# DME Happenings

Jurisdiction D

March 2018

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### APPEALS



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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CMS CENTERS FOR MEDICARE & MEDICAID SERVICES


Noridian Healthcare Solutions, LLC

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# Jurisdiction D DME MAC Supplier Contacts and Resources

| Phone Numbers | | |
|---|---|---|
| Interactive Voice Response System | 1-866-419-9458 | 24/7 for Eligibility<br>8 a.m. – 5 p.m. for all other inquiries |
| Supplier Contact Center | 1-866-419-9458 | 8 am – 5 pm ET Monday-Friday |
| Telephone Reopenings | 1-866-419-9458 | 8 am – 5 pm ET |
| Beneficiary Customer Service | 1-800-633-4227 | 24/7 |
| **Fax Numbers** | | |
| Reopenings/Redeterminations<br>Recovery Auditor Redeterminations | | 701-277-2425 |
| Recoupment<br>• Refunds to Medicare<br>• Immediate Offsets | | 701-277-2427 |
| MSP Refunds | | 701-277-7892 |
| Recovery Auditor Offsets | | 701-277-7896 |
| MR Medical Documentation | | 701-277-2426 |
| **Email Addresses/Websites** | | |
| NHS DME Customer Service | https://med.noridianmedicare.com/web/jadme/contact/email-customer-service | |
| Reopenings and Redeterminations | dmeredeterminations@noridian.com | |
| Noridian JA Website | https://med.noridianmedicare.com/web/jadme | |
| **Mailing Addresses** | | |
| • Claims<br>• Redetermination Requests<br>• Correspondence<br>• ADMC Requests<br>• Medical Review Documentation<br>• Recovery Auditor Overpayments | **Noridian JA DME**<br>Attn: _____<br>PO Box 6780<br>Fargo, ND 58108-6780 | |
| • Benefit Protection<br>• Administrative Simplification Compliance Act Exception Requests (ASCA) | **Noridian JA DME**<br>Attn: _____<br>PO Box 6736<br>Fargo, ND 58108-6736 | |
| Qualified Independent Contractor (QIC) | **C2C Solutions, Inc.**<br>Attn: DME QIC<br>PO Box 44013<br>Jacksonville, FL 32231-4013 | |
| • EFT Forms<br>• Overpayment Redeterminations<br>• Recovery Auditor Redeterminations | **Noridian JA DME**<br>Attn: _____<br>PO Box 6728<br>Fargo, ND 58108-6728 | |

| Other DME MACs and Other Resources | | |
|---|---|---|
| Noridian: Jurisdiction D | 877-320-0390 | https://med.noridianmedicare.com/web/jddme |
| 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

## Capped Rental Monthly Payment Calculator - Now Available

Noridian is excited to announce the creation of a new calculator for capped rental DMEPOS items. Suppliers are encouraged to use this new calculator to assist in determining the payment amount for rental months associated with capped rental DMEPOS items.

The calculator includes fields to enter the DMEPOS item HCPCS code and the fee schedule amount. In addition to entering the HCPCS code and fee schedule amount, suppliers select which month of the capped rental series they are billing to determine the correct payment.

Suppliers can find the new Capped Rental Monthly Payment Calculator on the Noridian Medicare website on the "Outreach & Education" page under Tools, the Fee Schedule page or the Capped Rental Items page.

## CERT Quick Look Documentation Tool

Are you receiving CERT errors? The CERT Quick Look Documentation Tool has been updated to reflect the top policies in error. This tool displays common CERT policies under review and the documentation that is usually required for the policy criteria to be met. Visit the CERT Quick Look Documentation Tool webpage for additional information.

## Co-Branded Education with Noridian and CGS

Attention DME suppliers! The DME MACs are joining together to provide the supplier community with co-branded education. Noridian and CGS Provider Outreach and Education (POE) staff will begin conducting select webinars in 2018 with this co-branded education. The term "co-branded" means the DME MACs have created a single training document that will be used when educating suppliers in all four jurisdictions on these select topics.

To provide consistency within all four jurisdictions on how the education is provided, CGS and Noridian will present a co-branded webinar including the actual DMEPOS policy education slides in the presentation. Our first topic will be the Positive Airway Pressure (PAP) policy and both Noridian and CGS will be hosting a webinar in January with this national consistent approach.

Each Contractor will retain their own Resources and Reminders portion of the presentations as many are specific to that contractor. In addition, each Contractor may have small differences in our presentation format such as pausing for questions at points throughout the presentation. Suppliers will notice the actual slides of the co-branded education presentation will have a different look including style and color. How will you know if the presentation is co-branded? The POE teams will indicate that the subject is co-branded on the cover slide and the host will announce during the presentation that the presentation is a co-branded webinar.

CGS and Noridian look forward to your input on the increased consistency and collaboration. Please be sure to attend the upcoming webinars and let us know what you think of this initiative.

Noridian JD Schedule of Events

## Event Materials Page Renovation

As announced in several of the recent Webinars, a copy of the training presentation viewed during webinars will no longer be available on the Noridian website.

The Event Materials page in the Education and Outreach section of the Noridian website contains webinar presentations and the Q&As from these on-line training sessions. With this change, you will no longer be able to obtain a copy of the presentation from the website.

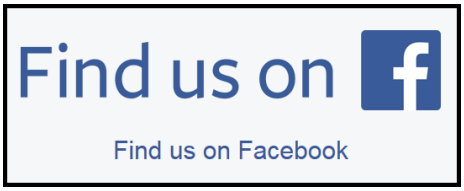
However, a copy of the webinar presentation will still be accessible from the handout section of the webinars you attend. The accumulated questions and answers from prior webinars will remain on the Event Materials page and continue to be updated.

## Noridian is Now on Facebook!

Noridian is excited to announce that our provider and supplier community can now find us on Facebook. The Noridian Facebook page will pass along updates from Noridian and Medicare through articles and links previously published to our website. Upcoming educational events and self-paced tutorials will also be available here for you to stay connected.

Inquiries may be submitted and answered during regular business hours, however, some inquiries may require further research from another department. Keep in mind that PHI or PII is not accepted.

Give us a 'Like' and 'Follow' us to stay connected. We hope to see you there!




## Online Q&A Sessions Expanded from Monthly to Weekly in 2018

Are you a supplier with a specific inquiry? Would you like the opportunity to ask your question and chat live with a Noridian Education Representative? If so, join us every Monday beginning January 8, 2018 for a 30-minute live online Question and Answer (Q&A) session from 2 – 2:30 p.m. Central Time. Suppliers will be able to provide general information and type in or ask questions out loud.

No Personal Health Information (PHI) or Personally Identifiable Information (PII) is allowed during these events.

Register today and mark your calendars for these sessions and any other webinars or events of interest.

## Modifier KH, KI and KJ Billing Reminders

Noridian has seen an increase in the inappropriate use of the capped rental "K" modifiers on claims. During our processing of "K" modifier claims, many suppliers use the same rental modifier each month. This is incorrect billing as the KH, KI and KJ modifiers must be applied to the correct rental month as outlined in the table below. This table also provides the denial codes when modifiers are used in inappropriately and how to correct the claim.

Below are some reminders on appropriate capped rental "K" modifier submission:

- KH modifier is required on new Capped Rental, PEN pumps or when the NU modifier is used for new equipment.
- KH modifier can only be used on the claim for the first rental month or first month of purchase.
- KI modifier shall only be used for the second and third months of billing for rentals.
- KJ modifier shall be used for the remainder of the capped rental period, months fourth-thirteen or months four-fifteen for PEN pumps.

| Modifier | Scenario | Result and Remittance Message | Next Steps |
|---|---|---|---|
| KH | First Month Rental | Pay | N/A |
| | First Month Purchase | Pay | N/A |
| | If KH not billed on first month of purchase | Deny: Return/Reject N519 4 | Resubmit claim with KH modifier |
| | If KH billed on any claim after first month | Deny: 181 M20 | Request Reopening, either phone, written or Noridian Medicare Portal |

| | | | |
|---|---|---|---|
| KI | Second month rental | Pay | N/A |
| | Third month rental | Pay | N/A |
| | If KI billed on any claim except months 2 and 3 | Deny: Return/Reject N519 4 | Resubmit claims with KI modifier |

## Serial Claims Initiative - Implemented April 2017

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Appeals workgroup collaborated with CMS in development of the Serial Claims Initiative, implemented in April 2017, to improve the way claims billed in a series are adjudicated.

This initiative:

- Provides a process to connect a favorable determination on a serial claim to other claims in series that were denied for same or similar reasons
  - A serial claim is defined as capped rental equipment paid on a monthly rental basis not to exceed a period of continuous use of 13 months or 36 months (oxygen)
  - If related claims are currently pending with Qualified Independent Contractor (QIC) or Office of Medicare Hearings and Appeals (OMHA), DME MAC will communicate favorable decision so it may be considered when adjudicating related appeals pending at such levels
- Allows future claims in series to pay
- Includes data analysis of all favorable serial claim appeal decisions made over previous three years to identify pending appeals in series that may be eligible for resolution
- Enhances supplier's experience by ensuring items that have been subject to medical review and have been determined to meet medical necessity will continue to be paid consistently for duration of rental period, thus reducing volume of new denials and subsequent appeals and improving adjudication process for currently pending appeals

## Weekly Q&A News – Name Changed to Monday Live Chat

The Noridian DME Education team is excited to be able to offer the 2018 General Question & Answer (Q&A) sessions weekly instead of monthly. These sessions are being renamed to Monday Live Chat effective immediately.

The process for registering for these sessions remains the same; however, once "Register" has been chosen, use the drop-down box to indicate which date you would like to attend. Go To Webinar will automatically default to the first date given.

Each session will be every Monday at 2 p.m. Central Time and will be approximately 30 minutes. This is a great opportunity to receive general information and ask verbal and written questions of the Education and Outreach team.

## SNF PPS Fiscal Year (FY) 2018 Pricer Off-Cycle Update

**MLN Matters Number: MM10377**
**Related Change Request (CR) Number: 10377**
**Related CR Release Date: November 22, 2017**
**Effective Date: October 1, 2017**
**Related CR Transmittal Number: R3928CP**
**Implementation Date: January 2, 2018**

### PROVIDER TYPES AFFECTED

This MLN Matters® Article is intended for freestanding Skilled Nursing Facilities (SNFs), SNFs affiliated with acute care facilities, and all non-Critical Access Hospital (CAH) swing-bed rural hospitals submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

### PROVIDER ACTION NEEDED

Change Request (CR) 10377 adds logic into the Skilled Nursing Facility (SNF) Prospective Payment System (PPS) Pricer to apply the Quality Reporting Program (QRP) payment reduction for Fiscal Year (FY) 2018 for those facilities that do submit require quality data. Please make sure your billing staffs are aware of this update.

### BACKGROUND

Section 1888(e)(6)(B)(i)(II) of the Social Security Act (the Act) requires that each SNF submit, for FYs beginning on or after the specified application date (as defined in Section 1899B(a)(2)(E) of the Act), data on quality measures specified under Section 1899B(c)(1) of the Act and data on resource use and other measures specified under Section 1899B(d)(1) of the Act in a manner and within the time frames specified by the Secretary.

The SNF QRP applies to freestanding SNFs, SNFs affiliated with acute care facilities, and all non-Critical Access Hospital (CAH) swing-bed rural hospitals.

Beginning with FY 2018 and in each subsequent year, if an SNF does not submit required quality data; their payment rates for the year are reduced by 2 (two) percentage points for that FY. Application of the 2-percent reduction may result in an update that is less than 0.0 for an FY and in payment rates for an FY being less than such payment rates for the preceding FY. In addition, reporting-based reductions to the market basket increase factor will not be cumulative; rather they will only apply for the FY involved.

### ADDITIONAL INFORMATION

The official instruction, CR10377, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3928CP.pdf.

For an overview of the Quality Payment Program, go to https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-Quality-Payment-Program-webinar-slides-10-26-16.pdf.

To review the SNF Billing Reference, go to https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/SNFSpellIllnesschrt.pdf.

### DOCUMENT HISTORY

| Date of Change | Description |
|---|---|
| November 22, 2017 | Initial article released |

## DMEPOS Fee Schedule CY 2018 Update

**MLN Matters Number: MM10395**
**Related Change Request (CR) Number: 10395**
**Related CR Release Date: December 1, 2017**
**Effective Date: January 1, 2018**
**Related CR Transmittal Number: R3931CP**
**Implementation Date: January 2, 2018**

### PROVIDER TYPES AFFECTED

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

**PROVIDER ACTION NEEDED**

Change Request (CR) 10395 provides the Calendar Year (CY) 2018 annual update for the Medicare DMEPOS fee schedule. The instructions include information on the data files, update factors and other information related to the update of the fee schedule. Make sure your billing staffs are aware of these updates.

**BACKGROUND**

Section 1834(a), (h), and (i) of the Social Security Act (the Act) requires payment on a fee schedule for certain DMEPOS. Also, payment on a fee-schedule basis is a regulatory requirement at 42 CFR Section 414.102 for Parenteral and Enteral Nutrition (PEN), splints, casts, and Intraocular Lenses (IOLs) inserted in a physician's office.

Section 1834(a)(1)(F)(ii) of the Act mandates adjustments to the fee schedule amounts for certain items furnished on or after January 1, 2016, in areas that are not competitive bid areas, based on information from Competitive Bidding Programs (CBPs) for DME. Section 1842(s)(3)(B) of the Act provides authority for making adjustments to the fee schedule amounts for enteral nutrients, equipment, and supplies (enteral nutrition) based on information from CBPs. Regulations at 42 CFR Section 414.210(g) established the methodologies for adjusting DMEPOS fee schedule amounts using information from CBPs. Recent program instructions on these changes are available in Transmittal 3551, CR9642, dated June 23, 2016 (MM9642 is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM9642.pdf), and Transmittal 3416, CR9431, dated November 23, 2015 (MM9431 is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM9431.pdf).

The DMEPOS and Parenteral and Enteral Nutrition (PEN) fee schedule files contain HCPCS codes that are subject to the adjusted fee schedule amounts as well as codes that are not subject to the fee schedule CBP adjustments. Fee schedule amounts that are adjusted using information from CBPs will not be subject to the annual DMEPOS covered item update, but will be updated pursuant to 42 CFR Section 414.210(g)(8) when information from the CBPs is updated.

Pursuant to 42 CFR Section 414.210(g)(4), for items where the Single Payment Amounts (SPAs) from CBPs no longer in effect are used to adjust fee schedule amounts, the SPAs are increased by the percentage changes in the Consumer Price Index for all Urban Consumers (CPI-U) from the last year of the applicable CBP to the current year. Information on the update factor for CY 2018 is included below.

The ZIP code associated with the address used for pricing a DMEPOS claim determines the rural fee schedule payment applicability for codes with rural and non-rural adjusted fee schedule amounts. ZIP codes for non-continental Metropolitan Statistical Areas (MSAs) are not included in the DMEPOS Rural ZIP code file. The DMEPOS Rural ZIP code file is updated on a quarterly basis, as necessary. Regulations at 42 CFR 414.202 define a rural area to be a geographical area represented by a postal ZIP code where at least 50 percent of the total geographical area of the ZIP code is estimated to be outside any MSA. A rural area also included any ZIP code within an MSA that is excluded from a competitive bidding area established for that MSA.

The DMEPOS fee schedule file contains fee schedule amounts for non-rural and rural areas. Also, the PEN fee schedule file includes state fee schedule amounts for enteral nutrition items and national fee schedule amounts for parenteral nutrition items.

The DMEPOS and PEN fee schedules and the rural zip code Public Use Files (PUFs) will be available for State Medicaid Agencies, managed care organizations, and other interested parties at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched.

**New Codes Added**

New DMEPOS codes added to the HCPCS file, effective January 1, 2018, where applicable, are:

- E0953 and E0954 in the Inexpensive/Routinely Purchased (IN) payment category
- L3761, L7700, L8625, L8694, and Q0477, which are all in the Prosthetics and Orthotics (PO) payment category.

For gap-filling pricing purposes, deflation factors are applied before updating to the current year. The deflation factors for 2017 by the payment category are:

- 0.447 for Oxygen
- 0.450 for Capped Rental
- 0.451 for Prosthetics and Orthotics
- 0.572 for Surgical Dressings
- 0.623 for Parental and Enteral Nutrition
- 0.953 for Splints and Casts
- 0.937 for Intraocular Lenses

**Codes Deleted**

No HCPCS codes will be deleted from the DMEPOS fee schedule files effective January 1, 2018.

**Specific Coding and Pricing Issues**

Effective January 1, 2018, new Off-The-Shelf orthotic (OTS) code L3761 - Elbow Orthosis (EO), with adjustable position locking joint(s) prefabricated off-the-shelf - is included in the fee schedule file. Code L3760 was split into two codes: The existing code revised, effective January 1, 2018, to only describe devices customized to fit a specific patient by an individual with expertise, and a new code describing OTS items (L3761).

The fee schedule amount for existing code L3760 will be applied to new code L3761 effective January 1, 2018. The cross-walking of fee schedule amounts for a single code that is split into two codes for distinct complete items is in accordance with the instructions stated in Chapter 3, Section 60.3.1 of the "Medicare Claims Processing Manual." An update will be made to the list of orthotic codes that are designated as OTS at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/OTS_Orthotics.html to reflect added code L3761.

As part of this update, a corrected calculation is applied to the adjusted fee schedule amounts for codes A4619, E0147, and E0580. The fee schedule adjustment methodology at 42 CFR 414.210(g) was incorrectly applied to these codes, and therefore corrections to the adjusted fee schedule amounts for these codes have been made.

Effective January 1, 2018, the replacement external sound processor (HCPCS code L8691) is split into two codes in order to appropriately identify devices where the actuator is a separate component from the sound processor, microphones, and battery. The two codes are a revised L8691 and a new L8694 transducer/actuator code.

Effective January 1, 2018, the existing fee schedules for L8691 are revised to remove payment for the separate transducer/actuator component. Suppliers billing for replacement sound processors that do not separate the sound processor and the actuator should use both L8691 and L8694 to describe the replaced items. Suppliers billing for replacement sound processors that separate the sound processor and the actuator components should use either or both L8691 and L8694 as appropriate to describe the sound processor component(s).

The replacement Ventricular Assist Device (VAD) power module code Q0479 is split in order to separately identify the patient cable. Effective January 1, 2018, HCPCS code Q0477 identifies a replacement patient cable. Thus, the fees for Q0479 are revised to reflect the establishment of the new patient cable code.

The Centers for Medicare & Medicaid Services (CMS) is also adjusting the fee schedule amounts for shoe modification codes A5503 through A5507 in order to reflect more current allowed service data. Section 1833(o)(2)(C) of the Act required that the payment amounts for shoe modification codes A5503 through A5507 be established in a manner that prevented a net increase in expenditures when substituting these items for therapeutic shoe insert codes (A5512 or A5513). To establish the fee schedule amounts for the shoe modification codes, the base fees for codes A5512 and A5513 were weighted based on the approximated total allowed services for each code for items furnished during the second quarter of calendar year 2004.

For 2018, CMS is updating the weighted average insert fees used to establish the fee schedule amounts for the shoe modification codes with more current allowed service data for each insert code. The base fees for A5512 and A5513 will be weighted based on the approximated total allowed services for each code for items furnished during the calendar year 2016. The fee schedule amounts for shoe modification codes

A5503 through A5507 are being revised to reflect this change, effective January 1, 2018.

As part of this file update, the jurisdiction for HCPCS code E0781 is revised from 'J' to 'D'.

HCPCS code Q0477 (Power Module Patient Cable for Use with Electric or Electric/Pneumatic Ventricular Assist Device, Replacement Only) is being added to the HCPCS file, effective January 1, 2018, to describe a replacement accessory for Ventricular Assist Devices (VADs). Similar to the other VAD supplies and accessories coded at Q0478 thru Q0495, Q0497-Q0502, and Q0504 thru Q0509, CMS has determined the reasonable useful lifetime for code Q0477 to be one year. Therefore, CMS will deny claims for Q0477 before the lifetime of these items has expired. Suppliers and providers will need to add modifier RA to claims for code Q0477 in cases where the battery is being replaced because it was lost, stolen, or irreparably damaged.

Fees for the 'KU' modifier when billed with wheelchair codes E0953 and E0954 are included in the January 2018 file for billing when these items are furnished in connection with Group 3 complex rehabilitative power wheelchairs.

**Diabetic Testing Supplies**

The fee schedule amounts for non-mail order Diabetic Testing Supplies (DTS) (without KL modifier) for codes A4233, A4234, A4235, A4236, A4253, A4256, A4258, and A4259 are not updated by the annual covered item update. In accordance with Section 636(a) of the American Taxpayer Relief Act of 2012, the fee schedule amounts for these codes were adjusted in CY 2013 so that they are equal to the Single Payment Amounts (SPAs) for mail order DTS established in implementing the national mail order CBP under Section 1847 of the Act. The National Mail-Order Recompete DTS SPAs are available at https://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home.

The non-mail order DTS amounts on the fee schedule file will be updated each time the SPAs are updated. This can happen no less often than every time the mail order CBP contracts are recompeted. The CBP for mail order diabetic supplies is effective July 1, 2016, to December 31, 2018. The program instructions reviewing these changes are included in Transmittal 2709, Change Request (CR) 8325, dated May 17, 2013, and Transmittal 2661, CR8204, dated February 22, 2013. You can review related article MM8325 at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8325.pdff and MM8204 at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8204.pdf.

**2018 Fee Schedule Update Factor of 1.1 Percent**

For CY 2018, an update factor of 1.1 percent is applied to certain DMEPOS fee schedule amounts. In accordance with the statutory Sections 1834(a)(14) of the Act, certain DMEPOS fee schedule amounts are updated for 2018 by the percentage increase in the CPI- U for the 12-month period ending June 30, 2017, adjusted by the change in the economy-wide productivity equal to the 10-year moving average of changes in annual economy-wide private non-farm business Multi-Factor Productivity (MFP). The MFP adjustment is 0.5 percent and the CPI-U percentage increase is 1.6 percent. Thus, the 1.6 percentage increase in the CPI-U is reduced by the 0.5 percentage increase in the MFP resulting in a net increase of 1.1 percent for the update factor.

**2018 Update to the Labor Payment Rates**

The CY 2018 allowed payment amounts for HCPCS labor payment codes K0739, L4205, and L7520 are in the table below. Since the percentage increase in the CPI- U for the 12-month period ending with June 30, 2017, is 1.6 percent, this change is applied to the 2017 labor payment amounts to update the rates for CY 2018.

| STATE | K0739 | L4205 | L7520 | STATE | K0739 | L4205 | L7520 |
|---|---|---|---|---|---|---|---|
| AK | $28.74 | $32.75 | $38.53 | NC | $15.26 | $22.74 | $30.87 |
| AL | $15.26 | $22.74 | $30.87 | ND | $19.02 | $32.67 | $38.53 |
| AR | $15.26 | $22.74 | $30.87 | NE | $15.26 | $22.71 | $43.04 |
| AZ | $18.87 | $22.71 | $37.98 | NH | $16.39 | $22.71 | $30.87 |
| CA | $23.41 | $37.33 | $43.49 | NJ | $20.58 | $22.71 | $30.87 |
| CO | $15.26 | $22.74 | $30.87 | NM | $15.26 | $22.74 | $30.87 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| CT | $25.48 | $23.25 | $30.87 | NV | $24.31 | $22.71 | $42.07 |
| DC | $15.26 | $22.71 | $30.87 | NY | $28.09 | $22.74 | $30.87 |
| DE | $28.09 | $22.71 | $30.87 | OH | $15.26 | $22.71 | $30.87 |
| FL | $15.26 | $22.74 | $30.87 | OK | $15.26 | $22.74 | $30.87 |
| GA | $15.26 | $22.74 | $30.87 | OR | $15.26 | $22.71 | $44.38 |
| HI | $18.87 | $32.75 | $38.53 | PA | $16.39 | $23.39 | $30.87 |
| IA | $15.26 | $22.71 | $36.95 | PR | $15.26 | $22.74 | $30.87 |
| ID | $15.26 | $22.71 | $30.87 | RI | $18.19 | $23.41 | $30.87 |
| IL | $15.26 | $22.71 | $30.87 | SC | $15.26 | $22.74 | $30.87 |
| IN | $15.26 | $22.71 | $30.87 | SD | $17.06 | $22.71 | $41.27 |
| KS | $15.26 | $22.71 | $38.53 | TN | $15.26 | $22.74 | $30.87 |
| KY | $15.26 | $29.11 | $39.47 | TX | $15.26 | $22.74 | $30.87 |
| LA | $15.26 | $22.74 | $30.87 | UT | $15.30 | $22.71 | $48.07 |
| MA | $25.48 | $22.71 | $30.87 | VA | $15.26 | $22.71 | $30.87 |
| MD | $15.26 | $22.71 | $30.87 | VI | $15.26 | $22.74 | $30.87 |
| ME | $25.48 | $22.71 | $30.87 | VT | $16.39 | $22.71 | $30.87 |
| MI | $15.26 | $22.71 | $30.87 | WA | $24.31 | $33.31 | $39.58 |
| MN | $15.26 | $22.71 | $30.87 | WI | $15.26 | $22.71 | $30.87 |
| MO | $15.26 | $22.71 | $30.87 | WV | $15.26 | $22.71 | $30.87 |
| MS | $15.26 | $22.74 | $30.87 | WY | $21.28 | $30.31 | $43.04 |
| MT | $15.26 | $22.71 | $38.53 | | | | |

**2018 National Monthly Fee Schedule Amounts for Stationary Oxygen Equipment**

CMS is implementing the 2017 monthly fee schedule payment amounts for stationary oxygen equipment (HCPCS codes E0424, E0439, E1390, and E1391), effective for claims with dates of service from January 1, 2018, through December 31, 2018. As required by statute, the addition of the separate payment classes for Oxygen Generating Portable Equipment (OGPE) and stationary and portable oxygen contents must be annually budget neutral. Medicare expenditures must account for these separate oxygen payment classes.

Therefore, the fee schedule amounts for stationary oxygen equipment are reduced by a certain percentage each year to balance the increase in payments made for the additional separate oxygen payment classes. For dates of service January 1, 2018, through December 31, 2018, the monthly fee schedule payment amounts for stationary oxygen equipment range from approximately $66 to $76 incorporating the budget neutrality adjustment factor.

When updating the stationary oxygen equipment amounts, corresponding updates are made to the fee schedule amounts for HCPCS codes E1405 and E1406 for oxygen and water vapor enriching systems. Since 1989, the payment amounts for codes E1405 and E1406 have been established based on a combination of the Medicare payment amounts for stationary oxygen equipment and nebulizer codes E0585 and E0570, respectively.

**2018 Maintenance and Servicing Payment Amount for Certain Oxygen Equipment**

CMS is also updating for 2018 the payment amount for maintenance and servicing for certain oxygen equipment. Payment for claims for maintenance and servicing of oxygen equipment was instructed in Transmittal 635, CR6792, dated February 5, 2010, and Transmittal 717, CR6990, dated June 8, 2010.(You can review related articles MM6792 at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6792.pdf and MM6990 at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6990.pdf.) To summarize, payment for maintenance and servicing of certain oxygen equipment can occur every 6 months beginning 6 months after the end of the 36th month of continuous use or end of the supplier's or manufacturer's warranty, whichever is later for either HCPCS code E1390, E1391, E0433, or K0738, billed with the "MS" modifier. Payment cannot occur more than once per

beneficiary, regardless of the combination of oxygen concentrator equipment and/or transfilling equipment used by the beneficiary, for any 6-month period.

Per 42 CFR 414.210(e)(5)(iii), the 2010 maintenance and servicing fee for certain oxygen equipment was based on 10 percent of the average price of an oxygen concentrator. For CY 2011 and subsequent years, the maintenance and servicing fee is adjusted by the covered item update for DME as set forth in §1834(a)(14) of the Act. Thus, the 2017 maintenance and servicing fee is adjusted by the 1.1 percent MFP-adjusted covered item update factor to yield a CY 2018 maintenance and servicing fee of $70.74 for oxygen concentrators and transfilling equipment.

### ADDITIONAL INFORMATION

The official instruction, CR10395, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3931CP.pdf.

### DOCUMENT HISTORY

| Date of Change | Description |
|---|---|
| January 5, 2018 | Initial article released. |

## PWK Segment of the esMD System Implementation Modifications

**MLN Matters Number: MM10397**
**Related Change Request (CR) Number: 10397**
**Related CR Release Date: February 16, 2018**
**Effective Date: July 1, 2018**
**Related CR Transmittal Number: R20310TN**
**Implementation Date: July 2, 2018**

### PROVIDER TYPE AFFECTED

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

### PROVIDER ACTION NEEDED

Change Request (CR) 10397updates the business requirements to enable MACs to receive unsolicited documentation (also known as paperwork (PWK)) via the Electronic Submission of Medical Documentation (esMD) system. CR10397 is for esMD purposes only. Please make sure your billing staffs are aware of these updates.

### BACKGROUND

CR10397 also contains attachments that include cover sheets that must be used for electronic, fax, or mail submissions of documentation. There are three cover sheets, one each for Part A and Part B providers, as well as one for durable medical equipment (DME) suppliers. In addition, there are two companion guides attached to CR10397, one for institutional claims and one for professional claims. A link to CR10397 is available in the Additional Information section of this article.

With CR10397, MACs will modify PWK, also known as unsolicited documentation procedures to include electronic submission(s) via esMD. Also, Medicare systems will accept PWK 02 values "EL" and "FT" for those MACs in a CMS-approved esMD system. This mechanism will suppress initial auto letter generation, if applicable, when PWK 02 is "EL" or "FT," and is present at any level of the claim or line.

Providers will receive communication from MACs via companion documents for 5010 X12 837 to include:

- The value "EL" (electronic) in PWK 02 to represent an esMD submission for sending the documentation using X12 Standards (6020 X12 275)
- The value "FT" (file transfer) in PWK 02 to represent an esMD submission for sending the documentation in PDF format using XDR specifications.

MACs will allow 7 calendar "waiting days" (from the date of receipt) for additional information to be submitted when the PWK 02 value is "EL" or "FT."

MACs will use RC Client to reject the PWK data submissions as administrative error(s) when the received cover sheet (via esMD) is incomplete or incorrectly filled out as applicable to current edits. Providers can expect to see new generic reason statements introduced to convey these errors as follows (Codes for these statements will be finalized and sent along with the RC implementation guide):

- The date(s) of service on the cover sheet received is missing or invalid.
- The NPI on the cover sheet received is missing or invalid.
- The state where services were provided is missing or invalid on the cover sheet received.
- The Medicare ID on the cover sheet received is missing or invalid.
- The billed amount on the cover sheet received is missing or invalid.
- The contact phone number on the cover sheet received is missing or invalid.
- The beneficiary name on the cover sheet received is missing or invalid.
- The claim number on the cover sheet received is missing or invalid.
- The Attachment Control Number (CAN) on the cover sheet is missing or invalid.

Once again, examples of the cover sheet are included as an attachment to CR10397.

### ADDITIONAL INFORMATION

The official instruction, CR 10397, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R2031OTN.pdf.

The X12 837 Companion Guides are available at

https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/CompanionGuides.html.

### DOCUMENT HISTORY

| Date of Change | Description |
|---|---|
| February 16, 2018 | Initial article released. |

## HPTCS April 2018 Code Set Update

**MLN Matters Number: MM10402**
**Related Change Request (CR) Number: 10402**
**Related CR Release Date: February 16, 2018**
**Effective Date: July 1, 2018**
**Related CR Transmittal Number: R3977CP**
**Implementation Date: July 2, 2018**

### PROVIDER TYPES AFFECTED

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

### WHAT YOU NEED TO KNOW

Change Request (CR) 10402 directs MACs to obtain the most recent Healthcare Provider Taxonomy Codes (HPTCs) code set and use it to update their internal HPTC tables and/or reference files. Make sure your billing staffs are aware of these changes.

### BACKGROUND

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that covered entities comply with the requirements in the electronic transaction format implementation guides adopted as

national standards. The institutional and professional claim electronic standard implementation guides (X12 837-I and 837-P) each require use of valid codes contained in the HPTC set when there is a need to report provider type or physician, practitioner, or supplier specialty for a claim.

You should note that:

- Valid HPTCs are those codes approved by the National Uniform Claim Committee (NUCC) for current use.
- Terminated codes are not approved for use after a specific date.
- Newly approved codes are not approved for use prior to the effective date of the code set update in which each new code first appears.
- Specialty and/or provider type codes issued by any entity other than the NUCC are not valid.
- Medicare would be guilty of non-compliance with HIPAA if MACs accepted claims that contain invalid HPTCs.

The HPTC set is maintained by the National Uniform Claim Committee (NUCC) for standardized classification of health care providers. The NUCC updates the code set twice a year with changes effective April 1 and October 1. The HPTC list is available for view or for download from the NUCC website at http://www.nucc.org/index.php/code-sets-mainmenu-41/provider-taxonomy-mainmenu-40.

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

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

### ADDITIONAL INFORMATION

The official instruction, MM10402, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and- Guidance/Guidance/Transmittals/2018Downloads/R3977CP.pdf.

### DOCUMENT HISTORY

| Date of Change | Description |
|---|---|
| February 16, 2018 | Initial article released. |

## Medicare Deductible, Coinsurance and Premium Rates – 2018 Update

**MLN Matters Number: MM10405**
**Related Change Request (CR) Number: CR10405**
**Related CR Release Date: December 8, 2017**
**Effective Date: January 1, 2018**
**Related CR Transmittal Number: R111GI**
**Implementation Date: January 2, 2018**

### PROVIDER TYPE AFFECTED

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

### PROVIDER ACTION NEEDED

Change Request (CR) 10405 provides instruction for MACs to update the claims processing system with the new Calendar Year (CY) 2018 Medicare deductible, coinsurance, and premium rates. Make sure your billing staffs are aware of these changes.

## BACKGROUND

Beneficiaries who use covered Part A services may be subject to deductible and coinsurance requirements. A beneficiary is responsible for an inpatient hospital deductible amount, which is deducted from the amount payable by the Medicare program to the hospital, for inpatient hospital services furnished in a spell of illness. When a beneficiary receives such services for more than 60 days during a spell of illness, he or she is responsible for a coinsurance amount equal to one-fourth of the inpatient hospital deductible per-day for the 61st - 90th day spent in the hospital. An individual has 60 lifetime reserve days of coverage, which they may elect to use after the 90th day in a spell of illness. The coinsurance amount for these days is equal to one-half of the inpatient hospital deductible. A beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible per day for the 21st through the 100th day of Skilled Nursing Facility (SNF) services furnished during a spell of illness.

Most individuals age 65 and older, and many disabled individuals under age 65, are insured for Health Insurance (HI) benefits without a premium payment. The Social Security Act provides that certain aged and disabled persons who are not insured may voluntarily enroll, but are subject to the payment of a monthly premium. Since 1994, voluntary enrollees may qualify for a reduced premium if they have 30 - 39 quarters of covered employment. When voluntary enrollment takes place more than 12 months after a person's initial enrollment period, a 10 percent penalty is assessed for 2 years for every year they could have enrolled and failed to enroll in Part A.

Under Part B of the Supplementary Medical Insurance (SMI) program, all enrollees are subject to a monthly premium. Most SMI services are subject to an annual deductible and coinsurance (percent of costs that the enrollee must pay), which are set by statute. When Part B enrollment takes place more than 12 months after a person's initial enrollment period, there is a permanent 10 percent increase in the premium for each year the beneficiary could have enrolled and failed to enroll.

## 2018 PART A HOSPITAL INSURANCE (HI)

- Deductible: $1,340.00
- Coinsurance
  - $335.00 a day for 61st - 90th day
  - $670.00 a day for 91st - 150th day (lifetime reserve days)
  - $167.50 a day for 21st - 100th day (Skilled Nursing Facility coinsurance)
- Base Premium (BP): $422.00 a month BP with 10 percent surcharge: $464.20 a month
- BP with 45 percent reduction: $232.00 a month (for those who have 30-39 quarters of coverage)
- BP with 45 percent reduction and 10 percent surcharge: $255.20 a month

## 2018 PART B - SUPPLEMENTARY MEDICAL INSURANCE (SMI)

- Standard Premium: $134.00 a month
- Deductible: $183.00 a year
- Pro Rata Data Amount:
  - $126.88 1st month
  - $56.12 2nd month
- Coinsurance: 20 percent

## ADDITIONAL INFORMATION

The official instruction, CR10405, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R111GI.pdf.

## DOCUMENT HISTORY

| Date of Change | Description |
|---|---|
| December 8, 2017 | Initial document released. |

## DMEPOS HCPCS Code 2018 Jurisdiction List

MLN Matters Number: MM10416
Related Change Request (CR) Number: 10416
Related CR Release Date: January 12, 2018
Effective Date: January 1, 2018
Related CR Transmittal Number: R3950CP
Implementation February 13, 2018

### PROVIDER TYPES AFFECTED

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

### PROVIDER ACTION NEEDED

Change Request (CR) 10416 updates the list of Healthcare Common Procedure Coding System (HCPCS) codes for the MACs and DME MACs. Please make sure your billing staffs are aware of these updates.

### WHAT YOU NEED TO KNOW

The Centers for Medicare & Medicaid Services (CMS) annually updates a spreadsheet that contains a list of the HCPCS codes for DME MACs and Part B MACs jurisdictions to reflect codes that have been added or discontinued (deleted) each year. The jurisdiction list is an Excel file and is available at http://www.cms.gov/Center/Provider-Type/Durable-Medical-Equipment-DME-Center.html.

The file is also available as an attachment to CR10416.

### ADDITIONAL INFORMATION

The official instruction, CR 10416, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-andGuidance/Guidance/Transmittals/2018Downloads/R3950CP.pdf.

### DOCUMENT HISTORY

| Date of Change | Description |
|---|---|
| January 12, 2018 | Initial article released. |

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

MLN Matters Number: MM10433
Related Change Request (CR) Number: 10433
Related CR Release Date: February 2, 2018
Effective Date: July 1, 2018
Related CR Transmittal Number: R3965CP
Implementation Date: For claims processed on or after July 2, 2018

### PROVIDER TYPES AFFECTED

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

### WHAT YOU NEED TO KNOW

Effective with Change Request (CR) 10433, the Centers for Medicare & Medicaid Services (CMS) will reintroduce Qualified Medicare Beneficiary (QMB) information in the Medicare Remittance Advice (RA) and Medicare Summary Notice (MSN). CR 9911 modified the Fee-For-Service (FFS) systems to indicate

the QMB status and zero cost-sharing liability of beneficiaries on RAs and MSNs for claims processed on or after October 2, 2017. On December 8, 2018, CMS suspended CR 9911 to address unforeseen issues preventing the processing of QMB cost-sharing claims by States and other secondary payers outside of the Coordination of Benefits Agreement (COBA) process. CR 10433 remediates these issues by including revised "Alert" Remittance Advice Remark Codes (RARC) in RAs for QMB claims without adopting other RA changes that impeded claims processing by secondary payers. CR 10433 reinstates all changes to the MSNs under CR 9911. Please make sure your billing staff is aware of these changes.

**BACKGROUND**

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

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

System Changes to Assist Providers under CR 9911

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

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

Additionally, CR 9911 changed the display of patient responsibility on the RA by replacing Claim Adjustment Group Code "Patient Responsibility" (PR) with Group Code "Other Adjustment" (OA). CMS zeroed out the deductible and coinsurance amounts associated with Claim Adjustment Reason Code (CARC) 1 (deductible) and/or 2 (coinsurance) and used CARC 209 – ("Per regulatory or other agreement, the provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to the patient if collected. (Use only with Group code OA).")

However, the changes to the display of patient liability in the RAs for QMB claims caused unforeseen issues affecting the processing of QMB cost-sharing claims directly submitted by providers to states and other payers secondary to Medicare. Providers rely on RAs to bill State Medicaid Agencies and other secondary payers outside the Medicare COBA claims crossover process. States and other secondary payers generally require RAs that separately display the Medicare deductible and coinsurance amounts with the Claim Adjustment Group Code "PR" and associated CARC codes and could not process claims involving the RA changes from CR 9911. Barriers to the processing of secondary claims have additional implications for institutional providers that claim bad debt under the Medicare program since they must obtain a Medicaid Remittance Advice to seek reimbursement for unpaid deductibles and coinsurance as a Medicare bad debt for QMBs.

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

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

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

The RA for QMB claims will retain the display of patient liability amounts needed by secondary payers to process QMB cost-sharing claims. CMS systems shall output Claim Adjustment Group Code "PR"

along with CARC 1 and/or 2, as applicable, with monetary values expressed on outbound Medicare 835 Electronic Remittance Advices (ERAs) and on standard paper remittance advices (SPRs), as applicable. Medicare's shared systems shall discontinue the practice of outputting Claim Adjustment Group Code OA with CARC 209 and reflecting the CARC 1 and 2 monetary amounts as zero.

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

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

CR 10433 reestablishes all CR 9911 changes to the MSN by including QMB messages and reflecting $0 cost-sharing liability for the period beneficiaries are enrolled in QMB.

### ADDITIONAL INFORMATION

The official instruction, MM10433, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and- Guidance/Guidance/Transmittals/2018Downloads/R3965CP.pdf.

### DOCUMENT HISTORY

| Date of Change | Description |
|---|---|
| February 2, 2018 | Initial article released. |

## ASP Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files for April 2018

**MLN Matters Number: MM10447**
**Related Change Request (CR) Number: 10447**
**Related CR Release Date: January 5, 2018**
**Effective Date: April 1, 2018**
**Related CR Transmittal Number: R3947CP**
**Implementation Date: April 2, 2018**

### PROVIDER TYPE AFFECTED

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

### PROVIDER ACTION NEEDED

Change Request (CR) 10447 instructs MACs to download and implement the April 2018 and, if released, the revised January 2018, October 2017, July 2017, and April 2017 ASP drug pricing files for Medicare Part B drugs via the Centers for Medicare & Medicaid Services (CMS) Data Center (CDC). Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after April 2, 2018, with dates of service April 1, 2018, through June 30, 2018. Make sure that your billing staffs are aware of these changes.

### BACKGROUND

The Average Sales Price (ASP) methodology is based on quarterly data submitted by manufacturers to CMS. CMS supplies MACs with the ASP and Not Otherwise Classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the Outpatient Prospective Payment System (OPPS) are incorporated into the Outpatient Code Editor (OCE) through separate instructions that are available in Chapter 4, Section 50 of the Medicare Claims Processing Manual at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf.

- File: April 2018 ASP and ASP NOC -- Effective for Dates of Service of April 1, 2018, through June 30, 2018
- File: January 2018 ASP and ASP NOC -- Effective for Dates of Service of January 1, 2018, through March 31, 2018
- File: October 2017 ASP and ASP NOC -- Effective for Dates of Service of October 1, 2017, through December 31, 2017
- File: July 2017 ASP and ASP NOC -- Effective for Dates of Service of July 1, 2017, through September 30, 2017
- File: April 2017 ASP and ASP NOC -- Effective for Dates of Service of April 1, 2017, through June 30, 2017

For any drug or biological not listed in the ASP or NOC drug pricing files, your MACs will determine the payment allowance limits in accordance with the policy described in the Medicare Claims Processing Manual Chapter 17, Section 20.1.3 at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c17.pdf.

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

### ADDITIONAL INFORMATION

The official instruction, CR 10447, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R3947CP.pdf.

### DOCUMENT HISTORY

| Date of Change | Description |
|---|---|
| January 5, 2018 | Initial article released |

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

**MLN Matters Number: MM10454**
**Related Change Request (CR) Number: 10454**
**Related CR Release Date: February 2, 2018**
**Effective Date: April 1, 2018**
**Related CR Transmittal Number: R3966CP**
**Implementation Date: April 2, 2018**

### PROVIDER TYPES AFFECTED

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

### WHAT YOU NEED TO KNOW

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

### BACKGROUND

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

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

- HCPCS Code: Q5101
  - Short Description: Injection, zarxio
  - Long Description: Injection, filgrastim-sndz, biosimilar, (zarxio), 1 microgram
- HCPCS Code: Q5103
  - Short Description: Injection, inflectra
  - Long Description: Injection, infliximab-dyyb, biosimilar, (inflectra), 10 mg
  - Type of Service (TOS) Code: 1,P
  - Medicare Physician Fee Schedule Database (MPFSDB) Status Indicator: E
- HCPCS Code: Q5104
  - Short Description: Injection, renflexis
  - Long Description: Injection, infliximab-abda, biosimilar, (renflexis), 10 mg
  - TOS Code: 1, P
  - MPFSDB Status Indicator: E
- HCPCS Code:Q2041
  - Short Description: Axicabtagene ciloleucel car+
  - Long Description: Axicabtagene Ciloleucel, up to 200 million autologous Anti-CD19 CAR T Cells, Including leukapheresis and dose preparation procedures, per infusion
  - TOS Code: 1
  - MPFSDB Status Indicator: E

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

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

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

**ADDITIONAL INFORMATION**

The official instruction, CR 10454, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R3966CP.pdf.

**DOCUMENT HISTORY**

| Date of Change | Description |
|---|---|
| February 2, 2018 | Initial article released. |

## Modifier KH, KI and KJ Billing Reminders

Noridian has seen an increase in the inappropriate use of the capped rental "K" modifiers on claims. During our processing of "K" modifier claims, many suppliers use the same rental modifier each month. This is incorrect billing as the KH, KI and KJ modifiers must be applied to the correct rental month as outlined in the table below. This table also provides the denial codes when modifiers are used in inappropriately and how to correct the claim.

Below are some reminders on appropriate capped rental "K" modifier submission:

- KH modifier is required on new Capped Rental, PEN pumps or when the NU modifier is used for new equipment.
- KH modifier can only be used on the claim for the first rental month or first month of purchase.
- KI modifier shall only be used for the second and third months of billing for rentals.
- KJ modifier shall be used for the remainder of the capped rental period, months fourth-thirteen or months four-fifteen for PEN pumps.

| Modifier | Scenario | Result and Remittance Message | Next Steps |
|---|---|---|---|
| KH | First Month Rental | Pay | N/A |
| | First Month Purchase | Pay | N/A |
| | If KH not billed on first month of purchase | Deny: Return/Reject N519 4 | Resubmit claim with KH modifier |
| | If KH billed on any claim after first month | Deny: 181 M20 | Request Reopening, either phone, written or Noridian Medicare Portal |
| KI | Second month rental | Pay | N/A |
| | Third month rental | Pay | N/A |
| | If KI billed on any claim except months 2 and 3 | Deny: Return/Reject N519 4 | Resubmit claims with KI modifier |

## Serial Claims Initiative - Implemented April 2017

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Appeals workgroup collaborated with CMS in development of the Serial Claims Initiative, implemented in April 2017, to improve the way claims billed in a series are adjudicated.

This initiative:

- Provides a process to connect a favorable determination on a serial claim to other claims in series that were denied for same or similar reasons
  - A serial claim is defined as capped rental equipment paid on a monthly rental basis not to exceed a period of continuous use of 13 months or 36 months (oxygen)
  - If related claims are currently pending with Qualified Independent Contractor (QIC) or Office of Medicare Hearings and Appeals (OMHA), DME MAC will communicate favorable decision so it may be considered when adjudicating related appeals pending at such levels
- Allows future claims in series to pay
- Includes data analysis of all favorable serial claim appeal decisions made over previous three years to identify pending appeals in series that may be eligible for resolution
- Enhances supplier's experience by ensuring items that have been subject to medical review and have been determined to meet medical necessity will continue to be paid consistently for duration of rental period, thus reducing volume of new denials and subsequent appeals and improving adjudication process for currently pending appeals

## Weekly Q&A News – Name Changed to Monday Live Chat

The Noridian DME Education team is excited to be able to offer the 2018 General Question & Answer (Q&A) sessions weekly instead of monthly. These sessions are being renamed to Monday Live Chat effective immediately.

The process for registering for these sessions remains the same; however, once "Register" has been chosen, use the drop-down box to indicate which date you would like to attend. Go To Webinar will automatically default to the first date given.

Each session will be every Monday at 2 p.m. Central Time and will be approximately 30 minutes. This is a great opportunity to receive general information and ask verbal and written questions of the Education and Outreach team.

## Telephone Reopenings: Resources for Success

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

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

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

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

| | |
|---|---|
| **What may I request as a Telephone Reopening?** | The following is a list of clerical errors and omissions that **may** be completed as a Telephone Reopening. Note: This list is not all-inclusive.<br>Diagnosis code changes or additions<br>Date of Service (DOS) changes<br>HCPCS code changes<br>Certain modifier changes or additions (not an all-inclusive list)<br>KH<br>KI<br>KJ<br>RR<br>NU<br>AU<br>KL<br>RT<br>LT<br>A1 – A9<br>**Note:** If, upon research, any of the above change are determined too complex, the caller will be notified the request needs to be sent in writing as a redetermination with the appropriate supporting documentation. |
| **What is not accepted as a Telephone Reopening?** | The following will not be accepted as a Telephone Reopening and must be submitted as a redetermination with supporting documentation.<br>Overutilization denials that require supporting medical records<br>Certificate of Medical Necessity (CMN) and Durable Medical Equipment Information Form (DIF) issues. Please see the article posted March 21, 2013<br>Oxygen break in service (BIS) issues<br>Overpayments or reductions in payment<br>Medicare Secondary Payer (MSP) issues<br>Claims denied for timely filing<br>Reopenings past one year from the initial determination<br>Complex Medical Reviews or Additional Documentation Requests<br>Advance Beneficiary Notice of Noncoverage (ABN) issues and other liability issues<br>Repair and labor claims<br>Miscellaneous HCPCS codes and all HCPCS codes that require manual pricing<br>The following modifier changes or additions:<br>K0 through K4<br>GA<br>GY<br>GZ<br>KX<br>EY<br>RA<br>RB<br>RP<br>JW<br>KK<br>Certain HCPCS codes (not all-inclusive list)<br>A4450 through A4452<br>E0194<br>E0748<br>E1028<br>J1559<br>J1561<br>J1562<br>K0108<br>K0462 |

| | |
|---|---|
| **What do I do when I have a large amount of corrections?** | If a supplier has at least 10 of the same correction, that are able to be completed as a reopening, the supplier should notify a Telephone Reopenings representative. The representative will gather the required information for the supplier to submit a Special Project. |
| **Where can I find more information on Telephone Reopenings?** | Supplier Manual Chapter 13<br>Reopening Section on the Noridian DME website<br>IOM Publication 100-04, Chapter 34 |
| **Additional assistance available** | Suppliers can email questions and concerns regarding reopenings and redeterminations to dmeredeterminations@noridian.com. Please note, emails containing Protected Health Information (PHI) will be returned as unprocessable. |

## Clerical Changes to Recovery Auditor Contractor (RAC) Overpayments

Effective March 1, 2018, a written reopening opening must be submitted if a clerical error is identified on a RAC overpayment instead of a written redetermination as previously done.

Proper completion of the Written Reopening Form will ensure appropriate processing of these requests. In the "Reason for Adjustment" section, please check the "Other" box and write/type "RAC" next to it.

## Voluntary Refunds Sent to Noridian

A voluntary refund is a situation that causes a supplier to owe money to Medicare on previously paid claims. Medicare may have not notified the supplier of this overpayment, so a voluntary refund needs to be submitted.

When submitting a voluntary refund, the Overpayment Refund Form (JD) must be completed and returned with a check to Noridian to ensure proper recording and receipt of the check and timely processing. Mail or fax the form to the address or fax number below.

Noridian Healthcare Solutions, LLC
PO Box 6727
Fargo, ND 58108-6727

Fax:

- MSP: 701-277-7892
- Non-MSP: 701-277-7894

Checks should be made payable to Noridian Healthcare Solutions, LLC and mailed to:

JD DME
PO Box 511531
Los Angeles, CA 90051-8086

## Low Volume Appeals Settlement

On February 5, 2018, CMS started accepting Expressions of Interest (EOIs) for its low volume appeals (LVA) settlement process. The LVA settlement option is for providers, physicians and suppliers (appellants) with fewer than 500 combined appeals pending at the Office of Medicare Hearings and Appeals (OMHA) and the Medicare Appeals Council (Council) at the Departmental Appeals Board, as of November 3, 2017, with a total billed amount of $9,000 or less per appeal.

EOIs will be accepted

February 5, 2018 through March 9, 2018 for appellants with NPIs ending in an **even** number (0, 2, 4, 6, 8)

March 12, 2018 through April 11, 2018 for appellants with NPIs ending in an **odd** number (1, 3, 5, 7, 9)

If interested in participating in LVA to address pending appeals, visit CMS' website at go.cms.gov/LVA.

## Serial Claims Initiative – Implemented April 2017

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Appeals workgroup collaborated with CMS in development of the Serial Claims Initiative, implemented in April 2017, to improve the way claims billed in a series are adjudicated.

This initiative:

- Provides a process to connect a favorable determination on a serial claim to other claims in series that were denied for same or similar reasons
    - A serial claim is defined as capped rental equipment paid on a monthly rental basis not to exceed a period of continuous use of 13 months or 36 months (oxygen)
    - If related claims are currently pending with Qualified Independent Contractor (QIC) or Office of Medicare Hearings and Appeals (OMHA), DME MAC will communicate favorable decision so it may be considered when adjudicating related appeals pending at such levels
- Allows future claims in series to pay
- Includes data analysis of all favorable serial claim appeal decisions made over previous three years to identify pending appeals in series that may be eligible for resolution
- Enhances supplier's experience by ensuring items that have been subject to medical review and have been determined to meet medical necessity will continue to be paid consistently for duration of rental period, thus reducing volume of new denials and subsequent appeals and improving adjudication process for currently pending appeals

## 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.

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

## MLN Matters Number: SE17022 Revised

## Article Release Date: December 13, 2017

This article was revised on December 13, 2017, to advise providers that the public health emergency declaration and Section 1135 waiver authority expired on December 2, 2017, for Florida and on December 3, 2017, for the United States Virgin Islands and the Commonwealth of Puerto Rico. All other information remains the same.

### PROVIDER TYPE AFFECTED

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

### PROVIDER INFORMATION AVAILABLE

On September 5, 2017, pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act, President Trump declared that, as a result of the effects of Hurricane Irma, an emergency exists in the United States Virgin Islands, Commonwealth of Puerto Rico and State of Florida. Also on September 6, 2017, for the United States Virgin Islands and Commonwealth of Puerto Rico and September 7, 2017 for the State of Florida, Secretary Price of the Department of Health & Human Services declared that a public health emergency exists in the United States Virgin Islands, Commonwealth of Puerto Rico and State of Florida and authorized waivers and modifications under Section 1135 of the Social Security Act (the Act), retroactive to September 5, 2017, for the United States Virgin Islands and Commonwealth of Puerto Rico and retroactive to September 4, 2017, for the State of Florida. The Public Health Emergency declaration and Social Security Act waivers including the Section 1135 waiver authority expired on December 2, 2017, for Florida and on December 3, 2017, for the United States Virgin Islands and the Commonwealth of Puerto Rico.

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

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

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

### BACKGROUND

Section 1135 and Section 1812(f) Waivers

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

1. Change Request (CR) 6451 (Transmittal 1784, Publication 100-04) issued on July 31, 2009, applies to items and services furnished to Medicare beneficiaries within the United States Virgin Islands and Commonwealth of Puerto Rico from September 5, 2017, and the State of Florida from September 4, 2017, for the duration of the emergency. In accordance with CR6451, use of the "DR" condition code and the "CR" modifier are mandatory on claims for items and services for which Medicare payment is conditioned

on the presence of a "formal waiver" including, but not necessarily limited to, waivers granted under either Section 1135 or Section 1812(f) of the Act.

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

- The first listed file addresses policies and procedures that are applicable without any Section 1135 or other formal waiver. These policies are always applicable in any kind of emergency or disaster, including the current emergency in the United States Virgin Islands, Commonwealth of Puerto Rico and State of Florida.
- The second file addresses policies and procedures that are applicable only with approved Section 1135 waivers or, when applicable, approved Section 1812(f) waivers. These Q&As are applicable for approved Section 1135 blanket waivers and approved individual 1135 waivers requested by providers and are effective September 5, 2017, for the United States Virgin Islands and Commonwealth of Puerto Rico and September 4, 2017, for the State of Florida.

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

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

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

**Blanket Waivers Issued by CMS**

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

Skilled Nursing Facilities

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

Home Health Agencies

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

Critical Access Hospitals

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

Housing Acute Care Patients In Excluded Distinct Part Units

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

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

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

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

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

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

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

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

For more information refer to the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies for Medicare Beneficiaries Impacted by an Emergency or Disaster fact sheet at https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Emergency-DME-Beneficiaries-Hurricanes.pdf.

Facilities Quality Reporting

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

Appeal Administrative Relief for Areas Affected by Hurricane Irma

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

Replacement Prescription Fills

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

Requesting an 1135 Waiver

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

**ADDITIONAL INFORMATION**

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

Providers may also want to view the Survey and Certification Frequently Asked Questions at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/index.html.

**DOCUMENT HISTORY**

| Date of Change | Description |
|---|---|
| December 13, 2017 | The article was revised to advise providers that the public health emergency declaration and Section 1135 waiver authority expired on December 2, 2017, for Florida and on December 3, 2017, for the United States Virgin Islands and the Commonwealth of Puerto Rico. All other information remains the same. |
| September 19, 2017 | The article was revised to include new waivers regarding care for excluded inpatient psychiatric unit patients in the acute care unit of a hospital and care for excluded inpatient rehabilitation unit patients in the acute care unit of a hospital, to add information on replacement prescription fills of covered Part B drugs, and information on Facilities Quality Reporting. All other information remains the same. All other information remains the same. |
| September 8, 2017 | Initial article released. |

## Hurricane Irma and Medicare Disaster Related South Carolina and Georgia Claims – Third Revision

### MLN Matters Number: SE17024 Revised
### Article Release Date: December 13, 2017

This article was revised on December 13, 2017, to advise providers that the public health emergency declaration and Section 1135 waiver authority expired on December 4, 2017, for South Carolina and on December 5, 2017, for Georgia. All other information remains the same.

**PROVIDER TYPES AFFECTED**

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

**PROVIDER INFORMATION AVAILABLE**

On September 7, 2017, pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act, President Trump declared that, as a result of the effects of Hurricane Irma, an emergency exists in the State of South Carolina. On September 8, 2017, pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act, President Trump declared that, as a result of the effects of Hurricane Irma, an emergency exists in the State of Georgia. Also on September 8, 2017, Secretary Price of the Department of Health & Human Services declared that a public health emergency exists in the States of South Carolina and Georgia and authorized waivers and modifications under Section 1135 of the Social Security Act (the Act), retroactive to September 6, 2017, for the State of South Carolina and retroactive to September 7, 2017, for the State of Georgia. The Public Health Emergency declaration and Social Security Act waivers including the Section 1135 waiver authority expired on December 4, 2017, for South Carolina and on December 5, 2017, for Georgia.

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

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

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

**BACKGROUND**

Section 1135 and Section 1812(f) Waivers

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

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

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

- The first listed file addresses policies and procedures that are applicable without any Section 1135 or other formal waiver. These policies are always applicable in any kind of emergency or disaster, including the current emergency in the States of South Carolina and Georgia.
- The second file addresses policies and procedures that are applicable only with approved Section 1135 waivers or, when applicable, approved Section 1812(f) waivers. These Q&As are applicable for approved Section 1135 blanket waivers and approved individual 1135 waivers requested by providers and are effective September 6, 2017, for the State South Carolina and September 7, 2017, for the State of Georgia.

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

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

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

**Blanket Waivers Issued by CMS**

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

Skilled Nursing Facilities

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

Home Health Agencies

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

Critical Access Hospitals

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

Housing Acute Care Patients In Excluded Distinct Part Units

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

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

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

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

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

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

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

equipment must be replaced and are reminded to maintain documentation indicating that the DMEPOS was lost, destroyed, irreparably damaged or otherwise rendered unusable as a result of the hurricane.

For more information refer to the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies for Medicare Beneficiaries Impacted by an Emergency or Disaster fact sheet at https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Emergency-DME-Beneficiaries-Hurricanes.pdf.

Appeal Administrative Relief for Areas Affected by Hurricane Irma

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

Replacement Prescription Fills

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

Requesting an 1135 Waiver

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

**ADDITIONAL INFORMATION**

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

Providers may also want to view the Survey and Certification Frequently Asked Questions at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/index.html.

**DOCUMENT HISTORY**

| Date of Change | Description |
|---|---|
| December 13, 2017 | The article was revised to advise providers that the public health emergency declaration and Section 1135 waiver authority expired on December 4, 2017, for South Carolina and on December 5, 2017, for Georgia. All other information remains the same. |
| September 19, 2017 | The article was revised to include new waivers regarding care for excluded inpatient psychiatric unit patients in the acute care unit of a hospital and care for excluded inpatient rehabilitation unit patients in the acute care unit of a hospital and to add information on replacement prescription fills of covered Part B drugs. All other information remains the same. |
| September 11, 2017 | Initial article released. |

## Hurricane Nate and Medicare Disaster Related Alabama, Florida, Louisiana and Mississippi Claims – Revised

### MLN Matters Number: SE17034 Revised

### Article Release Date: January 19, 2018

This article was revised on January 19, 2018, to advise providers that the public health emergency declaration and Section 1135 waiver authority has expired as noted below. All other information remains the same.

**PROVIDER TYPES AFFECTED**

This MLN Matters® Special Edition Article is intended for providers and suppliers who submit claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries in the States of Alabama, Florida, Louisiana, and Mississippi, who were affected by Hurricane Nate.

**PROVIDER INFORMATION AVAILABLE**

Pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act, President Trump declared that, as a result of the effects of Hurricane Nate, an emergency exists in Alabama, Florida, Louisiana and Mississippi.

On October 8, 2017, Acting Secretary Wright of the Department of Health & Human Services declared that a public health emergency exists in the States of Louisiana retroactive to October 5, 2017; Mississippi, and Alabama retroactive to October 6, 2017; and Florida retroactive to October 7, 2017, and authorized waivers and modifications under §1135 of the Social Security Act.

The Public Health Emergency declaration and Social Security Act waivers including the Section 1135 waiver authority expired as follows:

- The authority expired on January 2, 2018, for Louisiana.
- The authority expired on January 3, 2018, for Alabama and Mississippi.
- The authority expired on January 4, 2018, for Florida.

On October 10, 2017, the Administrator of the Centers for Medicare & Medicaid Services (CMS) authorized waivers under §1812(f) of the Social Security Act for the States of Louisiana retroactive to October 5, 2017; Mississippi, and Alabama retroactive to October 6, 2017; and Florida retroactive to October 7, 2017 for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of Hurricane Nate in 2017. These waivers will prevent gaps in access to care for beneficiaries impacted by the emergency. Providers do not need to apply for an individual waiver if a blanket waiver has been issued. Providers can request an individual Section 1135 waiver, if there is no blanket waiver, by following the instructions available at https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Requesting-an-1135-Waiver-Updated-11-16-2016.pdf.

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

**BACKGROUND**

Section 1135 and Section 1812(f) Waivers

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

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

The most current information can be found at https://www.cms.gov/emergency posted in the downloads section at the bottom of the Emergency Response and Recovery webpage.

Also referenced below are Q&As that are applicable for items and services furnished to Medicare beneficiaries within the Alabama, Florida, Louisiana and Mississippi. These Q&As are displayed in two files:

- One file addresses policies and procedures that are applicable without any Section 1135 or other formal waiver. These policies are always applicable in any kind of emergency or disaster, including the current emergency in Alabama, Florida, Louisiana and Mississippi
- Another file addresses policies and procedures that are applicable only with approved Section 1135 waivers or, when applicable, approved Section 1812(f) waivers. These Q&As are applicable for approved Section 1135 blanket waivers and approved individual 1135 waivers requested by providers for Alabama, Florida, Louisiana and Mississippi.

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

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

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

Blanket Waivers for Alabama, Florida, Louisiana and Mississippi

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

Skilled Nursing Facilities

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

Home Health Agencies

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

Critical Access Hospitals

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

Housing Acute Care Patients in Excluded Distinct Part Units

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

Durable Medical Equipment

- As a result of Hurricane Nate, CMS has determined it is appropriate to issue a blanket waiver to suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) where DMEPOS is lost, destroyed, irreparably damaged, or otherwise rendered unusable. Under this waiver, the face-to-face requirement, a new physician's order, and new medical necessity documentation are not required for replacement. Suppliers must still include a narrative description on the claim explaining the reason why the equipment must be replaced and are reminded to maintain documentation indicating that the DMEPOS was lost, destroyed, irreparably damaged or otherwise rendered unusable as a result of the hurricane.
- As a result of Hurricane Nate, CMS is temporarily extending the 10 business day deadline to provide notification of any subcontracting arrangements. During the temporary extension period, affected contract suppliers will have 30 business days to provide notice to the Competitive Bidding Implementation Contractor of any subcontracting arrangements. CMS will notify DMEPOS Competitive Bidding contract suppliers via e-mail when this temporary extension expires. All other competitive bidding program requirements remain in force. Note: CMS will provide notice of any changes to reporting timeframes for future events.

For more information refer to the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies for Medicare Beneficiaries Impacted by an Emergency or Disaster fact sheet at https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Emergency-DME-Beneficiaries-Hurricanes.pdf.

Replacement Prescription Fills

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

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

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

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

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

These temporary emergency policies would apply to the timeframes specified in the waiver(s) issued under Section 1135 of the Act in connection with the effect of Hurricane Nate in Alabama, Florida, Louisiana and Mississippi. More information is available in the 1135 Waiver Letter, which is posted in the Downloads section at https://www.cms.gov/About-CMS/Agency-Information/Emergency/Hurricanes.html.

Requesting an 1135 Waiver

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

**ADDITIONAL INFORMATION**

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

**DOCUMENT HISTORY**

| Date of Change | Description |
|---|---|
| January 19, 2018 | The article was revised to include information on the expiration of the public health emergency declaration and Section 1135 waiver authority. |
| October 11, 2017 | Initial article released. |

# Medicare FFS Response to 2017 Southern California Wildfires

## MLN Matters Number: SE17037

## Article Revised Date: December 18, 2017

### PROVIDER TYPES AFFECTED

This MLN Matters® Special Edition Article is intended for providers and suppliers who submit claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries who were affected by the December 2017 wildfires in the State of California.

### PROVIDER INFORMATION AVAILABLE

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

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

On December 13, 2017, the Administrator of the Centers for Medicare & Medicaid Services (CMS) authorized waivers under §1812(f) of the Social Security Act for the State of California retroactive to December 4, 2017 for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of wildfires. Providers can request an individual Section 1135 waiver by following the instructions available at https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Requesting-an-1135-Waiver-Updated-11-16-2016.pdf.

### BACKGROUND

Section 1135 and Section 1812(f) Waivers

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

Change Request (CR) 6451 (Transmittal 1784, Publication 100-04) issued on July 31, 2009, applies to items and services furnished to Medicare beneficiaries within the State of California retroactive to December 4, 2017, for the duration of the emergency. In accordance with CR6451, use of the "DR" condition code and the "CR" modifier are mandatory on claims for items and services for which Medicare payment is conditioned on the presence of a "formal waiver" including, but not necessarily limited to, waivers granted under either Section 1135 or Section 1812(f) of the Act.

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

Also referenced below are Q&As that are applicable for items and services furnished to Medicare beneficiaries within the State of California. These Q&As are displayed in two files:

- One file addresses policies and procedures that are applicable without any Section 1135 or other formal waiver. These policies are always applicable in any kind of emergency or disaster, including the current emergency.
- Another file addresses policies and procedures that are applicable only with approved Section 1135 waivers or, when applicable, approved Section 1812(f) waivers. These Q&As are applicable for approved individual 1135 waivers requested by providers for California.

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

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

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

### Waiver for California

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

### Skilled Nursing Facilities

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

### Administrative Relief

Appeal Administrative Relief for Areas Affected by California Wildfires

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

Requesting an 1135 Waiver

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

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

### DOCUMENT HISTORY

| Date of Change | Description |
|---|---|
| December 18, 2017 | Initial article released |

## External Infusion Pump Drug Calculator - Now Available

Noridian is excited to announce the creation of a new calculator for the drugs used with External Infusion Pumps (EIP). Suppliers are encouraged to use this new calculator to assist in determining the specific Units of Service (UOS) to bill on their claims for the drugs used with the EIPs.

The calculator includes a drop-down option of applicable drugs that may be used with the EIPs and billed for reimbursement by Medicare. In addition to selecting the appropriate drug, suppliers enter the vial strength, vial size, and number of milliliters (mL) dispensed to the patient in the calculator, then press "calculate" and the results will yield the billable UOS for the claim in question.

Suppliers can find the new EIP drug calculator on the Noridian Medicare website on the External Infusion Pump page under "Browse by DMEPOS Category" or on the "Outreach & Education" page under Tools.

# Immunosuppressive Drugs Special Requirements

**MLN Matters Number: MM10370**
**Related Change Request (CR) Number: 10370**
**Related CR Release Date: December 8, 2017**
**Effective Date: August 1, 2016**
**Related CR Transmittal Number: R3932CP**
**Implementation Date: March 9, 2018**

### PROVIDER TYPE AFFECTED

This MLN Matters Article is intended for physicians, providers and suppliers billing Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for immunosuppressive drugs provided to Medicare beneficiaries.

### WHAT YOU NEED TO KNOW

The Centers for Medicare & Medicaid Services (CMS) is revising the Part B date of service requirements for the first immunosuppressive drug claim after the beneficiary is discharged from an inpatient stay as follows: in order to allow payment for a claim for an immunosuppressive drug that is mailed by a supplier either 1 or 2 days before a beneficiary is discharged from an inpatient facility, the supplier may enter the date of discharge as the date of service. The manual changes in CR10370 are effective as of August 1, 2016. Make sure your billing staffs are aware of the revision.

### BACKGROUND

Under Medicare Part B, the date of service on a supplier's immunosuppressive drug claim must be the date the supplier actually delivered or mailed the item. Thus, if a supplier mails a prescription shortly before the end of a beneficiary's inpatient stay and uses the mailing date as the date of service, the claim processing system will reject the supplier's claim because the claim's date of service precedes the beneficiary's date of discharge. As a result, beneficiaries whose immunosuppressive drug prescriptions are mailed on the day of discharge from an inpatient facility may be at risk for an interruption in their immunosuppressive drug therapy.

CMS is revising the date of service requirements for the first immunosuppressive drug claim after the beneficiary is discharged from an inpatient stay as follows: in order to allow payment for a claim for an immunosuppressive drug that is mailed by a supplier either 1 or 2 days before a beneficiary is discharged from an inpatient facility, the supplier may enter the date of discharge as the date of service.

The Manual update associated with CR10370 is based on the section titled Special Optional Requirements for Immunosuppressive Drugs in CR 2731, which was issued on June 27, 2003. CR 2731 is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1804B3.pdf. The manual changes in CR10370 are limited to the date of service requirement for immunosuppressive drugs paid under Medicare Part B and do not alter coverage provisions, claim submission, or delivery requirements for immunosuppressive drugs.

Inpatient facilities (for example hospitals) are responsible for providing drugs during a beneficiary's inpatient stay. However, once the beneficiary has returned home, Part B suppliers (including pharmacies) provide immunosuppressive drugs, and the DME MACs make payments for Part B covered immunosuppressive drugs.

Under normal circumstances, the date of service listed on a supplier's claim must be the date the supplier actually delivered or mailed the item. However, suppliers that utilize mail-order delivery may wish to mail immunosuppressive drug prescriptions 1 or 2 days prior to the date that a beneficiary will be discharged from an inpatient facility, so that the drugs will be available at the beneficiary's home immediately after the beneficiary returns. In this situation, the systems will reject the supplier's immunosuppressive drug claim because the date of service precedes the beneficiary's date of discharge; the hospital remains responsible for the provision of immunosuppressive drugs while the beneficiary is still an inpatient.

In order to obtain payment for immunosuppressive drug prescriptions that have been mailed 1 or 2 days before a beneficiary's discharge, the supplier may enter the date of discharge as the date of service on the first claim it submits for the beneficiary after the beneficiary is discharged from an inpatient facility.

Note that this is an optional, not mandatory, process. If the supplier chooses not to mail the immunosuppressive drug(s) prior to the beneficiary's date of discharge from the hospital, they may wait for the beneficiary to be discharged before delivering the drugs, and follow all applicable Medicare and DME MAC rules for immunosuppressive drug billing (for example, the date of service will be the date of delivery).

Note that the following conditions also apply:

- The facility remains responsible for all immunosuppressive drugs required by the beneficiary for the duration of the beneficiary's inpatient stay. The supplier must not receive separate payment for immunosuppressive drugs prior to the date the beneficiary is discharged.
- The supplier must not mail or otherwise dispense the drugs any earlier than 2 days before the beneficiary is discharged. It is the supplier's responsibility to confirm the beneficiary's discharge date if they choose to take advantage of this option.
- The supplier must not submit a claim for payment prior to the beneficiary's date of discharge.
- The beneficiary's discharge must be to a qualified place of service (for example, home, or custodial facility), but not to another facility (for example, inpatient hospital or skilled nursing facility) that does not qualify as the beneficiary's home.

### ADDITIONAL INFORMATION

The official instruction, CR10370, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3932CP.pdf.

### DOCUMENT HISTORY

| Date of Change | Description |
|---|---|
| December 8, 2017 | Initial article released |

## Dear Physician Letter - Negative Pressure Wound Therapy (NPWT) Pump - January 2018

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Dear Physician Letter – Negative Pressure Wound Therapy (NPWT) Pump – January 2018" is now available on our (Noridian) website.

View the complete Dear Physician Letter – Negative Pressure Wound Therapy (NPWT) Pump – January 2018 webpage.

## Dear Physician Letter - Positive Airway Pressure (PAP) Devices Replacement - January 2018

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Dear Physician Letter - Positive Airway Pressure (PAP) Devices Replacement - January 2018" is now available on our (Noridian) website.

View the complete Dear Physician Letter - Positive Airway Pressure (PAP) Devices Replacement - January 2018 webpage.

## Dear Physician Letter - Positive Airway Pressure (PAP) Devices - Revised January 2018

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Dear Physician Letter – Positive Airway Pressure (PAP) Devices – Revised January 2018" is now available on our (Noridian) website.

View the complete Dear Physician Letter – Positive Airway Pressure (PAP) Devices – Revised – January 2018 webpage.

## Billing Instruction - Oxygen CMN Question 5

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

View the complete Billing Instruction - Oxygen CMN Question 5 webpage.

## Correct Coding – Custom Fabricated Wheelchair Seat and Back Cushions

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Correct Coding - Custom Fabricated Wheelchair Seat and Back Cushions" is now available on our (Noridian) website.

View the complete Correct Coding – Custom Fabricated Wheelchair Seat and Back Cushions webpage.

## Correct Coding – Inserts Used with Therapeutic Shoes for Persons with Diabetes (A5512, A5513, K0903)

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Publication "Correct Coding – Inserts Used with Therapeutic Shoes for Persons with Diabetes (A5512, A5513, K0903)" is now available on our (Noridian) website.

View the complete Correct Coding – Inserts Used with Therapeutic Shoes for Persons with Diabetes (A5512, A5513, K0903) webpage.

## Correct Coding – Warranty, Reasonable Useful Lifetime (RUL), and the Minimum Lifetime Requirement (MLR) for Durable Medical Equipment

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Publication "Correct Coding – Warranty, Reasonable Useful Lifetime (RUL), and the Minimum Lifetime Requirement (MLR) for Durable Medical Equipment" is now available on our (Noridian) website.

View the complete Correct Coding – Warranty, Reasonable Useful Lifetime (RUL), and the Minimum Lifetime Requirement (MLR) for Durable Medical Equipment webpage.

## Dear Physician Letter – Completion of Certificates of Medical Necessity – Annual Reminder

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Publication "Dear Physician Letter – Completion of Certificates of Medical Necessity – Annual Reminder" is now available on our (Noridian) website.

View the complete Dear Physician Letter – Completion of Certificates of Medical Necessity – January 2018 webpage.

## Items Provided on a Recurring Basis and Request for Refill Requirements - Annual Reminder

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Publication "Items Provided on a Recurring Basis and Request for Refill Requirements - Annual Reminder" is now available on our (Noridian) website.

View the complete Items Provided on a Recurring Basis and Request for Refill Requirements - Annual Reminder webpage.

## LCD and Policy Article Revisions Summary for December 21, 2017

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "LCD and Policy Article Revisions Summary for December 21, 2017" is now available on our (Noridian) website.

View the complete LCD and Policy Article Revisions Summary for December 21, 2017 webpage.

## Policy Article Revision Summary for February 1, 2018

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Publication "Policy Article Revision Summary for February 1, 2018" is now available on our (Noridian) website.

View the complete Policy Article Revision Summary for February 1, 2018 webpage.

## ICD-10 and Other Coding Revisions to NCDs - Revised

MLN Matters Number: MM10318 Revised

Related Change Request (CR) Number: 10318

Related CR Release Date: January 18, 2018

Effective Date: April 1, 2018 - Unless otherwise noted in CR10318

Related CR Transmittal Number: R2005OTN

Implementation Date: January 29, 2018 for local MAC edits; April 2, 2018 - for shared system edits (except FISS for NCDs (see below) 1, 8, 12, 19, 21); July 2, 2018 - FISS only for NCDs 1, 8, 12, 19, 21

This article was revised on January 19, 2018, to reflect a revised CR10318 issued on January 18. In the article, the CR release date, MAC implementation date, transmittal number, and the Web address of the CR are revised. All other information remains the same.

**PROVIDER TYPES AFFECTED**

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

**PROVIDER ACTION NEEDED**

Change Request (CR) 10318 constitutes a maintenance update of the International Code 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/CR10318.zip.

**BACKGROUND**

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

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

NOTE: The translations from ICD-9 to ICD-10 are not consistent one-to-one matches, nor are all ICD-10 codes appearing in a complete General Equivalence Mappings (GEMs) mapping guide or other mapping guides appropriate when reviewed against individual NCD policies. In addition, for those policies that expressly allow MAC discretion, there may be changes to those NCDs based on current review of those NCDs against ICD-10 coding. For these reasons, there may be certain ICD-9 codes that were once considered appropriate prior to ICD-10 implementation that are no longer considered acceptable.

CR10318 makes coding and clarifying adjustments to the following NCDs: \

- NCD20.9 Artificial Hearts
- NCD20.9.1 Ventricular Assist Devices (VADs)
- NCD20.16 Cardiac Output Monitoring by Thoracic Electrical Bioimpedance (TEB)
- NCD20.29 Hyperbaric Oxygen (HBO) Therapy
- NCD20.30 Microvolt T-Wave Alternans (MTWA)
- NCD20.33 Transcatheter Mitral Valve Repair (TMVR)
- NCD40.1 Diabetes Self-Management Training (DSMT)
- NCD80.2, 80.2.1, 80.3, 80.3.1 Photodynamic Therapy, OPT, Photosensitive Drugs, Verteporfin
- NCD110.18 Aprepitant
- NCD110.21 Erythropoiesis Stimulating Agents (ESAs) in Cancer
- NCD110.23 Stem Cell Transplants
- NCD160.27 Transcutaneous Electrical Nerve Stimulation (TENS) for Chronic Low Back Pain (CLBP)
- NCD190.3 Cytogenetic Studies
- NCD190.11 Home Prothrombin Time/International Normalized Ratio (PT/INR) for Anticoagulation Management

- NCD220.4 Mammograms
- NCD220.6.17 Positron Emission Tomography (FDG) for Solid Tumors
- NCD260.1 Adult Liver Transplantation
- NCD220.13 Percutaneous Image-Guided Breast Biopsy
- NCD270.1 Electrical Stimulation/Electromagnetic Therapy (ES/ET) for Wounds
- NCD270.3 Blood-Derived Products for Chronic Non-Healing Wounds
- NCD80.11 Vitrectomy

When denying claims associated with the above NCDs, except where otherwise indicated, MACs will use.

- Remittance Advice Remark Codes (RARC) N386 with Claim Adjustment Reason Code (CARC) 50, 96, and/or 119.
- Group Code PR (Patient Responsibility) assigning financial responsibility to the beneficiary (if a claim is received with occurrence code 32, or with occurrence code 32 and a GA modifier, indicating a signed Advance Beneficiary Notice (ABN) is on file).
- Group Code CO (Contractual Obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).
- For modifier GZ, use CARC 50

**ADDITIONAL INFORMATION**

The official instruction, CR10318, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R2005OTN.pdf.

**DOCUMENT HISTORY**

| Date of Change | Description |
|---|---|
| January 19, 2018 | The article was revised due to a revised CR10318 issued on January 18. In the article, the CR release date, MAC implementation date, transmittal number, and the Web address of the CR are revised. All other information remains the same. |
| November 16, 2017 | Initial article released. |

# MLN Connects – December 7, 2017

MLN Connects® for Thursday, December 7, 2017

View this edition as a PDF

**News & Announcements**

- First Breakthrough-Designated Test to Detect Extensive Number of Cancer Biomarkers
- CMS Finalizes Comprehensive Care for Joint Replacement Model Changes, Cancels Episode Payment Models & Cardiac Rehabilitation Incentive Payment Model
- Updated Medicare Part D Opioid Drug Mapping Tool
- Quality and Cost Measures under Consideration: CMS Releases List for 2018 Pre-rulemaking
- Hospice Provider Preview Reports: Review by December 30
- Quality Payment Program Hardship Exception Application Deadline: December 31
- IRF and LTCH Provider Preview Reports: Review by January 3
- New PEPPER Available for Short-term Acute Care Hospitals
- Quality Payment Program Resources
- Extreme and Uncontrollable Circumstances Policy for MIPS Clinicians in 2017
- Targeted Probe and Educate Limits MAC Medical Record Reviews
- Medical Record Documentation: Helpful Clinical Templates and Data Elements
- Qualified Medicare Beneficiary: HETS and Remittance Advice
- National Influenza Vaccination Week: December 3 through 9
- National Handwashing Awareness Week: December 3 through 9

**Provider Compliance**

- Hospital Discharge Day Management Services CMS Provider Minute Video — Reminder

**Claims, Pricers & Codes**

- January 2018 Average Sales Price Files Available

**Upcoming Events**

- Medicare Diabetes Prevention Program Model Expansion Orientation Webinar — December 13
- National Partnership to Improve Dementia Care and QAPI Call — December 14
- Home Health QRP: Proposed Removal of Influenza Vaccination Measure from Home Health Quality of Patient Care Star Rating Webinar — December 14

**Medicare Learning Network Publications & Multimedia**

- DMEPOS Quality Standards Educational Tool – Revised
- Advance Beneficiary Notice of Noncoverage Interactive Tutorial Educational Tool — Revised
- Medicare Advance Written Notices of Noncoverage Booklet — Revised
- How to Use the Searchable Medicare Physician Fee Schedule Booklet — Revised
- Long-Term Care Hospital Prospective Payment System Booklet — Revised
- Power Mobility Devices Booklet — Revised

# MLN Connects – December 14, 2017

MLN Connects® for Thursday, December 14, 2017

View this edition as a PDF

**News & Announcements**

- New Medicare Card: Less Than Four Months until Transition Begins
- IRF and LTCH Compare Quarterly Refresh: New Measures Added
- Hospice Compare Quarterly Refresh
- MACRA Measure Development Plan Technical Expert Panel: Submit Nominations by December 20
- Medicare Advisory Panel on Clinical Diagnostic Laboratory Tests: Request for Nominations
- QRDA I Conformance Statement Resource
- Provider Enrollment Application Fee Amount for CY 2018

**Provider Compliance**

- Payment for Outpatient Services Provided to Beneficiaries Who Are Inpatients of Other Facilities
- Bill Correctly for Device Replacement Procedures

**Claims, Pricers & Codes**

- If You Submit Paper Claims: Avoid Crossover Issues

**Medicare Learning Network Publications & Multimedia**

- IRF Medical Review Changes MLN Matters Article — New
- IRF Reference Booklet — New
- Quality Payment Program Call: Audio Recording and Transcript — New
- Hurricane Irma and Medicare Disaster Related United States Virgin Islands, Commonwealth of Puerto Rico and State of Florida Claims MLN Matters Article — Updated
- Hurricane Irma and Medicare Disaster Related South Carolina and Georgia Claims MLN Matters Article — Updated
- December 2017 Catalog — Revised
- IRF Prospective Payment System Booklet — Revised
- DMEPOS Competitive Bidding Program Grandfathering Requirements for Non-Contract Suppliers Fact Sheet — Revised
- DMEPOS Competitive Bidding Program Traveling Beneficiary Fact Sheet — Revised
- Medical Privacy of Protected Health Information Fact Sheet — Reminder
- Behavioral Health Integration Services Fact Sheet — Reminder
- Medicare Basics: Commonly Used Acronyms Educational Tool — Reminder
- Evaluation and Management Services Web-Based Training Course — Reminder

## MLN Connects – December 21, 2017

MLN Connects® for Thursday, December 21, 2017

View this edition as a PDF

**News & Announcements**

- 2018 Medicare EHR Incentive Program Payment Adjustment for Eligible Clinicians
- Physician Compare: 2016 Performance Information Available

**Provider Compliance**

- Medicare Hospital Claims: Avoid Coding Errors — Reminder

**Upcoming Events**

- Low Volume Appeals Settlement Option Call — January 9

**Medicare Learning Network Publications & Multimedia**

- Medicare FFS Response to the 2017 Southern California Wildfires MLN Matters Article — New
- Medicare Diabetes Prevention Program Model Call: Audio Recording and Transcript — New
- Hospice Payment System Booklet — Revised
- Ambulance Fee Schedule Fact Sheet — Revised
- Medicare Overpayments Fact Sheet — Revised

## MLN Connects – January 4, 2018

MLN Connects® for Thursday, January 4, 2018

View this edition as a PDF

**News & Announcements**

- CMS Launches Data Submission System for Clinicians in the Quality Payment Program
- CMS Updates Website to Compare Hospital Quality
- Patients over Paperwork: Get Updates on Burden Reduction
- Quality Payment Program: Qualified Registries and QCDRs
- Quality Payment Program Resources
- EHR Incentive Program Hospitals: Use QNet to Attest
- Medicare Diabetes Prevention Program Resources
- Post-Acute Care Quality Reporting Program Section GG Web-based Training
- Hospice Compare Update
- Are You Prepared for a Health Care Emergency?
- Get Your Patients Off to a Healthy Start in 2018

**Provider Compliance**

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

**Upcoming Events**

- Low Volume Appeals Settlement Option Call — January 9
- ESRD QIP: Final Rule for CY 2018 Call — January 23
- Medicare Learning Network Publications & Multimedia
- Dementia Care Call: Audio Recording and Transcript — New
- Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians Booklet — Revised

## MLN Connects – January 11, 2018

MLN Connects® for Thursday, January 11, 2018

View this edition as a PDF

**News & Announcements**

- New Payment Model to Improve Quality, Coordination, and Cost-effectiveness for Both Inpatient and Outpatient Care
- SNF Quality Reporting Program Confidential Feedback Reports
- Hospital Quality Reporting: Updated CY 2018 QRDA I Schematron
- January is Cervical Health Awareness Month

**Provider Compliance**

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

**Upcoming Events**

- New Medicare Card Project Special Open Door Forum — January 23
- ESRD QIP: Final Rule for CY 2018 Call — January 23
- Medicare Learning Network Publications & Multimedia
- Major Joint Replacement (Hip or Knee) Booklet — New
- Medicare-Required SNF PPS Assessments Educational Tool — Revised

## MLN Connects – January 18, 2018

MLN Connects® for Thursday, January 18, 2018

View this edition as a PDF

**News & Announcements**

- 2018 Value Modifier Results and Payment Adjustment Factor
- Final DMEPOS Quality Standards for Therapeutic Shoe Inserts
- Glaucoma Awareness Month: Make a Resolution for Healthy Vision

**Provider Compliance**

- CMS Provider Minute Video: CT Scans — Reminder

**Upcoming Events**

- New Medicare Card Project Special Open Door Forum — January 23
- ESRD QIP: Final Rule for CY 2018 Call — January 23
- MIPS Annual Call for Measures and Activities Webinar — February 5
- Comparative Billing Report on Opioid Prescribers Webinar — February 21

**Medicare Learning Network Publications & Multimedia**

- QRUR Video Presentation — New
- Low Volume Appeals Settlement Call: Audio Recording and Transcript — New
- Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians Web-based Training — Revised
- How to Use the Medicare Coverage Database Booklet — Revised
- Behavioral Health Integration Services Fact Sheet — Revised

## MLN Connects Special Edition – January 22, 2018

**MAC Operations Continue During Shutdown**

During the time that the partial government shutdown is in effect, Medicare Administrative Contractors will continue to perform all functions related to Medicare fee-for-service claims processing and payment.

## MLN Connects – January 25, 2018

MLN Connects® for Thursday, January 25, 2018

View this edition as a PDF

**News & Announcements**

- VA, HHS Announce Partnership to Strengthen Prevention of Fraud, Waste and Abuse Efforts
- CMS Updates Open Payments Data
- Improved Open Payments Data Website
- IRF and LTCH Quality Reporting Programs: Submission Deadline February 15
- Panel on Development of Potentially Preventable Hospitalization Measures for HHAs: Nominations due February 22
- SNF Quality Reporting Program: Submission Deadline Extended to May 15
- Hospice Quality Reporting Program: Quality Measure User's Manual Version 2
- Continue Seasonal Influenza Vaccination through January and Beyond

**Provider Compliance**

- Reporting Changes in Ownership — Reminder

**Upcoming Events**

- Low Volume Appeals Settlement Option Call — February 13
- Home Health Review and Correct Reports Webinar — March 6

**Medicare Learning Network Publications & Multimedia**

- Low Volume Appeals Settlement Call: Video Presentation — New
- Hurricane Nate and Medicare Disaster Related Alabama, Florida, Louisiana and Mississippi Claims MLN Matters Article — Updated
- Swing Bed Services Fact Sheet — Revised

## MLN Connects Special Edition – January 26, 2018

**In this Edition:**

- Therapy Cap Claims Rolling Hold
- New Medicare Card: Web Updates
- New Medicare Card: When Will My Medicare Patients Receive Their Cards?

**Therapy Cap Claims Rolling Hold**

CMS is immediately releasing for processing held therapy claims with the KX modifier with dates of receipt beginning January 1-10; CMS will also implement a "rolling hold" to minimize impact if legislation to extend the outpatient therapy caps exceptions process is enacted.

**New Medicare Card: Web Updates**

To help you prepare for the transition to the Medicare Beneficiary Identifier (MBI) on Medicare cards beginning April 1, 2018, review the new information about remittance advices.

Beginning in October 2018, through the transition period, when providers submit a claim using a patient's valid and active Health Insurance Claim Number (HICN), CMS will return both the HICN and the MBI on every remittance advice. Here are examples of different remittance advices:

Medicare Remit Easy Print (Medicare Part B providers and suppliers)

PC Print for Institutions

Standard Paper Remits: FISS (Medicare Part A/Institutions), MCS (Medicare Part B/Professionals), VMS (Durable Medicare Equipment)

Find more new information on the New Medicare Card provider webpage.

**New Medicare Card: When Will My Medicare Patients Receive Their Cards?**

Starting April 2018, CMS will begin mailing new Medicare cards to all people with Medicare on a flow basis, based on geographic location and other factors. Learn more about the Mailing Strategy. Also starting April 2018, your patients will be able to check the status of card mailings in their area on Medicare.gov.

For More Information:

Mailing Strategy

Questions from Patients? Guidelines

New Medicare Card overview and provider webpages

## MLN Connects – February 1, 2018

MLN Connects® for Thursday, February 1, 2018

View this edition as a PDF

**News & Announcements**

- Medicare Diabetes Prevention Program: Supplier Enrollment Open
- Targeted Probe and Educate: New Resources
- MIPS Clinicians: 2017 Extreme and Uncontrollable Circumstances Policy
- Quality Payment Program: Patient-facing Encounters Resources
- Eligible Hospitals and CAHs: Get Help with Attestation on QNet
- Find Medicare FFS Payment Regulations
- February is American Heart Month

**Provider Compliance**

- Cochlear Devices Replaced Without Cost: Bill Correctly — Reminder

**Upcoming Events**

- eCQM Reporting for Hospital IQR-EHR Incentive Program Webinar — February 6
- Low Volume Appeals Settlement Option Call — February 13

**Medicare Learning Network Publications & Multimedia**

- Next Generation Accountable Care Organization - Implementation MLN Matters® Article — Revised
- DMEPOS Quality Standards Educational Tool — Revised
- Home Oxygen Therapy Booklet — Revised
- Looking for Educational Materials?

## MLN Connects – February 8, 2018

MLN Connects® for Thursday, February 8, 2018

View this edition as a PDF

**News & Announcements**

- Patients over Paperwork: January Newsletter
- Open Payments Registration
- MIPS: Call for Advancing Care Information Measures and Improvement Activities
- Quality Payment Program: Advanced APM Table
- Hospice Quality Reporting Program Resources
- LTCH Quality Reporting Program: Materials from December Training
- SNF QRP Quality Measure and Review and Correct Report: Calculation Error
- Home Health Review and Correct Report: Correction
- Influenza Activity Continues: Are Your Patients Protected?

**Provider Compliance**

- Medicare Hospital Claims: Avoid Coding Errors — Reminder

**Upcoming Events**

- Low Volume Appeals Settlement Option Call — February 13
- What's New with Physician Compare Webinar — February 21 or 22
- Comparative Billing Report on Opioid Prescribers Webinar — February 21 or March 7
- ESRD QIP: Final Rule for CY 2018 Call — February 22

**Medicare Learning Network Publications & Multimedia**

- E/M Service Documentation Provided by Students MLN Matters Article — New
- Medicare Enrollment Resources Educational Tool — Revised
- Medicare Part B Immunization Billing Educational Tool — Reminder

## MLN Connects – February 15, 2018

MLN Connects® for Thursday, February 15, 2018

View this edition as a PDF

**News & Announcements**

- MIPS Reporting Deadlines Fast Approaching: 10 Things to Do and Know
- Quality Payment Program: Performance Scores for 2017 Claims Data
- Diabetic Self-Management Training Accreditation Program: New Webpage and Helpdesk
- Measures of Hospital Harm: Comment by February 16
- EHR Incentive Program: Accepting Proposals for New Measures by June 29
- New Option for Submission of Medicare Cost Reports

**Provider Compliance**

- Home Health Care: Proper Certification Required — Reminder

**Claims, Pricers & Codes**

- January 2018 OPPS Pricer File

**Upcoming Events**

- Improving Accessibility of Provider Settings Webinar — February 21
- ESRD QIP: Final Rule for CY 2018 Call — February 22
- 2018 QCDR Measures Workgroup Webinar — February 27
- Serving Adults with Disabilities on the Autism Spectrum Webinar — February 28
- MIPS Quality Data Submission Webinar — February 28
- Palliative and Hospice Care for Adults with Disabilities Webinar — March 7
- Low Volume Appeals Settlement Option Update Call — March 13
- Open Payments: The Program and Your Role Call — March 14
- MIPS Attestation for Advancing Care Information and Improvement Activities Webinar — March 14

**Medicare Learning Network Publications & Multimedia**

- Medicare Enrollment Resources Educational Tool — Revised
- PECOS FAQs Booklet — Revised
- PECOS for DMEPOS Suppliers Booklet — Revised
- Safeguard Your Identity and Privacy Using PECOS Booklet —Revised
- PECOS for Provider and Supplier Organizations Booklet — Revised
- PECOS Technical Assistance Contact Information Fact Sheet — Revised
- Health Professional Shortage Area Physician Bonus Program Fact Sheet — Revised
- Medicare Secondary Payer Booklet – Reminder
- Beneficiaries in Custody under a Penal Authority Fact Sheet — Reminder

## MLN Connects – February 22, 2018

MLN Connects® for Thursday, February 22, 2018

View this edition as a PDF

**News & Announcements**

- Low Volume Appeals Settlement Process

**Provider Compliance**

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

**Upcoming Events**

- Low Volume Appeals Settlement Option Update Call — March 13
- Open Payments: The Program and Your Role Call — March 14
- Dementia Care: Person-Centered Care Planning and Practice Recommendations Call — March 20
- CMS National Provider Enrollment Conference — April 24 and 25

**Medicare Learning Network Publications & Multimedia**

- CMS Provider Minute Video: Utilizing Your MAC to Prepare for CERT Review — New
- Low Volume Appeals Settlement Call: Audio Recording and Transcript — New
- Provider Compliance Tips for Hospital Beds and Accessories Fact Sheet — New
- Provider Compliance Tips for Infusion Pumps and Related Drugs Fact Sheet — New

- Provider Compliance Tips for Nebulizers and Related Drugs Fact Sheet — New
- Provider Compliance Tips for Laboratory Tests – Blood Counts Fact Sheet — New
- Provider Compliance Tips for Diabetic Test Strips Fact Sheet — Revised
- Overview of the Repetitive Scheduled Non-emergent Ambulance Prior Authorization Model MLN Matters Article — Revised
- Telehealth Services Booklet — Revised
- Medicare Enrollment for Institutional Providers Booklet — Revised
- PECOS for Physicians and NPPs Booklet — Revised
- DMEPOS Information for Pharmacies Fact Sheet — Reminder
- DMEPOS Accreditation Fact Sheet — Reminder
- Mass Immunizers and Roster Billing Booklet — Reminder

## MLN Connects Special Edition – February 28, 2018

**Medicare Expired Legislative Provisions Extended and Other Bipartisan Budget Act of 2018 Provisions**

On February 9, 2018, President Trump signed into law the Bipartisan Budget Act of 2018. This new law includes several provisions related to Medicare payment.

With regard to payment for outpatient therapy services, the law repeals application of the Medicare outpatient therapy caps but retains the former cap amounts as a threshold above which claims must include the KX modifier as a confirmation that services are medically necessary as justified by appropriate documentation in the medical record; and retains the targeted medical review process, but at a lower threshold amount. It also extends several recently expired Medicare legislative provisions affecting health care providers and beneficiaries, including the Medicare physician fee schedule work geographic adjustment floor, add-on payments for ambulance services and home health rural services, changes to the payment adjustment for low volume hospitals, and the Medicare dependent hospital program.

In addition, with regard to Section 53111 – Medicare Payment Update for Skilled Nursing Facilities, the Centers for Medicare & Medicaid Services has received questions from stakeholders about the impact of the FY 2019 Skilled Nursing Facility (SNF) update due to section 53111 of the BBA of 2018. To help answer these questions, we are providing information about the estimated market basket update for FY 2019 based on currently available data. This estimate may be updated in the Notice of Proposed Rulemaking for the FY 2019 SNF Prospective Payment System (PPS).

Read the full summary.

## Nebulizer Drug Calculator - Now Available

Noridian has added a new online calculator for Nebulizer drugs. The calculator has the ability to display the maximum number of units that can be billed in a 31 or 90 day period by inputting the strength of the drug, the size of the vial dispensed (if applicable) and the frequency the medication is taken.

The Nebulizer drug calculators are available for the following medications: Acetylcysteine, Albuterol, Arformoterol, Budesonide, Cromolyn Sodium, Dornase Alpha, DuoNeb, Formoterol, Ipratropium Bromide, Levalbuterol, and Metaproterenol.

Suppliers can find the new Nebulizer drug calculator on the Noridian Medicare website on the Nebulizers page under "Browse by DMEPOS Category" or on the "Outreach & Education" page under Tools.

## Now Available on NMP - Same and Similar Range Search for A, L and V Codes!

**You Spoke, We Listened!**

Noridian is pleased to announce that the Noridian Medicare Portal (NMP) enhancement to allow a same and similar search for the A, L, or V code ranges is live! Noridian listened to the supplier community through direct interactions and your feedback and have worked hard to enhance NMP with this added functionality.

This enhancement means that you will no longer have to speak to a Customer Service Representatives (CSRs) to obtain same and similar range information for these codes.

When selecting to use Option 2 in the Same and Similar function, suppliers will enter a code range with the same prefix. The supplier will then receive the most recently paid HCPCS code per side (if applicable) for each code the patient has received in that range.

Jurisdiction D suppliers will have access to data 5 years from the current date.

**Not a registered NMP user?**

Visit our the NMP page of the Noridian website to get all the information you need to register for NMP and the User Manual that explains all the information and functions that NMP provides.

## Self Service Reopenings Available on NMP

Noridian encourages suppliers to use the Self Service Reopening function on the Noridian Medicare Portal (NMP) to initiate a reopening. Take advantage of this self-service tool to eliminate time-consuming faxing, hardcopy mailing, or calling into the Contact Center. These adjustments are made in a real-time and a confirmation number is provided.

Reopening adjustments available on NMP:

- Billed Amount
- Modifier
- Date of Service (excludes change of year)
- Place of Service (only to POS 12)
- Reprocessing
- Diagnosis Code
- Procedure Code and Billed Amount
- Procedure Code, Modifier and Billed Amount
- Units and Billed Amount
- Units, Modifier and Billed Amount

Visit the Noridian Medicare Portal page today to learn more and for information on how to register if your facility is not yet enrolled. Share this notice with the company official so the organization can learn about all the benefits of joining.

## Orthotics and Prosthetics Split Out in Browse by DMEPOS Categories

In an effort to improve navigation of the Noridian website, we have created separate Orthotics and Prosthetics pages within the Browse by DMEPOS Category. Each page will offer topic specific information to help suppliers find the resources needed. Be sure to update any bookmarks to these pages.

The Orthotics page will provide information on:

- AFO/KAFO
- Knee Orthotics
- Spinal Orthotics

The Prosthetics page will provide information on:

- External Breast Prosthesis
- Eye Prosthesis
- Facial Prosthesis
- Lower Limb Prosthesis

## Physicians! Are You Ordering External Breast Prostheses and Supplies for Your Patient?

Following this guidance will help your patients and the Medicare program by verifying there is medical documentation to support the provision of external breast prostheses and supplies.

Medicare coverage requires the patient's medical record to show a past mastectomy and a valid and complete order. Coverage includes supplies both at the time of the mastectomy and after.

The DMEPOS supplier must have a verbal/dispensing/preliminary order prior to providing the prostheses and /or supplies. The supplier cannot submit a claim for reimbursement until you supply a detailed written order. The detailed written order must contain the elements in the chart below. Help your patient by providing this timely.

There must also be information in the patient's medical record that justifies continued medical need and it must be made available to the supplier or review contractor upon request.

The following may serve as documentation justifying continued medical need for the External Breast Prostheses and supplies:

- A recent order by the treating physician for refills
    - Does not have to be the surgeon
    - Current treatment not necessarily related to the mastectomy, however addressing on-going care
- A recent change in prescription
- Timely documentation in beneficiary's medical record showing usage of item(s)
    - Defined as a record entered in preceding 12 months
    - Must indicate mastectomy or absence of breast
    - In absence of evidence of reconstruction, original mastectomy surgery documentation is sufficient to verify mastectomy

| DWO elements prior to billing | For periodic items (i.e., bras) DWO must also include: |
|---|---|
| Beneficiary's name | Item(s) to be dispensed |
| Prescribing practitioner's name | Frequency (how often are bras to be dispensed) |
| Date of the order | Quantity to be dispensed (number of bras) |
| Detailed description of the item(s) | Number of refills |
| Prescribing practitioner's signature and signature date | |

For coverage and limitations of these supplies review Local Coverage Determination (LCD) L33317 ad Policy Article A52478.

LCD for External Breast Prostheses can be located at the following:

Jurisdiction A - CT, DE, MA, ME, MD, NH, NJ, NY, PA, RI, VT, Washington D.C.

Jurisdiction B - Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio, Wisconsin

Jurisdiction C - Alabama, Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas, Virgin Islands, Virginia, West Virginia

Jurisdiction D - Am. Samoa, Guam, N. Mariana Is., AK, AZ, CA, HI, ID, IA, KS, MO, MT, NE, NV, ND, OR, SD, UT, WA, WY

## Oxygen Q Modifier CR 9848 Chart – Now Available

A reference chart has been added the Oxygen page of the Noridian Medicare website. This chart will assist suppliers when billing oxygen and a Q modifier is required. The chart will identify the codes, modifiers, liters per minute and the fee schedule for high liter flow.

View the Oxygen Q Modifier CR 9848 Chart on the Oxygen page for more information.

## Top Reasons for Denial for Oxygen and Oxygen Equipment Quarterly Results for Redeterminations

The Jurisdiction D, Redetermination department, completed a review of the top appealed claims for the last quarter of 2017. The top appealed policy was Oxygen and Oxygen Equipment at an appeal rate of 20.58%.

The E1390 (Oxygen Concentrator) was the top procedure code an appeal rate of 40.51%.

**Top Initial Denial Reasons**

Missing Initial Certificate of Medical Necessity (CMN)

Missing Recertification CMN

Documentation does not support coverage criteria as it is either missing or inadequate to support the medical necessity criteria of the Local Coverage Determination (LCD)

**Educational Tools and Resources for Success**

Utilize the CMN Rejection Report from your billing software company to identify claims missing CMN's.

Resubmit the claim with CMN attached; or,

Submit the CMN to Written Reopenings requesting that the CMN be loaded and denied dates of service paid

Have a consistent and thorough intake process that includes checking for same/similar equipment or supplies in the Noridian Medicare Portal (NMP)

Obtain medical records prior to dispensing to ensure the documentation exists and the beneficiary qualifies for the item(s)

Utilize the "Dear Physician" letters and other educational tools available from Noridian to educate physicians about the Medicare documentation requirements

Utilize "Documentation Checklists" to ensure complete appeal request to meet policy requirements

For complete policy details, see Oxygen and Oxygen Equipment.

# Oxygen Flow Rate Revised and New Modifiers

**MLN Matters Number: MM10158**
**Related Change Request (CR) Number: 10158**
**Related CR Release Date: October 27, 2017**
**Effective Date: April 1, 2018**
**Related CR Transmittal Number: R3895CP**
**Implementation Date: April 2, 2018**

## PROVIDER TYPES AFFECTED

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

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

## PROVIDER ACTION NEEDED

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

## BACKGROUND

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

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

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

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

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

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

- If the prescribed amount of oxygen is less than 1 LPM, suppliers use the modifier "QE"; Home Health Agencies (HHAs) use revenue code 0602. The monthly payment amount for stationary oxygen is reduced by 50 percent.
- If the prescribed amount of oxygen is greater than 4 LPM, suppliers use the modifier "QG"; HHAs use revenue code 0603. The monthly payment amount for stationary oxygen is increased by 50 percent.
- If the prescribed amount of oxygen exceeds 4LPM and portable oxygen is prescribed, suppliers use the modifier "QF", HHAs use revenue code 0604. The monthly payment for stationary oxygen is increased

by the higher of 50 percent of the monthly stationary oxygen payment amount, or the fee schedule amount for the portable oxygen add-on. (A separate monthly payment is not allowed for the portable equipment if the stationary oxygen fee schedule amount is increased by 50 percent.) Effective April 1, 2017, the modifier "QF" must be used with both the stationary and portable oxygen equipment codes.

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

**KEY POINTS**

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

1. QA - Prescribed amounts of stationary oxygen for daytime use while at rest and nighttime use differ and the average of the two amounts is less than 1 liter per minute (LPM)

2. QB - Prescribed amounts of stationary oxygen for daytime used while at rest and nighttime use differ and the average of the two amounts exceeds 4 liters per minute (LPM) and portable oxygen is prescribed

3. QR - Prescribed amounts of stationary oxygen for daytime use while at rest and nighttime use differ and the average of the two amounts is greater than 4 liters per minute (LPM)

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

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

1. QE - Prescribed amount of stationary oxygen while at rest is less than 1 liter per minute (LPM)

2. QF - Prescribed amount of stationary oxygen while at rest exceeds 4 liters per minute (LPM) and portable oxygen is prescribed

3. QG - Prescribed amount of stationary oxygen while at rest is greater than 4 liters per minute (LPM)

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

- If the prescribed amount of oxygen is less than 1 LPM, suppliers use either of the following modifiers with the stationary oxygen HCPCS code:
  - The modifier "QE"; HHAs use revenue code 0602. The monthly payment amount for stationary oxygen is reduced by 50 percent.
  - The modifier "QA"; the monthly payment amount for stationary oxygen is reduced by 50 percent. This modifier is used when the prescribed flow rate is different for nighttime use and daytime use and the average of the two flow rates is used in determining the volume adjustment.
- If the prescribed amount of oxygen is greater than 4 LPM, suppliers use either of the following modifiers with the stationary oxygen HCPCS code:
  - The modifier "QG"; HHAs use revenue code 0603. The monthly payment amount for stationary oxygen is increased by 50 percent.
  - The modifier "QR"; HHAs use revenue code 0603. The monthly payment amount for stationary oxygen is increased by 50 percent.
- If the prescribed amount of oxygen is greater than 4 LPM and portable oxygen is prescribed, suppliers use either of the following modifiers with both the stationary and portable oxygen HCPCS code:
  - The modifier "QF"; HHAs use revenue code 0604. If the prescribed flow rate differs between stationary and portable oxygen equipment, the flow rate for the stationary equipment is used. The

monthly payment for stationary oxygen is increased by the higher of 50 percent of the monthly stationary oxygen payment amount, or the fee schedule amount for the portable oxygen add-on. A separate monthly payment is not allowed for the portable equipment if the stationary oxygen fee schedule amount is increased by 50 percent. Effective April 1, 2017, the modifier "QF" must be used with both the stationary and portable oxygen equipment codes.

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

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

1. 50 percent of the monthly stationary oxygen payment amount (codes E0424, E0439, E1390 or E1391); or

2. The fee schedule amount for the portable oxygen add-on (codes E0431, E0433, E0434, E1392 or K0738).

### ADDITIONAL INFORMATION

The official instruction, CR10158, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R3895CP.pdf.

### DOCUMENT HISTORY

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

## HBO Therapy – Section C, Topical Application of Oxygen

**MLN Matters Number: MM10220**
**Related Change Request (CR) Number: 10220**
**Related CR Release Date: November 17, 2017**
**Effective Date: April 3, 2017**
**Related CR Transmittal Number: R3921CP and R203NCD**
**Implementation Date: December 18, 2017**

### PROVIDER TYPES AFFECTED

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

### WHAT YOU NEED TO KNOW

Change Request (CR) 10220 informs MACs that, effective April 3, 2017, coverage of topical oxygen for the treatment of chronic wounds will be determined by the MACs. Make sure your billing staffs are aware of this change.

### BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) received a reconsideration request to remove the coverage exclusion of Continuous Diffusion of Oxygen Therapy (CDO) from the "Medicare National Coverage Determinations (NCD) Manual" (Pub. 100-03, Ch.1, Part 1, 20.29, Hyperbaric Oxygen (HBO) Therapy, Section C). This section of the NCD (Topical Application of Oxygen) considers treatment known

as CDO as the application of topical oxygen and nationally non-covers this treatment. CMS asserts that the topical application of oxygen does not meet the definition of HBO therapy as stated in NCD 20.29.

Effective April 3, 2017, CMS decided that no NCD is appropriate at this time concerning the use of topical oxygen for the treatment of chronic wounds. As a result, CMS will amend NCD 20.29 by removing Section C, Topical Application of Oxygen. Medicare coverage of topical oxygen for the treatment of chronic wounds will be determined by your MAC.

NOTE: Although a MAC has discretion to cover topical oxygen for the treatment of chronic wounds, there shall be no coverage for any separate or additional payment for any physician's professional services related to this procedure.

**ADDITIONAL INFORMATION**

The official instruction, CR10220, consists of two transmittals. The first updates the "Medicare Claims Processing Manual" and is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3921CP.pdf. The second updates the "National Coverage Determinations Manual" and it is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R203NCD.pdf.

**DOCUMENT HISTORY**

| Date of Change | Description |
|---|---|
| November 22, 2017 | Initial article released. |

## Criterion C - Coverage Requirements for Power Mobility Devices - Revised

Insufficient documentation to support the beneficiary meets the medical necessity of Criterion C is the most common reason for denial, or non-affirmation, of Prior Authorization (PA) reviews and medical record reviews for Power Mobility Devices (PMD). This article intends to clarify the requirements as defined by the Local Coverage Determination (LCD) for PMD (L33789).

The PMD LCD defines Criterion C as:

The beneficiary does not have sufficient upper extremity function to self-propel an optimally-configured manual wheelchair (MWC) in the home to perform Mobility Related Activities of Daily Living (MRADL) during a typical day.

- Limitations of strength, endurance, range of motion (ROM), or coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function.
- An optimally-configured MWC is one with an appropriate wheelbase, device weight, seating options, and other appropriate nonpowered accessories.

The evaluation should be tailored to the individual beneficiary's condition(s). The history should paint a picture of the beneficiary's functional abilities and limitations on a typical day and contain as much objective data as possible. The physical examination should be focused on the body systems that are responsible for the beneficiary's MRADL limitations.

Examples of documentation that may support Criterion C:

- Objective or quantifying information of upper extremity strength, endurance, ROM, pain and/or coordination issues that inhibit the ability to self-propel an optimally-configured MWC.
- Objective information regarding the location, severity, contributing factors and alleviating factors as it relates to propelling an optimally configured MWC, if pain is a contributing factor.
- Objective, quantified endurance related information and how endurance is contributing to the inability to propel an optimally configured MWC, if endurance is a contributing factor (i.e. cardiac issues).
- Objective, quantified respiratory related information and how respiratory status is contributing to the inability to propel an optimally configured MWC, if respiratory issues are a contributing factor.
    - If oxygen is used, include a description of the frequency, use and specific quantifying information about limitations.

## 7-Element Order Face-to-Face Examination Date - Revised

An invalid face-to-face examination completion date provided on the 7-Element Order is one of the most common reasons for denial, or non-affirmation, of Prior Authorization (PA) reviews and medical record reviews for Power Mobility Devices (PMD). This article intends to clarify the requirements as defined by the Local Coverage Determination (LCD) and Policy Article for PMD (L33789).

**What date should be reported on the PMD 7-element order for the face-to-face (F2F) examination completion?**

The PMD F2F examination has two components. These components are:

Decision component – An in-person visit between the beneficiary and the ordering physician/practitioner to document the decision to order a PMD; and,

Medical evaluation component – A medical examination to document the beneficiary's mobility limitations and functional condition.

Both components are required and must be documented in the prescribing physician/practitioner's medical records.

Several possible scenarios can affect the determination of the correct completion of the F2F examination.

**F2F Scenarios**

Physician/practitioner only involvement

The ordering physician/practitioner completes the entire F2F examination (both #1 & #2 above) during the initial, in-person encounter with the beneficiary. If this is the case, the date of the F2F examination is the date of that in-person encounter.

The ordering physician/practitioner has an initial in-person encounter with the beneficiary (#1 above) but does not complete the medical evaluation component (#2 above) of the F2F examination at this initial visit. At a subsequent visit with the ordering physician/practitioner, the medical evaluation component is completed. In this situation, the date of the F2F examination is the date of the subsequent in-person encounter when the medical evaluation is completed.

Licensed/certified medical professional (LCMP) included in evaluation

The ordering physician/practitioner completes the decision component (#1 above) of the F2F examination at the initial in-person encounter with the beneficiary. The beneficiary is referred to another licensed/certified medical professional (LCMP), such as an Occupational Therapist (OT) or Physical Therapist (PT), who has experience and training in mobility evaluations to perform all or a portion of the medical evaluation component (#2 above) of the F2F examination. The physician/practitioner must indicate concurrence or any disagreement with the information in the written evaluation, sign and date the document. The F2F date listed on the 7-element order is the date the physician/practitioner signed, dated and indicated concurrence or disagreement with the LCMP evaluation.

The ordering physician/practitioner refers the beneficiary to an LCMP prior to the in-person encounter (#1 above) with the beneficiary. Once the physician/practitioner has received and reviewed (stated concurrence, signed, and dated) the written report of the LCMP medical examination (#2 above), the physician/practitioner must see the beneficiary and complete the decision component (#1 above). In this scenario, the date of the F2F examination reported on the 7-element order would be the date of the in-person encounter between the physician/practitioner and beneficiary.

The F2F examination is performed and completed during an inpatient hospital or nursing home stay, the date of the F2F examination reported on the 7-element order is either: 1) the date that both components 1 and 2 above are completed; or, 2) the date of discharge.

Amendment or correction scenarios

The F2F examination has been completed, but the physician/practitioner later identifies that there is information not properly documented in the medical record about the beneficiary which is necessary to support coverage criteria for a PMD. If the physician/practitioner provides an amendment, correction or addenda to the F2F examination with information that arose from the previously performed F2F evaluation (both #1 & #2 above), the F2F examination date does not change on the 7-element order. The amendment, correction or addenda to the F2F evaluation should appear in the beneficiary's medical record.

The F2F examination has been completed, but the physician/practitioner later identifies that there is information that was not addressed during the F2F examination (both #1 & #2 above) which is necessary to support coverage criteria for a PMD. The physician/practitioner must provide this new information in the medical record but since this was not a part of the original F2F, this does require a new in-person visit for the patient with the physician/practitioner. This new F2F visit date becomes the F2F date on the 7-element order.

If the date of the F2F examination is entered incorrectly or if any other information on the 7-element order must be corrected, it is recommended the supplier request that the physician/practitioner who completed the original 7-element order complete a new 7-element order. However, if a new 7-element order cannot be obtained, a corrected 7-element order is acceptable only when properly corrected/amended by the physician/practitioner who originally signed it.

**Additional Resources**

CMS Medicare Program Integrity Manual 100-08, chapter 3, section 3.3.2.3 for information on amendments, corrections and delayed entries in medical documentation.

Information on how to change a 7-element order can be found in the Noridian article, Changing a 7-Element-Order for a Power Mobility Device.

PMD coverage and documentation requirements in the PMD Local Coverage Determination (LCD) and Policy Article L33789/A52498.

# SPR Suppression in 45 Days if Also Receiving ERA – Revised

**MLN Matters Number: MM10151 Revised**
**Related Change Request (CR) Number: 10151**
**Related CR Release Date: December 28, 2017**
**Effective Date: January 1, 2018**
**Related CR Transmittal: R1994OTN**
**Implementation Date: January 2, 2018**

This article was revised on December 29, 2017, to reflect the revised CR10151 issued on December 28, 2017. In the article, the CR release date, transmittal number, and the Web address for accessing the CR are revised. All other information remains the same.

### PROVIDER TYPES AFFECTED

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

### PROVIDER ACTION NEEDED

Change Request (CR) 10151 provides notice that beginning January 2, 2018, Medicare's Shared System Maintainers (SSMs) must eliminate issuance of Standard Paper Remittance Advice (SPRs) to those providers/suppliers (or a billing agent, clearinghouse, or other entity representing those providers/suppliers) who also have been receiving Electronic Remittance Advice (ERA) transactions for 45 days or more. The shared system changes to suppress the distribution of SPRs were implemented in January 2006 per CR3991 (issued August 12, 2005, Transmittal 645). Make sure your billing staffs are aware of the suppression of the SPR.

### BACKGROUND

The SPR is the hard copy version of an ERA. MACs, including Durable Medical Equipment (DME) MACs must be capable of producing SPRs for providers/suppliers who are unable or choose not to receive an ERA. The MACs and the DME MACs suppress distribution of SPRs if an Electronic Data Interchange (EDI) enrolled provider/supplier is also receiving ERAs for more than 31 days for Institutional Health Care Claims (837I) and 45 days for DME and Professional Health Care Claims (837P). Internet-Only-Manuals (IOMs), MLN Matters Article MM4376 provided information to the MACs regarding the receipt of SPR and ERA distribution time lines.

Beginning February 14, 2018, the SSMs shall suppress the delivery of SPR to the MACs EDI enrolled providers/suppliers who are also receiving both the ERA and SPR. In rare situations (such as natural or man-made disasters) exceptions to this policy may be allowed at the discretion of the Centers for Medicare & Medicaid Services (CMS). MACs will not send a SPR/hard copy version to a particular provider/supplier unless this requirement causes hardship and CMS has approved a waiver requested by your MAC.

Note: MM4376 is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM4376.pdf.

### ADDITIONAL INFORMATION

The official instruction, CR10151, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1994OTN.pdf.

### DOCUMENT HISTORY

| Date of Change | Description |
|---|---|
| December 29, 2017 | This article was revised to reflect the revised CR10151 issued on December 28, 2017. In the article, the CR release date, transmittal number, and the Web address for accessing the CR are revised. All other information remains the same. |

| | |
|---|---|
| December 22, 2017 | This article was revised to reflect the revised CR10151 issued on December 21, 2017. In the article, the CR release date, transmittal number, and the Web address for accessing the CR are revised. All other information remains the same. |
| August 7, 2017 | Initial article released. |

## Automating First Claim Review in Serial Claims for DMEPOS

**MLN Matters Number: MM10426**
**Related Change Request (CR) Number: 10426**
**Related CR Release Date: February 2, 2018**
**Effective Date: July 2, 2018**
**Related CR Transmittal Number: R2029OTN**
**Implementation Date: January 7, 2019**

### PROVIDER TYPE AFFECTED

This MLN Matters® Article is intended for providers and suppliers who submit claims to DME Medicare Administrative Contractors (MACs) for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) services provided to Medicare beneficiaries.

### WHAT YOU NEED TO KNOW

Change Request (CR) 10426 alerts providers of a system solution initiative intended to reduce provider burden, MAC burden and appeals by increasing the consistency of medical review decisions when the same item/supply is provided to the same beneficiary on a recurring basis.

The Centers for Medicare & Medicaid Services (CMS) considers serial claims to be claims that are so closely related to one another that the same payment decision should be applied to each claim. In general, serial claims are for the same Healthcare Common Procedure Coding System (HCPCS) code and same beneficiary.

CMS plans to implement a system that will enable the DME MACs to perform a pre-payment complex medical review on a claim line and then, based on the results of the complex medical review:

- Pay subsequent claims in the series after passing existing validation edits, OR
- Deny subsequent claims in the series unless the provider submits additional documentation with the subsequent claim line.

Providers and suppliers should be aware that if a serial claim is denied after a complex medical review, subsequent claims in the series will be denied unless additional documentation is submitted to demonstrate that the services are reasonable and medically necessary. The process used to submit additional documentation will depend on how the claim is submitted:

- If a paper claim is submitted, any additional documentation must be attached to the claim form.
- If an electronic claim is submitted, the existing PWK process must be followed and the claim must also include the word "serial" in the NTE segment. (Refer to MLN article MM7041 for the existing PWK process.)

Make sure your billing staff is aware of these changes.

### ADDITIONAL INFORMATION

The official instruction, CR10426, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and- Guidance/Guidance/Transmittals/2018Downloads/R2029OTN.pdf. There is an Excel® spreadsheet attached to CR10426 containing the HCPCS codes and related serial certification period covered by CR10426.

### DOCUMENT HISTORY

| Date of Change | Description |
|---|---|
| February 2, 2018 | Initial article released. |

## RARC, CARC, MREP and PC Print Update

**MLN Matters Number: MM10489**
**Related Change Request (CR) Number: 10489**
**Related CR Release Date: February 16, 2018**
**Effective Date: July 1, 2018**
**Related CR Transmittal Number: R3980CP**
**Implementation Date: July 2, 2018**

### PROVIDER TYPES AFFECTED

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

### WHAT YOU NEED TO KNOW

Change Request (CR) 10489 updates the Remittance Advice Remark Codes (RARC) and Claims Adjustment Reason Code (CARC) lists and instructs Medicare Shared System Maintainers (SSMs) to update Medicare Remit Easy Print (MREP) and PC Print. Be sure your staff are aware of these changes and obtain the updated MREP and PC Print software if they use that software.

#### Background

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

The Centers for Medicare & Medicaid Services (CMS) instructs MACs to conduct updates based on the code update schedule that results in publication three times per year – around March 1, July 1, and November 1. This Recurring Update Notification applies to Chapter 22, Sections 40.5, 60.1, and 60.2 of the "Medicare Claims Processing Manual."

The Shared System Maintainers (SSMs) have the responsibility to implement code deactivation, making sure that any deactivated code is not used in original business messages and allowing the deactivated code in derivative messages. SSMs must make sure that Medicare does not report any deactivated code on or after the effective date for deactivation as posted on the Washington Publishing Company (WPC) website. If any new or modified code has an effective date past the implementation date specified in CR 10489, MACs must implement on the date specified on the WPC website, available at: http://wpc-edi.com/Reference/.

A discrepancy between the dates may arise as the WPC website is only updated three times per year and may not match the CMS release schedule. For this recurring CR, the MACs and the SSMs must get the complete list for both CARC and RARC from the WPC website to obtain the comprehensive lists for both code sets and determine the changes that are included on the code list since the last code update, CR 10270 (see MLN Matters article MM10270).

### ADDITIONAL INFORMATION

The official instruction, MM10489, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R3980CP.pdf.

## DOCUMENT HISTORY

| Date of Change | Description |
|---|---|
| February 16, 2018 | Initial article released |

# New "K" Code for Therapeutic Shoe Inserts

MLN Matters Number: MM10436
Related Change Request (CR) Number: 10436
Related CR Release Date: February 2, 2018
Effective Date: April 1, 2018
Related CR Transmittal Number: R241BP
Implementation Date: April 2, 2018

## PROVIDER TYPE AFFECTED

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

## PROVIDER ACTION NEEDED

Change Request (CR) 10436 establishes a "K" code (K0903) for a new type of therapeutic shoe inserts. The code will be added to the HCPCS code set effective April 1, 2018. The addition of this code will allow the DME MACs to correctly adjudicate claims. Make sure that your billing staffs are aware of these changes.

## BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) recently revised Appendix C of the DMEPOS Quality Standards to include a new type of therapeutic shoe insert for individuals with diabetes that is fabricated without molding it to beneficiary-specific physical positive model. The revisions allow the use of direct carving (milling) using a Computer-Aided Design/Computer-Aided Manufacturing (CAD-CAM) or similar system, without the creation of a physical positive model, as a custom fabricated therapeutic shoe insert manufacturing technique falling under the scope of the Therapeutic Shoes Part B benefit.

To facilitate implementation of this new category of therapeutic shoe inserts, the following new code will be added to the HCPCS code set effective April 1, 2018:

**K0903:** For diabetics only, multiple density insert, made by direct carving with CAM technology from a rectified CAD model created from a digitized scan of the patient, total contact with patient's foot, including arch, base layer minimum of 3/16 inch material of shore a 35 durometer or higher), includes arch filler and other shaping material, custom fabricated, each.

CMS reminds suppliers to use the KX modifier on all claims for K0903 when all requirements in the medical policy are met.

The billing jurisdiction for this code is the DME MAC.

In addition, CR10436 updates the definition of inserts located in the "Medicare Benefit Policy Manual," Chapter 15, Section 140. The revised manual section is attached to CR10436.

## ADDITIONAL INFORMATION

The official instruction, CR10436, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R241BP.pdf.

## DOCUMENT HISTORY

| Date of Change | Description |
|---|---|
| February 2, 2018 | Initial article released |

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