that CAQH CORE conducts once a year to accommodate code combinations that are currently being used by health plans including Medicare, as the industry needs them.

See http://www.wpc-edi.com/ reference for CARC and RARC updates and http://www.caqh.org/CORECodeCombinations.php for CAQH CORE defined code combination updates.

**NOTE:** As the Affordable Care Act requires, all health plans including Medicare must comply with CORE 360 Uniform Use of CARCs and RARCs (835) rule or CORE developed maximum set of CARC/RARC and CAGC combinations for a minimum set of four (4) business scenarios. Medicare can use any code combination if the business scenario is not one of the four (4) CORE defined business scenarios. With the four (4) CORE defined business scenarios, Medicare must use the code combinations from the lists published by CAQH CORE.

### ADDITIONAL INFORMATION

The official instruction, CR10566, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4054CP.pdf.

### DOCUMENT HISTORY

| Date of Change | Description |
|---|---|
| May 18, 2018 | Initial article released. |

## Publication 100-04, Chapters 1 and 27, to Replace RARC MA61 with N382 Update

**MLN Matters Number: MM10619**
**Related Change Request (CR) Number: 10619**
**Related CR Release Date: May 11, 2018**
**Effective Date: August 13, 2018**
**Related CR Transmittal Number: R4047CP**
**Implementation Date: August 13, 2018**

### PROVIDER TYPES AFFECTED

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

### WHAT YOU NEED TO KNOW

Change Request (CR) 10619 initiates both Medicare manual changes and operational changes related to the New Medicare Card. Medicare will replace the use of Remittance Advice Remark Code (RARC) MA61, referenced in the Medicare Claims Processing Manual, Chapters 1 and 27, with RARC N382 - missing/incomplete/invalid patient identifier (HICN or MBI). Effective for claims processed on or after the effective date of CR10619, MACs will use N382 in place of MA61 to communicate reject/denials for patient identifiers (HICN or MBI) in all remittance advices and 835 transactions. However, MACs will continue to use RARC MA61 only when/if communicating rejections/denials related to a missing/incomplete/invalid social security number. Make sure your billing staffs are aware of these updates.

### BACKGROUND

With the implementation of the Medicare Beneficiary Identifier (MBI), references to the Health Insurance Claim Number (HICN) will be replaced with a more generic reference (Patient Identifier). CR 16019 initiates the manual changes and operational changes to accomplish this task.

### ADDITIONAL INFORMATION

The official instruction, CR 10619, issued to your MAC regarding this change, is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4047CP.pdf.

### DOCUMENT HISTORY

| Date of Change | Description |
|---|---|
| May 14, 2018 | Initial article released. |

# RARC, CARC, MREP and PC Print Update

MLN Matters Number: MM10620
Related Change Request (CR) Number: 10620
Related CR Release Date: May 18, 2018
Effective Date: October 1, 2018
Related CR Transmittal Number: R4057CP
Implementation Date: October 1, 2018

## PROVIDER TYPES AFFECTED

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

## PROVIDER ACTION NEEDED

Change Request (CR) 10620 updates the Remittance Advice Remark Code (RARC) and Claims Adjustment Reason Code (CARC) lists and instructs Medicare Shared System Maintainers (SSMs) to update Medicare Remit Easy Print (MREP) and PC Print. Be sure your staff are aware of these changes and obtain the updated MREP and PC Print software if they use that software.

## BACKGROUND

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

The Centers for Medicare & Medicaid Services (CMS) instructs MACs to conduct updates based on the code update schedule that occurs three times per year – around March 1, July 1, and November 1. CMS provides CR10620 as a code update notification indicating when updates to CARC and RARC lists are made available on the Washington Publishing Company (WPC) website. Medicare's SSMs have the responsibility to implement code deactivation, making sure that any deactivated code is not used in original business messages and allowing the deactivated code in derivative messages. SSMs must make sure that Medicare does not report any deactivated code on or after the effective date for deactivation as posted on the WPC website. If any new or modified code has an effective date past the implementation date specified in CR 10620, MACs must implement on the date specified on the WPC website available at http://wpc-edi.com/Reference/.

A discrepancy between the dates may arise because the WPC website is only updated three times per year and may not match the CMS release schedule. For CR 10620, MACs and SSMs must get the complete list for both CARC and RARC from the WPC website to obtain the comprehensive lists for both code sets and determine the changes that are included on the code list since the last code update referenced in CR10489.

## ADDITIONAL INFORMATION

The official instruction, CR10620, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4057CP.pdf.

## DOCUMENT HISTORY

| Date of Change | Description |
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