DME Happenings

Jurisdiction D

December 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 6 a.m. – 8 p.m. CT for all other inquiries
Supplier Contact Center	877-320-0390	Monday – Friday 8 a.m. – 6 p.m. CT
Telephone Reopenings	877-320-0390	Monday – Friday 8 a.m. – 4:30 p.m. CT
Beneficiary Customer Service	800-633-4227	24/7
Fax Numbers		
Reopenings/Redeterminations Recovery Auditor Redeterminations		701-277-7886
Recoupment • Refunds to Medicare • 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 • Redetermination Requests • Correspondence • ADMC Requests • Medical Review Documentation • Recovery Auditor Overpayments	**Noridian JD DME** Attn: _____ PO Box 6727 Fargo, ND 58108-6727
• Benefit Protection • Administrative Simplification Compliance Act Exception Requests (ASCA)	**Noridian JD DME** Attn: _____ PO Box 6736 Fargo, ND 58108-6736
Qualified Independent Contractor (QIC)	**C2C Solutions, Inc.** Attn: DME QIC PO Box 44013 Jacksonville, FL 32231-4013
• EFT Forms • Overpayment Redeterminations • Recovery Auditor Redeterminations	**Noridian JD DME** Attn: _____ PO Box 6728 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

Condition of Payment Prior Authorization Lookup Tool Now Available

Are you a supplier who would like to know which HCPCS codes require a prior authorization request? Noridian now has a tool to determine this for all Condition of Payment Prior Authorization codes

Access the Prior Authorization Lookup Tool from the Pre-Claim Review webpage.

Medicare Minute: Telehealth Benefit Video Now Available

All Jurisdiction D providers are encouraged to watch this special edition of Medicare Minute MD. In the video, Dr. Robert Hoover, the Jurisdiction C Medical Director, discusses Medicare's Telehealth Benefit and provides insight into various arrangements for telemedicine that all treating practitioners need to consider before engaging in these types of practices. This video was produced by CGS Administrators, LLC, the Jurisdictions B and C DME MAC, in collaboration with Noridian Healthcare Solutions, the Jurisdiction A and Jurisdiction D DME MAC.

Access this Telehealth tutorial, and many more, from our DME on Demand webpage.

CMS Awards Funding for Quality Measure Development

CMS NEWS

FOR IMMEDIATE RELEASE
September 21, 2018

Contact: CMS Media Relations
(202) 690-6145 | CMS Media Inquiries

Agency funds new partnerships to develop meaningful measures for the Medicare Quality Payment Program

The CMS today awarded seven organizations new cooperative agreements to partner with the agency in developing, improving, updating, or expanding quality measures for Medicare's Quality Payment Program (QPP). These cooperative agreements, authorized under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), represent the first funding initiative supporting public-private efforts to develop measures for the Quality Payment Program. Through these partnerships, CMS will work closely with external organizations—such as clinical professional organizations and specialty societies, patient advocacy groups, educational institutions, independent research institutions, and health systems—to develop and implement measures that offer the most promise for improving patient care.

"CMS looks forward to collaborating with these clinicians, patients, and other key stakeholders to identify quality measures that will meaningfully impact patient care," said Administrator Seema Verma. "Through our Meaningful Measures initiative, CMS is committed to advancing measures that minimize burden on clinicians, improve outcomes for patients, and drive high-quality care. We need the expertise and firsthand experience of those on the front lines to develop measures that achieve these goals."

This funding program aligns with CMS's Meaningful Measures framework, which identifies high priorities for quality measurement and improvement. As outlined in the CMS Quality Measure Development Plan, the work announced today is intended to fill gaps in the QPP measure set. This could involve removing measures with limited value and adding others that are more clinically appropriate, increase value, reduce provider burden, and enhance patient care. Program partners will work to establish more appropriate measures for clinical specialties underrepresented in the current measure set with the goal of improving patient care, and focus on outcome measures, including patient-reported and functional-status measures, to better reflect what matters most to patients.

The measures developed through this initiative will help shape Medicare's Quality Payment Program, which CMS established to implement certain provisions of MACRA. Heading into its third year in 2019, the Quality Payment Program consists of two participation pathways for doctors and other clinicians—the Merit-based Incentive Payment System or MIPS, which measures performance in four categories to determine an adjustment to Medicare payment, and Advanced Alternative Payment Models or Advanced APMs, in which clinicians may earn an incentive payment through sufficient participation in risk-based payment models.

This year, CMS has removed or proposed to eliminate reporting requirements for 105 measures across the agency's programs, saving healthcare providers $178 million over the next three years. More than 400 measures remain across these programs, and CMS remains committed to patient safety and quality.

The next phase of Meaningful Measures is identifying a set of measures that minimizes provider time spent collecting and submitting data to CMS, while assessing those core issues that are the most critical to providing high-quality care.

For more information on today's funding awards to support Medicare quality measure development, please visit: https://go.cms.gov/1Gb6GDL

Source

- CMSLISTS Email Update dated September 21, 2018

IVIG Demonstration: Payment Update for 2019

MLN Matters Number: MM10896
Related CR Release Date: October 19, 2018
Related CR Transmittal Number: R211DEMO
Related Change Request (CR) Number: 10896
Effective Date: January 1, 2019
Implementation Date: January 7, 2019

Change Request (CR) 10896 establishes the payment rate for demonstration services rendered to eligible beneficiaries enrolled in the demonstration for services rendered in 2019. All other processes related to uploading application files and processing claims under this demonstration remain the same. The payment rate for Q2052: "Services, Supplies and Accessories Used in the Home under the Medicare IVIG Demonstration" for dates of service from January 1, 2019 - December 31, 2019 will be $366.25. Make sure your billing staffs are aware of this update.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)10896.

Order Requirements When Prescribing Practitioner is also the Supplier and is Permitted to Furnish Specific Items of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

MLN Matters Number: MM10984
Related Change Request (CR) Number: 10984
Related CR Release Date: October 12, 2018
Effective Date: November 13, 2018
Related CR Transmittal Number: R834PI
Implementation Date: November 13, 2018

Change Request (CR) 10984 clarifies the requirements of Centers for Medicare & Medicaid Services (CMS) for a written order when the prescribing practitioner is also the supplier, and is permitted to furnish specific items of DMEPOS.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)10984.

Influenza Resources for Health Care Professionals for 2018 - 2019

MLN Matters Number: SE18015
Article Release Date: September 24, 2018

Special Edition (SE) MLN Matters article SE18015 provides information about influenza (flu) resources for health care professionals and providers relevant to the 2018-2019 flu season.

View the complete CMS Medicare Learning Network (MLN) Matters (MM) Special Edition (SE)18015.

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 7 a.m. - 6 p.m. CT 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. • National Provider Identifier (NPI) • Provider Transaction Access Number (PTAN) • Last five digit of Tax ID Number (TIN) • Supplier name • Beneficiary's Health Insurance Claim Number (HICN) • Beneficiary's first and last name • Date of service (DOS) • Last five of the Claim Control Number (CCN) • Healthcare Common Procedure Coding System (HCPCS) code(s) in question • Corrective action to be taken **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.

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.
	• Diagnosis code changes or additions
	• Date of Service (DOS) changes
	• HCPCS code changes
	• Certain modifier changes or additions (not an all-inclusive list)
	  • KH
	  • KI
	  • KJ
	  • RR
	  • NU
	  • AU
	  • KL
	  • RT
	  • LT
	  • A1 – A9
	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.

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.
	• Overutilization denials that require supporting medical records
	• Certificate of Medical Necessity (CMN) and Durable Medical Equipment Information Form (DIF) issues. Please see the article posted March 21, 2013
	• Oxygen break in service (BIS) issues
	• Overpayments or reductions in payment
	• Medicare Secondary Payer (MSP) issues
	• Claims denied for timely filing
	• Reopenings past one year from the initial determination
	• Complex Medical Reviews or Additional Documentation Requests
	• Advance Beneficiary Notice of Noncoverage (ABN) issues and other liability issues
	• Repair and labor claims
	• Miscellaneous HCPCS codes and all HCPCS codes that require manual pricing
	• The following modifier changes or additions:
	  • K0 through K4
	  • GA
	  • GY
	  • GZ
	  • KX
	  • EY
	  • RA
	  • RB
	  • RP
	  • JW
	  • KK
	• Certain HCPCS codes (not all-inclusive list)
	  • A4450 through A4452
	  • E0194
	  • E0748
	  • E1028
	  • J1559
	  • J1561
	  • J1562
	  • K0108
	  • 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.

Where can I find more information on Telephone Reopenings?	• Supplier Manual Chapter 13 • Reopening Section on the Noridian DME website • 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.

Overpayment Appeals

Are you a supplier who has received a demand letter indicating an overpayment determination has been made? Is the overpayment subject to Limitation on Recoupment? And if it is, how does Limitation on Recoupment apply to Appeals?

View the Limitation on Recoupment webpage for information about the types of overpayments that are subject to the Limitation on Recoupment, what the timeframe is on collection activities, how it applies to the appeals process, and access CMS resources.

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.

HCPCS Drug/Biological Code Changes - October 2018 Update - Second Revision

MLN Matters Number: MM10834 Revised
Related Change Request (CR) Number: 10834
Related CR Release Date: September 13, 2018
Effective Date: July 12, 2018, for Q5108; October 1, 2018, for Q5110
Related CR Transmittal Number: R4134CP
Implementation Date: October 1, 2018

The HCPCS code set is updated on a quarterly basis. CR 10834 informs MACs of the October 2018 addition of new HCPCS codes, Q5108 and Q5110. The codes are payable by Medicare effective with dates of service on or after July 12, 2018, for Q5108 and effective with dates of service on or after October 1, 2018, for Q5110.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)10834.

ICD-10 and Other Coding Revisions to NCDs - Revised

MLN Matters Number: MM10859 Revised
Related CR Release Date: November 8, 2018
Related CR Transmittal Number: R2200OTN
Related CR Number: 10859
Effective Date: January 1, 2019
Implementation Date: January 7, 2019, shared edits. September 28, 2018, local edits

Change Request (CR) 10859 constitutes a maintenance update of International Classification of Diseases, Tenth Revision (ICD-10) conversions and other coding updates specific to national coverage determinations (NCDs). These NCD coding changes are the result of newly available codes, coding revisions to NCDs released separately, or coding feedback received. Please follow the link below for the NCD spreadsheets included with this CR: https://www.cms.gov/Medicare/Coverage/DeterminationProcess/downloads/CR10859.zip. Make sure that your billing staffs are aware of these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)10859.

Hurricane Maria and Medicare Disaster Related United States Virgin Islands and Commonwealth of Puerto Rico Claims - Third Revision

MLN Matters Number: SE17028 Revised
Article Release Date: September 13, 2018

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

View the complete CMS Medicare Learning Network (MLN) Matters (MM) Special Edition (SE)17028.

Hurricane Florence and Medicare Disaster Related North Carolina, South Carolina, and the Commonwealth of Virginia Claims - Revised

MLN Matters Number: SE18014 Revised
Article Release Date: October 10, 2018

On September 10, 2018, pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act, President Trump declared that, as a result of the effects of Hurricane Florence, an emergency exists in North Carolina and South Carolina. On September 11, 2018, President Trump declared an emergency exists in the Commonwealth of Virginia as a result of Hurricane Florence. Also, on September 11, 2018, Secretary Azar of the Department of Health & Human Services declared that a public health emergency exists in North Carolina and South Carolina and authorized waivers and modifications under Section 1135 of the Social Security Act (the Act), retroactive to September 7, 2018, for the State of North Carolina and retroactive to September 8, 2018, for the State of South Carolina. On September 12, Secretary Azar declared a public health emergency exists in the Commonwealth of Virginia, retroactive to September 8, 2018.

View the complete CMS Medicare Learning Network (MLN) Matters (MM) Special Edition (SE)18014.

Hurricane Michael and Medicare Disaster Related Florida and Georgia Claims MLN Matters Article - Revised

MLN Matters Number: SE18021 Revised
Article Release Date: October 12, 2018

Note: This article was revised on October 12, 2018, to add information regarding the emergency declared for the State of Georgia as a result of Hurricane Michael.

On October 9, 2018, pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act, President Trump declared that, as a result of the effects of Hurricane Michael, an emergency exists in the State of Florida. On October 10, 2018, President Trump declared a similar emergency for the State of Georgia as a result of Hurricane Michael. Also, on October 9, 2018, Secretary Azar of the Department of Health & Human Services declared that a public health emergency exists in Florida and authorized waivers and modifications under Section 1135 of the Social Security Act (the Act), retroactive to October 7, 2018, for Florida. Also, on October 11, 2018, Secretary Azar declared that a public health emergency exists in the State of Georgia, retroactive to October 9, 2018, and authorized the same waivers and modifications for Georgia.

View the complete revised CMS Medicare Learning Network (MLN) Matters (MM) Special Edition (SE)18021.

Typhoon Yutu and Medicare Disaster Related Commonwealth of the Northern Mariana Islands Claims

MLN Matters Number: SE18024

Article Release Date: October 31, 2018

On October 26, 2018, the Administrator of CMS authorized waivers under Section 1812(f) of the Social Security Act for the Commonwealth of the Northern Mariana Islands for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of Typhoon Yutu in the Commonwealth of the Northern Mariana Islands in 2018, retroactive to October 24, 2018.

View the complete CMS Medicare Learning Network (MLN) Matters (MM) Special Edition (SE)18024.

Medicare Fee-for-Service (FFS) Response to the 2018 California Wildfires

MLN Matters Number: SE18025

Article Revised Date: November 15, 2018

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 2018 wildfires in the State of California.

View the complete CMS Medicare Learning Network (MLN) Matters Special Edition (SE)18025.

2019 Open Enrollment Period

The 2019 Annual Participation Open Enrollment Period runs mid-November through December 31, 2018. The open enrollment period allows Medicare suppliers to revisit their choice to accept Medicare assignment for claims payment. The participation status only affects how a supplier is reimbursed from Medicare. Changing your status to non-participating does not terminate your Medicare billing privileges.

- Do nothing if you do not wish to change your participation status
- To change your status to participating, submit a request on CMS-460 form signed by authorized or delegated official as previously reported to National Supplier Clearinghouse (NSC)
- To change your status to non-participating, submit a request on your company's letterhead signed by company's authorized or delegated official as previously reported to NSC

The CMS-460 participation agreement can be downloaded from the CMS website.

If you do not wish to make any changes to your participation status, it is not necessary to respond during this period.

If you are currently enrolled in the Medicare program other than as a DMEPOS supplier, you may only change your participation status with one contractor. Participation status will be the same with all Medicare contractors.

For more information, contact NSC Customer Service.

CGM Supply and Accessory Claims Being Rejected

Are you a pharmacy that has received a claim rejection or error message when submitting a National Drug Code (NDC) for Continuous Glucose Monitor (CGM) supplies and accessories?

View the Tips section of the Glucose Monitors webpage to assist with proper billing of these items.

Correct Coding and Coverage - Panzyga (Immunoglobulin Intravenous (Human), 10%)

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Correct Coding and Coverage - Panzyga® (Immunoglobulin Intravenous (Human), 10%)" is now available on our (Noridian) website.

View the complete Correct Coding and Coverage - Panzyga® (Immunoglobulin Intravenous (Human), 10%) webpage.

Expanded Coverage of Blincyto

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Expanded Coverage of Blincyto®" is now available on our (Noridian) website.

View the complete Expanded Coverage of Blincyto® webpage.

LCD and Policy Article Revisions Summary for September 27, 2018

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "LCD and Policy Article Revisions Summary for September 27, 2018" is now available on our (Noridian) website.

View the complete LCD and Policy Article Revisions Summary for September 27, 2018 webpage.

LCD Revisions Summary for November 1, 2018

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "LCD Revisions Summary for November 1, 2018" is now available on our (Noridian) website.

View the complete LCD Revisions Summary for November 1, 2018 webpage.

Revised Billing Instruction - Oxygen Q Modifiers and Medical Documentation Joint DME MAC Article

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Revised Billing Instruction – Oxygen "Q" Modifiers and Medical Documentation Joint DME MAC Article" is now available on our (Noridian) website.

View the complete Revised Billing Instruction - Oxygen "Q" Modifiers and Medical Documentation Joint DME MAC Article webpage.

Clinician Resource Letters – Prior Authorization Condition of Payment for Certain Power Mobility Devices

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Clinician Resource Letters – Prior Authorization Condition of Payment for Certain Power Mobility Devices" is now available on our (Noridian) website.

View the complete Clinician Resource Letters – Prior Authorization Condition of Payment for Certain Power Mobility Devices

Dear Physician Letter - Documentation of Artificial Limbs and Braces (O&P) - November 2018

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Dear Physician Letter - Documentation of Artificial Limbs and Braces (O&P) - November 2018" is now available on our (Noridian) website.

Local Coverage Determinations (LCDs)

MLN Matters Number: MM10901
Related Change Request (CR) Number: 10901
Related CR Release Date: October 3, 2018
Effective Date: October 3, 2018
Related CR Transmittal Number: R829PI
Implementation Date: January 8, 2019

Change Request (CR) 10901 notifies MACs that, in accordance with Section 4009 of H.R. 34-21st Century Cures Act (Public Law No: 114-255), the Centers for Medicare & Medicaid Services (CMS) is updating the Medicare Program Integrity Manual with detailed changes to the Local Coverage Determination (LCD) process. You should ensure that your staffs are aware of these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)10901.

Policy Article Revisions Summary for September 13, 2018

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Policy Article Revisions Summary for September 13, 2018" is now available on our (Noridian) website.

View the complete Policy Article Revisions Summary for September 13, 2018 webpage.

Important New Medicare Card Mailing Update - Wave 7 Begins, Wave 5 Ends

CMS has started mailing new Medicare cards to people with Medicare who live in Wave 7 states and territories including: Kentucky, Louisiana, Michigan, Mississippi, Missouri, Ohio, Puerto Rico, Tennessee, and the Virgin Islands.

We are finished mailing cards to people with Medicare who live in states within Waves 1 through 4 and now Wave 5. If someone with Medicare who lives in one of these states says they did not get a card, you should instruct them to:

- Sign into MyMedicare.gov to see if we mailed their card. If so, they can print an official card. They will need to create an account if they do not already have one.
- Call 1-800-MEDICARE (1-800-633-4227) where we can verify their identity, check their address, and help them get their new card.

You can also print out and give them a copy of Still Waiting for Your New Card?, or you can order copies to hand out.

To ensure that people with Medicare continue to get care, you can use either the former Social Security number-based Health Insurance Claim Number (HICN) or the new alpha-numeric Medicare Beneficiary Identifier (MBI) for all Medicare transactions through December 31, 2019.

People with Medicare should continue to protect their new number to prevent medical identity theft and health care fraud, especially during Medicare Open Enrollment. View and share our new Guard your Medicare card video, which reminds people with Medicare to beware of scams. There are also new fraud prevention products on our new Medicare card Outreach & Education webpage for you to share with people with Medicare:

- Drop-in article (also in Spanish) and Public Service Announcement script reminding people to be wary of scams
- Flyer (also in Spanish) with fraud prevention tips during Open Enrollment

Continue to direct people with Medicare to Medicare.gov/NewCard for information about the mailings and to sign up to get emails about the status of card mailings in their state.

New Medicare Card - Progress Updates

The CMS continues to successfully mail newly-designed Medicare cards with the new Medicare Number and we're excited to share important progress updates with you.

As of August 31, we've mailed nearly 35 million cards and continue to mail more every day. We're processing claims and eligibility requests with the Medicare Beneficiary Identifier (MBI), showing that providers are successfully using the new number.

We started mailing new cards to people with Medicare who live in Wave 6 states this week and finished mailing cards to people who live in Waves 1, 2, 3 and 4 states. Because card mailing is progressing so well, we updated the mailing schedule to include an approximate start date for the last wave and we're on track to finish mailing new cards to all people with Medicare before April 2019.

With our ongoing focus on fraud and protecting the identities of people with Medicare, we're continuously adjusting and improving our mailing strategy to make sure we're mailing new cards to accurate addresses and using the highest levels of fraud protection throughout the mailing. To do this, we're:

- Using trusted industry tools and standards to verify addresses.
- Comparing each address against multiple information sources to ensure we're mailing to the right person and the right address.
- Mailing cards to people with Medicare when we have high confidence in their identity and address.

If someone with Medicare says they didn't get a card after their mailing wave ends, you should instruct them to:

- Call 1-800-MEDICARE (1-800-633-4227) where we can verify their identity, check their address and help them get their new card.
- Continue to use their current card to get health care services until they get their new card.

People with Medicare should continue to protect their new number to prevent medical identity theft and healthcare fraud. We'll continue to raise awareness about potential scams and how they can prevent fraud through our outreach and launched a national fraud prevention campaign in September before Medicare Open Enrollment.

Source

- CMSLISTS Email Update dated September 19, 2018

MLN Connects – September 6, 2018

MLN Connects® for Thursday, September 6, 2018

View this edition as a PDF

News & Announcements

- Physician Fee Schedule Year 3 Proposed Rule: Comments due September 10
- QRDA III Implementation Guide: Submit Comments by September 21
- PEPPERs for Short-term Acute Care Hospitals
- Hospice Quality Reporting Program: Training Materials from August Webinar
- Healthy Aging® Month: Discuss Preventive Services with your Patients

Provider Compliance

- CMS Provider Minute Video: The Importance of Proper Documentation — Reminder

Claims, Pricers & Codes

- Average Sales Price Files: October 2018

Upcoming Events

- Quality Payment Program All-Payer Combination Option Overview Webinar — September 12
- New Medicare Card Open Door Forum — September 13
- Dementia Care: Opioid Use & Impact for Persons Living with Dementia Call — September 18
- Medicare Diabetes Prevention Program: New Covered Service Call — September 26

Medicare Learning Network® Publications & Multimedia

- Review of Opioid Use during the IPPE and AWV MLN Matters® Article — New
- Update of the Hospital OPPS: October 2018 MLN Matters Article — New
- Physician Fee Schedule Listening Session: Audio Recording and Transcript — New
- Next Generation ACO Model 2019 Benefit Enhancement MLN Matters Article — Revised
- Mass Immunizers and Roster Billing Booklet — Revised

MLN Connects – September 13, 2018

MLN Connects® for Thursday, September 13, 2018

View this edition as a PDF

News & Announcements

- Help Your Medicare Patients Avoid and Report Scams
- Hospice Provider Preview Reports: Review Your Data by October 5
- IRF Provider Preview Reports: Review Your Data by October 8
- LTCH Provider Preview Reports: Review Your Data by October 8
- Open Payments: Key Thresholds for Program Year 2019 Reporting
- Open Payments: Program Year 2019 Teaching Hospital List
- Hand in Hand: A Training Series for Nursing Homes
- Quality Payment Program: Other Payer Advanced APM Resources
- Mapping Medicare Disparities Tool: Hospital View

- Physician Compare: Public Reporting Webinar Materials
- Prostate Cancer Awareness Month

Provider Compliance

- Bill Correctly for Device Replacement Procedures - Reminder

Upcoming Events

- Dementia Care: Opioid Use & Impact for Persons Living with Dementia Call — September 18
- Medicare Diabetes Prevention Program: New Covered Service Call — September 26
- Final Modifications to the Quality of Patient Care Star Rating Algorithm Call — October 3
- Comparative Billing Report on Psychologists Webinar — October 17

Medicare Learning Network® Publications & Multimedia

- Billing Requirements Implemented for non-OPPS Providers MLN Matters® Article — New
- Annual Clotting Factor Furnishing Fee: 2019 Update MLN Matters Article — New
- ASC Payment System: October 2018 Update MLN Matters Article — New
- Influenza Vaccine Payment Allowances: Annual Update MLN Matters Article — New
- Influenza Virus Vaccine Code: January 2019 Update MLN Matters Article — Revised
- Certification Statement Policies MLN Matters Article — Revised
- Telehealth Billing Requirements for Distant Site Services MLN Matters Article — Revised
- Complying with Documentation Requirements for Laboratory Services Fact Sheet — Revised
- Global Surgery Booklet— Revised
- Medicare Provider-Supplier Enrollment National Educational Products — Reminder

MLN Connects Special Edition – September 14, 2018

Hurricane Florence and Medicare Disaster Related North Carolina, South Carolina, and the Commonwealth of Virginia Claims MLN Matters Article — New

The President declared a state of emergency for the states of North Carolina, South Carolina, and the Commonwealth of Virginia, and the HHS Secretary declared a Public Health Emergency, which allows for CMS programmatic waivers based on Section 1135 of the Social Security Act. An MLN Matters Special Edition Article on Hurricane Florence and Medicare Disaster Related North Carolina, South Carolina, and the Commonwealth of Virginia Claims is available. Learn about blanket waivers CMS issued for the impacted geographical areas. These waivers will prevent gaps in access to care for beneficiaries impacted by the emergency.

MLN Connects Special Edition – September 17, 2018

New Medicare Card Mailing Update – Wave 6 Begins, Wave 4 Ends

CMS started mailing new Medicare cards to people with Medicare who live in Wave 6 states: Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Texas, Utah, Washington and Wyoming.

We finished mailing cards to people with Medicare who live in Waves 1, 2, 3, and now Wave 4 states and territories. If your Medicare patients say they did not get a card, ask them to:

- Sign into MyMedicare.gov to see if we mailed their card. If so, they can print an official card. They must create an account if they do not already have one.
- Call 1-800-MEDICARE (1-800-633-4227). There might be something that needs to be corrected, such as updating their mailing address.

You can also print out and give them a copy of Still Waiting for Your New Card?, or you can order copies to hand out.

To ensure your Medicare patients continue to get care, you can use either the former Social Security number-based Health Insurance Claim Number or the new alpha-numeric Medicare Beneficiary Identifier (MBI) for all Medicare transactions through December 31, 2019.

Check this website as the mailings progress. Continue to direct your Medicare patients to Medicare.gov/NewCard for information about the mailings and to sign up to get email about the status of card mailings in their state.

We are committed to mailing new cards to all people with Medicare by April 2019.

Information on the transition to the new MBI:

- New MBI Get It, Use It MLN Matters® Article
- Transition to New Medicare Numbers and Cards Fact Sheet
- New Medicare Card information website

MLN Connects Special Edition – September 19, 2018

New Medicare Card – Progress Updates

CMS continues to successfully mail newly-designed Medicare cards with the new Medicare number and we are excited to share important progress updates with you.

As of August 31, we mailed nearly 35 million cards and continue to mail more every day. We are processing claims and eligibility requests with the Medicare Beneficiary Identifier (MBI), showing that providers are successfully using the new number.

We started mailing new cards to people with Medicare who live in Wave 6 states this week and finished mailing cards to people who live in Waves 1, 2, 3 and 4 states. Because card mailing is progressing so well, we updated the mailing schedule to include an approximate start date for the last wave, and we are on track to finish mailing new cards to all people with Medicare before April 2019.

With our ongoing focus on fraud and protecting the identities of people with Medicare, we are continuously adjusting and improving our mailing strategy to make sure we are mailing new cards to accurate addresses and using the highest levels of fraud protection throughout the mailing. To do this, we are:

- Using trusted industry tools and standards to verify addresses
- Comparing each address against multiple information sources to ensure we are mailing to the right person and the right address
- Mailing cards to people with Medicare when we have high confidence in their identity and address

If your Medicare patients say they did not get a card after their mailing wave ends, ask them to:

- Call 1-800-MEDICARE (1-800-633-4227) where we can verify their identity, check their address, and help them get their new card
- Continue to use their current card to get health care services until they get their new card

Your Medicare patients should continue to protect their new number to prevent medical identity theft and health care fraud. We will continue to raise awareness about potential scams and how they can prevent fraud through our outreach and launched a national fraud prevention campaign in September before Medicare Open Enrollment.

MLN Connects – September 20, 2018

MLN Connects® for Thursday, September 20, 2018

View this edition as a PDF

News & Announcements

- CMS Proposes to Lift Unnecessary Regulations and Ease Burden on Providers
- Hospital Quality Reporting System Open for CY 2018 eCQM Data
- eCQM Value Sets: Updates for 2019 Reporting and Performance Periods
- MIPS Targeted Review Request: Deadline Extended to October 15
- Quality Payment Program: MIPS Resources
- Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier

Provider Compliance

- Billing for Stem Cell Transplants — Reminder

Claims, Pricers & Codes

- ASP Pricing Files and Coverage for Drugs

Upcoming Events

- Medicare Diabetes Prevention Program: New Covered Service Call — September 26
- FY 2019 IPPS/LTCH PPS Final Rule Webinar—September 26
- Final Modifications to the Quality of Patient Care Star Rating Algorithm Call — October 3
- Provider Compliance Focus Group Meeting — October 5
- Submitting Your Medicare Part A Cost Report Electronically Webcast — October 15
- Home Health Quality Reporting Program In-Person Training Event — November 6 and 7

Medicare Learning Network® Publications & Multimedia

- IMRT Planning Services Editing MLN Matters Article — New
- Payment Policy Changes Affecting Hospice Aggregate Cap Calculation and Designation of Hospice Attending Physicians MLN Matters Article — New
- Medicare Claims Processing Manual, Chapter 23: Update MLN Matters Article — New
- Procedure Coding: Using the ICD-10-PCS Web-Based Training — New
- ICD-10 and Other Coding Revisions to NCDs MLN Matters Article — Revised
- HCPCS Drug/Biological Code Changes: October 2018 Update MLN Matters Article — Revised
- Hurricane Maria and Medicare Disaster Related U.S Virgin Islands and Commonwealth of Puerto Rico Claims MLN Matters Article — Revised
- Preventive Services Poster Educational Tool — Revised
- Medicare Fraud & Abuse Poster — Revised

MLN Connects – September 27, 2018

MLN Connects® for Thursday, September 27, 2018

View this edition as a PDF

News & Announcements

- New Medicare Card: MBI on Remittance Advice October 1
- Quality Payment Program: Funding for Quality Measure Development
- Patients Over Paperwork September Newsletter
- Hospice Provider Preview Reports: Review Your Data by October 5
- IRF Provider Preview Reports: Review Your Data by October 8
- LTCH Provider Preview Reports: Review Your Data by October 8
- QRURs and PQRS Feedback Reports: Access Ends December 31
- 2019 Eligible Hospital eCQM Flows
- Connected Care Toolkit
- Development of a Disability Index
- Hurricane Resources from ASPR TRACIE
- Medicare Appeals Council: New Decision Format
- National Cholesterol Education Month and World Heart Day

Provider Compliance

- Improper Payment for Intensity-Modulated Radiation Therapy Planning Services

Claims, Pricers & Codes

- FY 2019 IPPS and LTCH PPS Claims Hold

Upcoming Events

- Final Modifications to the Quality of Patient Care Star Rating Algorithm Call - October 3
- Provider Compliance Focus Group Meeting - October 5
- Submitting Your Medicare Part A Cost Report Electronically Webcast - October 15

Medicare Learning Network® Publications & Multimedia

- New Waived Tests MLN Matters Article - New
- HCPCS Drug/Biological Code Changes: October Update MLN Matters Article - Revised

MLN Connects – October 4, 2018

MLN Connects® for Thursday, October 4, 2018
View this edition as a PDF

News & Announcements

- New Medicare Card: Replacement Card
- MIPS Targeted Review Request: Deadline October 15
- MIPS Virtual Groups: Election Period Open through December 31
- MIPS: List of Quality Measures Impacted by ICD-10 Updates
- LTCH Compare Refresh
- IRF Compare Refresh
- ABNs and Dual Eligible Beneficiaries: Special Guidelines
- Sickle Cell Disease Data Highlight
- Enteral Device Connectors that Reduce Patient Injury
- October is National Breast Cancer Awareness Month

Provider Compliance

- Outpatient Services Payment: Beneficiaries Who Are Inpatients of Other Facilities — Reminder

Upcoming Events

- Submitting Your Medicare Part A Cost Report Electronically Webcast — October 15
- Patient Relationship Categories and Codes Webcast — October 17

Medicare Learning Network® Publications & Multimedia

- Influenza Resources for Health Care Professionals: 2018-2019 MLN Matters Article — New
- HPSA Bonus Payments: 2019 Annual Update MLN Matters Article — New
- Laboratory NCD Edit Software: Changes for January 2019 MLN Matters Article — New
- AWV, IPPE, and Routine Physical – Know the Differences Educational Tool — New
- Dementia Care Call: Audio Recording and Transcript — New
- Looking for Educational Materials?

MLN Connects Special Edition – October 11, 2018

Hurricane Michael and Medicare Disaster Related Florida Claims MLN Matters Article — New

The President declared a state of emergency for the state of Florida, and the HHS Secretary declared a Public Health Emergency, which allows for CMS programmatic waivers based on Section 1135 of the Social Security Act. An MLN Matters Special Edition Article on Hurricane Michael and Medicare Disaster Related Florida Claims is available. Learn about blanket waivers CMS issued for the impacted geographical areas. These waivers will prevent gaps in access to care for beneficiaries impacted by the emergency.

MLN Connects – October 11, 2018

MLN Connects® for Thursday, October 11, 2018
View this edition as a PDF

News & Announcements

- New Medicare Card: Destroy the Old Card
- CMS to Strengthen Oversight of Medicare's Accreditation Organizations
- Participants in New Value-Based Bundled Payment Model
- Medicare Diabetes Prevention Program: New Covered Service
- Part A Providers: MCReF System Enhancement
- Protect Your Patients from Influenza this Season

Provider Compliance

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

Claims, Pricers & Codes

- Reprocessing Claims for Diagnostic Services by Certain PTs

Upcoming Events

- Submitting Your Medicare Part A Cost Report Electronically Webcast — October 15
- Patient Relationship Categories and Codes Webcast — October 17
- Physician Compare: Preview Period and Public Reporting Webcast — October 30

Medicare Learning Network® Publications & Multimedia

- LCDs MLN Matters Article — New
- Ensuring OC 22 is Billed Correctly on SNF Inpatient Claims MLN Matters Article — New
- HCPCS Codes for SNF CB: 2019 Annual Update MLN Matters Article — New
- Medicare Diabetes Prevention Program Call: Audio Recording and Transcript — New
- Medicare Preventive Services National Educational Products Listing — Revised

MLN Connects – October 18, 2018

MLN Connects® for Thursday, October 18, 2018
View this edition as a PDF

News & Announcements

- Hand in Hand: A Training Series for Nursing Homes
- MIPS Quality Data Submitted via Claims: 2018 Performance Feedback
- Quality Payment Program: 2018 CME Modules, Infographics, and Scoring Guide
- 2019 QRDA III Implementation Guide, Schematron, and Sample Files
- Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier

Provider Compliance

- Cardiac Device Credits: Medicare Billing — Reminder

Claims, Pricers & Codes

- 2019 MS-DRG Definitions Manual and Software

Upcoming Events

- Hospital Reporting: Successful eCQM Submission for CY 2018 Webinar — October 24
- Physician Compare: Preview Period and Public Reporting Webcast — October 30

Medicare Learning Network® Publications & Multimedia

- Systematic Validation Edits for OPPS Providers MLN Matters® Article — New
- IPPS and LTCH PPS: FY 2019 Changes MLN Matters Article — New
- Home Health Star Ratings Call: Audio Recording and Transcript — New
- Annual Wellness Visit Booklet — Revised
- Initial Preventive Physical Examination Educational Tool — Revised

MLN Connects – October 25, 2018

MLN Connects® for Thursday, October 25, 2018
View this edition as a PDF

News & Announcements

- New Medicare Card: Handouts and Videos for Patients
- DME: Formal Telephone Discussion Demonstration Expansion
- Emergency Preparedness: Hospital-based Incident Command System, Earthquakes, Medical Surge

Provider Compliance

- Coding for Specimen Validity Testing Billed in Combination with Urine Drug Testing — Reminder

Upcoming Events

- Physician Compare: Preview Period and Public Reporting Webcast — October 30
- Meeting the Needs of Dually Eligible Older Adults with Schizophrenia Webinar — November 6
- IRF Payment and Coverage Policies: FY 2019 Final Rule Call — November 15

Medicare Learning Network® Publications & Multimedia

- Order Requirements When Prescribing Practitioner is DMEPOS Supplier MLN Matters Article — New
- Updating CY 2019 MDPP Payment Rates MLN Matters Article — New
- Quality Payment Program 2018 MIPS Cost Performance Category Web-Based Training Course — New
- Quality Payment Program 2018 MIPS Improvement Activities Performance Category Web-Based Training Course — Revised
- Quality Payment Program 2018 MIPS APMs Web-Based Training Course — Revised
- Quality Payment Program 2018 Advanced APMs Web-Based Training Course — Revised
- Items and Services Not Covered under Medicare Booklet — Revised

MLN Connects Special Edition – October 31, 2018

CMS Takes Action to Modernize Medicare Home Health

On October 31, CMS finalized significant changes to the Home Health Prospective Payment System (PPS) to strengthen and modernize Medicare. Specifically, CMS made changes to improve access to solutions via remote patient monitoring technology, updated payments for home health care with a new case-mix system, begin the new home infusion therapy benefit, and reduce burden.

"This home health final rule focuses on patient needs and not on the volume of care," said CMS Administrator Seema Verma. "This rule also innovates and modernizes home health care by allowing remote patient monitoring. We are also proud to offer new home infusion therapy services. Using new technology and reducing unnecessary reporting measures for certifying physicians will result in an annual cost savings and provide Home Health Agencies (HHAs) and doctors what they need to give patients a personalized treatment plan that will result in better health outcomes."

Beginning with CY 2020, CMS is implementing changes required by law, including a new case-mix system called the Patient-Driven Groupings Model (PDGM) that puts the focus on patient needs rather than volume of care. The PDGM relies more heavily on patient characteristics to more accurately pay for home health services.

CMS is promoting innovation and modernization of home health care by allowing the cost of remote patient monitoring to be reported by home health agencies as allowable costs on the Medicare cost report form. This is expected to help foster the adoption of emerging technologies by home health agencies and result in more effective care planning, as data are shared among patients, their caregivers and their providers. The use of such technology can allow for greater patient independence and empowerment. Supporting patients in sharing their data will advance the MyHealthEData initiative.

This final rule implements the temporary transitional payments for home infusion therapy services for CYs 2019 and 2020, as required by the Bipartisan Budget Act of 2018, until the new permanent home infusion therapy services benefit begins on January 1, 2021. In addition, the final rule establishes the health and safety standards for qualified home infusion therapy suppliers of the new permanent home infusion therapy service benefit. The final rule also establishes the approval and oversight process for accrediting organizations of these suppliers as required by the 21st Century Cures Act. We are finalizing our proposal and also seeking further comments on our interpretation of "infusion drug administration calendar day" and on its potential effects on access to care.

CMS is eliminating the requirement that the certifying physician estimate how much longer home health services are needed when recertifying the need for continued home health care. This results in an estimated reduction in burden for physicians of $14.2 million, annually, and would allow physicians to spend more time with patients rather than on unnecessary paperwork.

The final rule helps advance the Comprehensive Meaningful Measures Initiative. CMS is removing seven Home Health Quality Reporting Program measures. Changes in data collection under the new case-mix system, coupled with the changes from these seven measure removals will reduce burden for HHAs by approximately $60 million annually, beginning in CY 2020.

For More Information:

- Final Rule
- Fact Sheet
- Home Health PPS website
- HHA Center website
- Home Health Quality Reporting Requirements webpage

MLN Connects Special Edition – November 1, 2018

Physician Fee Schedule and QPP: Changes to Advance Innovation, Restore Focus on Patients

On November 1, CMS finalized bold proposals that address provider burnout and provide clinicians immediate relief from excessive paperwork tied to outdated billing practices. The final 2019 Physician Fee Schedule (PFS) and the Quality Payment Program (QPP) rule also modernizes Medicare payment policies to promote access to virtual care, saving Medicare beneficiaries time and money while improving their access to high-quality services, no matter where they live. It makes changes to ease health information exchange through improved interoperability and updates QPP measures to focus on those that are most meaningful to positive outcomes. The rule also updates some policies under Medicare's Accountable Care Organization program that streamline quality measures to reduce burden and encourage better health outcomes. This rule is projected to save clinicians $87 million in reduced administrative costs in 2019 and $843 million over the next decade.

"The historic reforms CMS finalized today move us closer to a health care system that delivers better care for Americans at lower cost," said HHS Secretary Alex Azar. "Among other advances, improving how CMS pays for drugs and for physician visits will help deliver on two HHS priorities: bringing down the cost of prescription drugs and creating a value-based health care system that empowers patients and providers."

"Today's rule finalizes dramatic improvements for clinicians and patients and reflects extensive input from the medical community," said CMS Administrator Seema Verma. "Addressing clinician burnout is critical to keeping doctors in the workforce to meet the growing needs of America's seniors. Today's rule offers immediate relief from onerous requirements that contribute to burnout in the medical profession and detract from patient care. It also delays even more significant changes to give clinicians the time they need for implementation and provides time for us to continue to work with the medical community on this effort."

Coding requirements for physician services known as "Evaluation and Management" (E/M) visits have not been updated in 20 years. This final rule addresses longstanding issues and also responds to concerns raised by commenters on the proposed rule. CMS is finalizing several burden-reduction proposals immediately (effective January 1, 2019), where commenters provided overwhelming support. In response to concerns raised on the proposal, the final rule includes revisions that preserve access to care for complex patients, equalize certain payments for primary and specialty care, and allow for continued stakeholder engagement by delaying implementation of E/M coding reforms until 2021.

For the first time this rule will also provide access to "virtual" care. Medicare will pay providers for new communication technology-based services, such as brief check-ins between patients and practitioners and pay separately for evaluation of remote pre-recorded images and/or video. CMS is also expanding the list of Medicare-covered telehealth services. This will give seniors more choice and improved access to care.

In addition, the rule continues our work to deliver on President Trump's commitment to lowering prescription drug costs. Effective January 1, 2019, payment amounts for new drugs under Part B will be reduced, decreasing the amount seniors have to pay out-of-pocket, especially for drugs with high launch prices.

CMS is also finalizing an overhaul of Electronic Health Record (EHR) requirements in order to focus on promoting interoperability. The rule finalized changes to help make EHR tools that actually support efficient care instead of hindering care. Final policies for Year 3 of the QPP, part of the agency's implementation of MACRA, will advance the Meaningful Measures initiative while reducing clinician burden, ensuring a focus on outcomes, and promoting interoperability. CMS also introduced an opt-in policy so that certain clinicians who see a low volume of Medicare patients can still participate in the Merit-based Incentive Payment System program if they choose to do so. In addition, CMS is providing the option for clinicians who are based at a health care facility to use facility-based scoring to reduce the burden of having to report separately from their facility.

For More Information:

- Final Rule
- PFS Fact Sheet
- QPP Fact Sheet
- E/M Payment Amounts Chart

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

DME and ESRD Programs: Policies to Modernize and Drive Innovation

On November 1, CMS finalized innovative changes to the Medicare payment rules for Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) and the End-Stage Renal Disease (ESRD) programs. The policies aim to increase access to items and services for patients, drive competition and increase affordability.

"The rule finalized today makes innovative changes to the Medicare payment rules for the durable medical equipment and end-stage renal disease programs. It also helps to ensure continued access to durable medical equipment and makes significant improvements to our competitive bidding system." said CMS Administrator Seema Verma. "Based on many comments we received on our DME proposal from suppliers, manufacturers and their associations -- all of whom supported our proposals -- we are implementing market-oriented reforms to Medicare's DMEPOS Competitive Bidding Program that also reduce burden on suppliers by simplifying the bidding process."

Improved Access to Durable Medical Equipment (DME)

The rule finalizes market-oriented reforms to the Medicare's DMEPOS Competitive Bidding Program (CBP). The final rule will increase beneficiary access to items and services, leverage opportunities to increase the program's effectiveness and better ensure the long-term sustainability of the DMEPOS CBP by streamlining the program and strengthening the bidding rules. Changes to the DMEPOS CBP that we finalized also will reduce burden on suppliers by simplifying the bidding process. This rule establishes lead item bidding, which means suppliers will only need to submit one bid per product category. In addition, the single payment amounts for items in each product category under the DMEPOS CBP would apply to the lead item in the product category. These changes streamline the program, enhance quality and access to innovative products, and help ensure the long term sustainability of the program and the savings it generates. Also, the rule finalizes increases in DMEPOS fee schedule rates, using a blend of adjusted and unadjusted fee amounts, in order to protect access to needed durable medical equipment in rural areas that are not subject to the DMEPOS CBP.

The process for recompeting contracts with suppliers currently in effect under the DMEPOS CBP has not yet been initiated and the current contracts for the DMEPOS CBP will expire on December 31, 2018. As a result, starting January 1, 2019, and until new contracts are awarded under the DMEPOS CBP, there will be a temporary gap period in the entire DMEPOS CBP and National Mail Order CBP that CMS expects will last two years until December 31, 2020. During that time, Medicare beneficiaries will continue to receive DMEPOS items from any Medicare-enrolled DMEPOS supplier and in most cases, they won't need to switch suppliers.

As required by the 21st Century Cures Act, this rule also finalizes Medicare fee schedule payments for DME furnished on or after January 1, 2019 in areas of the country where competitive bidding is not in effect. For more information, see the Temporary Gap Period fact sheet.

End-Stage Renal Disease Prospective Payment System

CMS is also taking steps to support innovation in Medicare's ESRD Prospective Payment System by expanding the Transitional Drug Add-on Payment Adjustment (TDAPA) for new ESRD drugs and biologicals, effective January 1, 2020. As the largest payer for kidney care, expanding TDAPA to all new renal dialysis drugs and biological products will help incentivize the development and use of transformative and innovative therapies.

Finally, this final rule takes significant steps forward by strengthening quality incentives, improving patient outcomes and reducing administrative burden. These changes advance the Patients Over Paperwork initiative and will allow doctors to spend less time on paperwork and more time with their patients. Based on stakeholder feedback, CMS reduced ESRD facility-related documentation burdens for the comorbidity

payment adjustment so that the documentation requirements are more consistent with other payment systems. CMS also reduced the reporting burden for the ESRD Quality Incentive Program by finalizing a more limited measure set that better aligns with the CMS Meaningful Measures Initiative.

For More Information:

- Final Rule
- Fact Sheet

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

MLN Connects – November 1, 2018

MLN Connects® for Thursday, November 1, 2018
View this edition as a PDF

News & Announcements

HHS Advances Payment Model to Lower Drug Costs for Patients

SNF Quality Reporting Program Data on Nursing Home Compare

IRF, LTCH, and SNF Quality Reporting Programs: Submission Deadline November 15

Hospital Cost Report Data: User-Friendly Version

Medicare Diabetes Prevention Program: New Covered Service

November is Home Care and Hospice Month

Provider Compliance

Ophthalmology Services: Questionable Billing and Improper Payments - Reminder

Upcoming Events

IRF Payment and Coverage Policies: FY 2019 Final Rule Call - November 15

Medicare Learning Network® Publications & Multimedia

Typhoon Yutu and Medicare Disaster Related Commonwealth of the Northern Mariana Islands Claims MLN Matters Article - New

MRI MLN Matters Article - New

Incomplete Colonoscopies Billed with Modifier 53 MLN Matters Article - New

CWF Edit of MA Inpatient Claims from Approved Teaching Hospitals MLN Matters Article - New

Correction to CWF IUR 7272 for Intervening Stay MLN Matters Article - New

Redesign of Hospice Periods MLN Matters Article - New

ASP Medicare Part B Drug Pricing Files and Revisions: January 2019 MLN Matters Article - New

MCReF System Webcast: Audio Recording and Transcript - New

Patient Relationship Categories and Codes Webcast: Audio Recording and Transcript - New

Medicare Podiatry Services Fact Sheet - Revised

Medicare and Medicaid Basics Booklet - Revised

MLN Connects Special Edition – November 2, 2018

CY 2019 OPPS and ASC Rule Encourages More Choices and Lower Costs for Seniors

On November 2, CMS released a final rule that strengthens the Medicare program by providing seniors more choices and lower cost options in making the best decisions on their care. The policies adopted in the Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System final rule with comment period will help lay the foundation for a patient-driven healthcare system.

"President Trump is committed to strengthening Medicare and lowering costs for patients. Today's rule advances competition by creating a level playing field for providers so they can compete for patients on the basis of quality and care," said CMS Administrator Seema Verma. "The final policies remove unnecessary and inefficient payment differences so patients can have more affordable choices and options."

To increase the sustainability of the Medicare program and improve the quality of care for patients, CMS is finalizing its proposed method to control unnecessary volume increases for certain clinical visits by utilizing site-neutral payments for these visits. This change will be phased in over two years. Clinic visits are the most common service billed under the OPPS. Currently, CMS and beneficiaries often pay more for the same type of clinic visit in the hospital outpatient setting than in the physician office setting. This policy would result in lower copayments for beneficiaries and savings for the Medicare program in an estimated amount of $380 million for 2019. For example, for a clinic visit furnished in an excepted off-campus provider-based department (PBD), average beneficiary cost sharing is currently $23. Under this final rule, that cost sharing would be reduced to $16 (based on a two year phase-in), saving beneficiaries an average of $7 each time they visit an off-campus department in CY 2019.

Additionally, CMS is giving patients more options on where to obtain care by increasing the services that can be furnished in ASCs. These changes are intended to help improve access and convenience and ensure that CMS policies are not favoring any particular provider type. For 2019, CMS is finalizing policies that will:

- Expand the number of surgical procedures payable at ASCs to include additional procedures that can safely be performed in that setting
- Ensure ASC payment for procedures involving certain high-cost devices generally parallels the payment amount provided to hospital outpatient departments for these devices
- Help ensure that ASCs remain competitive by addressing the differential between how ASC payment rates and hospital outpatient department payment rates are updated for inflation

As part of the agency's "Patients Over Paperwork" Initiative-a cross-cutting process that evaluates and streamlines regulations with the goal of reducing burden-CMS is finalizing proposals to remove measures from the Hospital Outpatient Quality Reporting Program and from the Ambulatory Surgery Center Quality Reporting Program. These removals are aimed at enabling providers to focus on tracking and reporting the measures that are most impactful on patient care. This action will decrease burden for providers by approximately $27 million over the next two years.

In 2018, CMS implemented a payment policy to help beneficiaries save on coinsurance for drugs that were administered at hospital outpatient departments that were acquired through the 340B program-a program that allows certain hospitals to buy outpatient drugs at lower cost. Due to CMS' policy change, Medicare beneficiaries are now benefitting from the discounts that 340B hospitals enjoy when they receive 340B-acquired drugs. In 2018 alone, beneficiaries are saving an estimated $320 million on out-of-pocket payments for these drugs. For 2019, CMS is expanding on this policy by extending the 340B payment change to additional off-campus provider-based hospital outpatient departments that are paid under the Physician Fee Schedule.

In response to recommendations from the President's Commission on Combating Drug Addiction and the Opioid Crisis, to comply with the requirements of the SUPPORT for Patients and Communities Act (P.L. 115-271), and to avoid any potential unintended consequences that would encourage overprescribing of opioids, CMS is removing questions regarding pain communication from the hospital patient experience survey. Additionally, CMS is adopting a policy to encourage increased use of non-opioid drugs following a surgical procedure in the ASC setting.

The President's Commission on Combating Drug Addiction and the Opioid Crisis also recommended that CMS review its payment policies for certain drugs that function as a supply, specifically non-opioid pain management treatments. Payment for drugs that function as a supply in surgical procedures or

diagnostic tests is packaged under the OPPS and ASC payment systems. However, in response to this recommendation as well as stakeholder comments and peer-reviewed evidence, for 2019, CMS is finalizing the proposal to pay separately at average sales price plus 6 percent for non-opioid pain management drugs that function as a supply when used in a covered surgical procedure performed in an ASC.

For More Information:

- Final Rule
- Fact Sheet

Read the full text of this excerpted CMS Press Release (issued November 2)

MLN Connects - November 8, 2018

MLN Connects® for Thursday, November 8, 2018
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News & Announcements

- New Medicare Card: Questions?
- DMEPOS Competitive Bidding Updates
- SNF Provider Preview Reports: Review Your Data by November 30
- QRURs and PQRS Feedback Reports: Access Ends December 31
- Quality Payment Program: Multi-Payer Other Payer Advanced APMs List
- Quality Payment Program: Visit the Resource Library Website
- Raising Awareness of Diabetes in November

Provider Compliance

- Reporting Changes in Ownership - Reminder

Claims, Pricers & Codes

- Hospitals: Incorrect Maximum Payment for Sentinel Cerebral Protection System™

Upcoming Events

- Home Health Services: Review Choice Demonstration Call - November 13
- IRF Payment and Coverage Policies: FY 2019 Final Rule Call - November 15
- Quality Payment Program Year 3 Final Rule Overview Webinar - November 15
- Physician Fee Schedule Final Rule: Understanding 3 Key Topics Call - November 19
- IMPACT Act: National Beta Test of Candidate SPADEs Meeting - November 27

Medicare Learning Network® Publications & Multimedia

- Prescriber's Guide: New Medicare Part D Opioid Overutilization Policies for 2019 MLN Matters Article - New
- NGACO Model Post Discharge Home Visit HCPCS MLN Matters Article - New
- Hospital and CAH Swing-Bed Manual Revisions MLN Matters Article - New
- Manual Updates to Correct SNF Errors and Omissions: 2018 Q4 MLN Matters Article - New
- Temporary Transitional Payment for HIT Services for CYs 2019 and 2020 MLN Matters Article - New
- Revision of SNF CB Edits for Ambulance Services in a Part A Facility Stay MLN Matters Article - New
- Medicare Diabetes Prevention Program Expanded Model Booklet - New
- Medicare Billing: CMS Form CMS-1450 and the 837 Institutional Booklet - Revised
- Medicare Billing: CMS Form CMS-1500 and the 837 Professional Booklet - Revised
- Medicare Preventive Services National Educational Products Listing - Revised

MLN Connects Special Edition - November 13, 2018

New Medicare Card Mailing Update - Wave 6 Ends

CMS finished mailing cards to people with Medicare who live in Waves 1-5 and now Wave 6 states (Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Texas, Utah, Washington, and Wyoming). Card mailing in Wave 7 states and territories continues.

If someone with Medicare says they did not get a card, you should instruct them to:

- Sign into MyMedicare.gov to see if we mailed their card. If so, they can print an official card. They will need to create an account, if they do not already have one.
- Call 1-800-MEDICARE (1-800-633-4227) where we can verify their identity, check their address, and help them get their new card.

You can print out and give them a copy of Still Waiting for Your New Card?, or you can order copies to hand out. Continue to direct people with Medicare to Medicare.gov/NewCard for information about the mailings and to sign up to get email about the status of card mailings in their state.

To ensure that people with Medicare continue to get care, health care providers and suppliers can use either the former Social Security number-based Health Insurance Claim Number or the new alpha-numeric Medicare Beneficiary Identifier for all Medicare transactions through December 31, 2019.

People with Medicare should continue to protect their new number to prevent medical identity theft and health care fraud, especially during Medicare Open Enrollment. You can find fraud prevention resources on our Medicare card Outreach & Education page to share with people with Medicare

MLN Connects Special Edition - Thursday, November 15, 2018

The President declared a state of emergency for the state of California, and the HHS Secretary declared a Public Health Emergency, which allows for a CMS programmatic waivers based on Section 1135 of the Social Security Act. An MLN Matters Special Edition Article on Medicare Fee-for-Service (FFS) Response to the 2018 California Wildfires is available. Learn about blanket waivers CMS issued for the impacted geographical areas. These waivers will prevent gaps in access to care for beneficiaries impacted by the emergency.

MLN Connects - November 15, 2018

MLN Connects® for Thursday, November 15, 2018
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News & Announcements

- Patients Over Paperwork November Newsletter
- Quality Payment Program Year 1 Performance Results
- Quality Payment Program: Participation Status Tool Updated
- Hospice Quality Reporting Program: Quarterly Update Document
- Hospices: 4.5 Month Data Correction Deadline for Public Reporting
- Hospice Item Set Freeze Date: November 15
- CMS Health Equity Awards: Submit Nominations by December 7
- Physicians: Documentation of Artificial Limbs and Braces
- Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier
- Recognizing Lung Cancer Awareness Month and the Great American Smokeout

Provider Compliance

- Cochlear Devices Replaced Without Cost: Bill Correctly - Reminder

Claims, Pricers & Codes

- DME: Denial of Serial Claims

Upcoming Events

- Physician Fee Schedule Final Rule: Understanding 3 Key Topics Call - November 19

Medicare Learning Network® Publications & Multimedia

- Implementation of HCPCS Code J3591 and Changes for ESRD Claims MLN Matters Article - New
- DMEPOS Update MLN Matters Article - New
- Medicare Deductible, Coinsurance and Premium Rates: 2019 Update MLN Matters Article - New
- MCReF MLN Matters Article - Revised
- ICD-10 and Other Coding Revisions to NCDs MLN Matters Article - Revised
- Certifying Patients for the Medicare Home Health Benefit MLN Matters Article - Revised
- Certificate of Medical Necessity Web-Based Training Course - Revised
- Medicare Part B Immunization Billing Educational Tool - Revised

MLN Connects - November 21, 2018

MLN Connects® for Wednesday, November 21, 2018
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News & Announcements

- SNF PPS: New Patient Driven Payment Model Webpage
- Open Payments: Review Program Year 2017 Data through December 31
- Hospice Item Set Manual: New Version
- Hospice Comprehensive Assessment Quality Measure Fact Sheet
- Provider Enrollment Application Fee Amount for CY 2019
- National Rural Health Day, Improving Rural Health
- Recommend Influenza Vaccination: Each Office Visit is an Opportunity

Provider Compliance

- Improper Payment for Intensity-Modulated Radiation Therapy Planning Services - Reminder

Claims, Pricers & Codes

- Medicare Diabetes Prevention Program: Valid Claims

Upcoming Events

- SNF PPS: New Patient Driven Payment Model Call - December 11
- National Provider Enrollment Conference - March 12

Medicare Learning Network® Publications & Multimedia

- FISS: Implementation of the MolDX MLN Matters Article - New
- CWF Provider Queries NPI and Submitter ID MLN Matters Article - New
- ESRD PPS: CY 2019 Payment for Dialysis Furnished for AKI MLN Matters Article - New
- Home Health Rural Add-on Payments MLN Matters Article - New
- RHC AIR Payment Limit: CY 2019 Update MLN Matters Article - New
- HH PPS Rate: CY 2019 Update MLN Matters Article - New
- IVIG Demonstration: 2019 Payment Update MLN Matters Article - New

- RARC, CARC, MREP and PC Print Update MLN Matters Article - New
- Uniform Use of CARC, RARC, and CAGC Rule Update MLN Matters Article - New
- HCPCS Code Updates for Home Health Consolidated Billing Enforcement MLN Matters Article - New
- Physician Compare Webcast: Audio Recording and Transcript - New
- New Waived Tests MLN Matters Article - Revised

MLN Connects Special Edition - Tuesday, November 27, 2018

CMS is extending the public comment period on new product categories to be phased-in for the next round of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. Comments will now be accepted through December 17, 2018. See the Public Comments on New Product Categories webpage for more information.

MLN Connects - November 29, 2018

MLN Connects® for Thursday, November 29, 2018
View this edition as a PDF

News & Announcements

- CMS Takes Action to Lower Prescription Drug Costs by Modernizing Medicare
- Nursing Homes: Efforts to Improve Patient Safety, Quality of Care
- New Online Tool Displays Cost Differences for Certain Surgical Procedures
- Improved eCQI Resource Center Website
- Hospital-Based Incident Command Systems: Real Experiences and Practical Applications
- World AIDS Day is December

Provider Compliance

- Payment for Outpatient Services Provided to Beneficiaries Who Are Inpatients of Other Facilities - Reminder

Upcoming Events

- IPPS Final Rule: Changes to the Medicare Promoting Interoperability Program Webinar - December 5
- Palliative Care for Dually Eligible Older Adults Webinar - December 5
- SNF PPS: New Patient Driven Payment Model Call - December 11

Medicare Learning Network® Publications & Multimedia

- FQHC PPS Recurring File: CY 2019 Update MLN Matters Article - New
- Home Health Call: Audio Recording and Transcript - New
- Medicare Basics: Commonly Used Acronyms Educational Tool - Revised

CERT Claim Look Up Tool Available in the Noridian Medicare Portal

The Noridian Medicare Portal (NMP) now offers users the ability to look up CERT claims as part of the Claim Status Inquiry function. This new feature will allow access to look up outcomes for CERT claims that can be searched by a specific Claim Identifier (CID) number or the provider/supplier information to obtain a list of all CERT claims.

View the CERT Look Up Tool Brainshark and the NMP User Manual to get started today.

Additional Expanded Denial Details Available in NMP - Patient Denial, and Overlap Patient Denial

Noridian Medicare Portal (NMP) now provides the following denial details within Claim Status inquiry results.

- Patient Denial
- Overlap Denial

Outpatient During Outpatient

Inpatient During Inpatient

The overlapping claim information will be provided, with the facility NPI and applicable dates.

For more information, please see the Expanded Denial Details section of the NMP End User Manual.

NMP Offers Additional Expanded Denial Details - Alien, Incarcerated, SNF, and ESRD Facility

The Noridian Medicare Portal (NMP) now offers the ability to view claim denial details for Alien, Incarcerated, Skilled Nursing Facility (SNF), and End Stage Renal Disease (ESRD) Facility.

For alien and incarcerated denials, the listed dates will be shared. For SNF and ESRD denials, the overlapping dates and NPI will be shared.

For more information, see the Expanded Denial Details section of the NMP End User Manual.

NMP Offers Expanded Denial Details - Entitlement, Date of Death, Hospice, and Home Health

Noridian Medicare Portal (NMP) now offers the ability to view claim denial details for Entitlement, Date of Death, Hospice, and Home Health. This will share Part A and B benefits for entitlement denials. For date of death denials, the listed date of death will be shared. For hospice and home heath denials the overlapping dates and NPI will be shared.

Read the Expanded Denial Details section of the Noridian Medicare Portal End User Manual and view the Expanded Denial Details Brainshark to get started today.

NMP Allows Same or Similar Range Searches on All HCPCS Codes

The Noridian Medicare Portal (NMP) has been updated to allow a search on a range of HCPCS codes beginning with the same prefix for Same or Similar. In the past, Option 2, under Same or Similar, was limited to HCPCS codes starting with an A, L, or V (supplies, orthotics/prosthetics and vision).

Noridian encourages suppliers to use Option 2 for most same or similar searches, as Option 1 is limited to codes listed on the Same and Similar Reference Chart, but there are many codes in the same range, i.e., E codes, that are considered same or similar.

For example, for respiratory devices, E0601 and E0470 are on the same and similar chart, i.e. in Option 1, but the E0486, oral appliance, is also considered same or similar but is not listed on the chart so this search will only work during a range search using Option 2. Some other Option 2 examples are ventilator codes and wheelchairs options and accessories.

NMP searches claims back five years on most items; eight years for nutrition pumps. For oxygen, the portal searches lifetime.

Clinicians Ordering Oxygen for Patients

Are you a physician who orders oxygen therapy for patients who are Medicare beneficiaries? If so, please be sure to follow the requirements to ensure medical necessity is supported allowing Medicare to pay the claim(s) appropriately.

View the Clinicians: Are You Ordering Oxygen for Your Patient? webpage for details.

Oxygen Modifier Decision Tree Now Available

To help suppliers/providers determine which modifier, specific to durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), is considered with Oxygen billing, we now have an Oxygen Modifier Decision Tree.

For additional information on Oxygen, and helpful resources, visit the Noridian Oxygen webpage.

Topical Oxygen Request for Information Bibliography

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "**Topical Oxygen Request for Information Bibliography**" is now available on our (Noridian) website.

View the complete Topical Oxygen Request for Information Bibliography webpage.

Immediate Recoupment or Offset Option Available

To reduce the effort suppliers may spend obtaining a check and sending related paperwork to Noridian in response to an overpayment request letter, the "Immediate Recoupment" process gives suppliers the option to avoid interest from accruing on claim overpayments when the debt is recouped in full prior to or by the 30th day from that initial demand letter date.

To view details and benefits, visit the Immediate Recoupment or Offset webpage.

Temporary Transitional Payment for HIT Services for CYs 2019 and 2020

MLN Matters Number: MM10836
Related CR Release Date: August 10, 2018
Related CR Transmittal Number: R4112CP
Related Change Request (CR) Number: 10836
Effective Date: January 1, 2019
Implementation Date: January 7, 2019

CR 10836 alerts providers and suppliers that effective January 1, 2019 and until the implementation of the full Home Infusion Therapy (HIT) benefit, Medicare makes separate temporary transitional payments for HIT services to eligible home infusion suppliers (such as, a licensed pharmacy that provides external infusion pumps and external infusion pump supplies).

View the complete CMS Medicare Learning Network (MLN) Matters (MM)10836.

ASP Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files - January 2019

MLN Matters Number: MM11016
Related CR Release Date: October 26, 2018
Related CR Transmittal Number: R4154CP
Related Change Request (CR) Number: 11016
Effective Date: January 1, 2019
Implementation Date: January 7, 2019

CR11016 provides the quarterly update for Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to the prior quarterly pricing files.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)11016.

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Update

MLN Matters Number: MM10838
Related CR Release Date: November 2, 2018
Related CR Transmittal Number: R21930TN
Related Change Request (CR) Number: 10838
Effective Date: January 1, 2019
Implementation Date: January 7, 2019

Change Request (CR) 10838 instructs MACs to update the ViPS Medicare System (VMS) to process DMEPOS claims based on standard payment rules with dates of service on or after January 1, 2019, for beneficiaries who reside in a previous Competitive Bidding Area (CBA), since all DMEPOS competitive bidding contracts expire on December 31, 2018.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)10838.

Medicare Claims Processing Manual, Chapter 23, Section 60.3 Update

MLN Matters Number: MM10924
Related Change Request (CR) Number: 10924
Related CR Release Date: September 14, 2018
Effective Date: June 11, 2018
Related CR Transmittal Number: R4130CP
Implementation Date: October 15, 2018

Change Request (CR) 10924 advises providers about changes to the Internet-Only-Manual (IOM 100-04, Chapter 23) relating to the methodology for gap-filling Durable Medical Equipment, Prosthetic, Orthotic and Supplies (DMEPOS) fee schedules is being updated to reflect the use of new sources of gap-fill pricing information announced June 11, 2018, on the CMS Spotlight section of the DME Center page (https://www.cms.gov/Center/Provider-Type/Durable-Medical-Equipment-DME-Center.html).

View the complete CMS Medicare Learning Network (MLN) Matters (MM)10924.

2019 Annual Update of HCPCS Codes for SNF CB

MLN Matters Number: MM10981
Related Change Request (CR) Number: 10981
Related CR Release Date: October 5, 2018
Effective Date: January 1, 2019
Related CR Transmittal Number: R4143CP
Implementation Date: January 7, 2019

CR 10981 makes changes to HCPCS codes and Medicare Physician Fee Schedule (MPFS) designations that will be used to revise Common Working File (CWF) edits to allow MACs to make appropriate payments in accordance with policy for SNF CB in Chapter 6, Section 110.4.1 and Chapter 6, Section 20.6 in the Medicare Claims Processing Manual (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c06.pdf). Make sure your billing staff are aware of these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)10981.

Update to Medicare Deductible, Coinsurance and Premium Rates for 2019

MLN Matters Number: MM11025
Related CR Release Date: November 2, 2018
Related CR Transmittal Number: R119GI
Related Change Request (CR) Number: CR 11025
Effective Date: January 1, 2019
Implementation Date: January 7, 2019

CR 11025 provides instruction for MACs to update the claims processing system with the new Calendar Year (CY) 2019 Medicare deductible, coinsurance, and premium rates. Make sure your billing staffs are aware of these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)11025.

RARC, CARC, MREP and PC Print Update

MLN Matters Number: MM11038
Related CR Release Date: November 16, 2018
Related CR Transmittal Number: R4167CP
Related Change Request (CR) Number: 11038
Effective Date: April 1, 2019
Implementation Date: April 1, 2019

CR 11038 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/or PC Print software if they use that software.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)11038.

Implement Operating Rules - Phase III ERA EFT: CORE 360 Uniform Use of CARC, RARC and CAGC Rule - Update from CAQH CORE

MLN Matters Number: MM11039
Related CR Release Date: November 16, 2018
Related CR Transmittal Number: R4168CP
Related Change Request (CR) Number: 11039
Effective Date: April 1, 2019
Implementation Date: April 1, 2019

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 (ACA).

CR 11039 instructs MACs and Medicare's Shared System Maintainers (SSMs) to update systems based on the Committee on Operating Rules for Information Exchange (CORE) 360 Uniform use of Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC) and Claim Adjustment Group Code (CAGC) rule publications. These system updates are based on the CORE Code Combination List to be published on or about February 1, 2019. Make sure that your billing staffs are aware of these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)11039.

noridian Healthcare Solutions | DME Happenings
900 42nd St. S.
Fargo, ND 58103