DME Happenings

Jurisdiction D

December 2017

In This Issue...

FYI

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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Alphabetical Listing

Jurisdiction D DME MAC Supplier Contacts and Resources

Phone Numbers		
Interactive Voice Response System	1-866-419-9458	24/7 for Eligibility 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 Recovery Auditor Redeterminations		701-277-2425
Recoupment • Refunds to Medicare • 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 • Redetermination Requests • Correspondence • ADMC Requests • Medical Review Documentation • Recovery Auditor Overpayments		**Noridian JA DME** Attn: _____ PO Box 6780 Fargo, ND 58108-6780
• Benefit Protection • Administrative Simplification Compliance Act Exception Requests (ASCA)		**Noridian JA DME** Attn: _____ PO Box 6736 Fargo, ND 58108-6736
Qualified Independent Contractor (QIC)		**C2C Solutions, Inc.** Attn: DME QIC PO Box 44013 Jacksonville, FL 32231-4013
• EFT Forms • Overpayment Redeterminations • Recovery Auditor Redeterminations		**Noridian JA DME** Attn: _____ PO Box 6728 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

DME On Demands – Expand your Medicare Knowledge

The Noridian Provider Outreach and Education (POE) team offers self-paced educational materials called DME On Demand. When new staff is hired in your facility, or existing staff may need refresher training, take advantage of the DME on Demand products available on the Noridian website. There are more than 200 short narrated training sessions on a variety of topics that are available 24 hours a day, 7 days a week. A completion certificate is available via e-mail and some sessions contain quizzes to test your knowledge.

Some of the DME on Demand topics include:

- Noridian Medicare Portal
- Local Coverage Determinations (LCDs)
- Advanced Beneficiary Notice of Noncoverage (ABN)
- Certificate of Medical Necessity (CMN)
- DME Information Form (DIF)
- CMS-1500 Claim Form
- Documentation Requirements

View these and many other DME on Demands on the DME on Demand page of the Noridian website.

MSP Payment Calculator Now Offers Enhanced Details

Do you want a better understanding of Medicare Secondary Payer (MSP) payments and what the payment amounts mean? Use the updated MSP Payment calculator to assist in determining the line by line claim payment for covered services when Medicare is the secondary payer.

The Medicare remittance advice and the primary payer Explanation of Benefits (EOB) will provide the numbers needed for the MSP calculator. The MSP calculator allows the user to enter claim line details and view the estimated MSP payment and patient responsibility. Using the "Calculate with Details" option provides the Medicare primary payment, the primary allowed amount and the primary allowed minus primary paid amount for the information entered.

View the Medicare Secondary Payer (MSP) page to use the MSP Payment Calculator and learn more about MSP payments.

Noridian Self-Service Technology Saves You Time and Expense

Your time is important. Noridian, the Jurisdiction D DME MAC offers several different tools to assist DMEPOS suppliers that will save your facility time and money.

- The Noridian Medicare Portal (NMP) offers options including claim status, beneficiary eligibility, Additional Documentation Request (ADR) post review claim comments, redetermination letters, detailed overpayment information, same and similar and Self Service Reopenings.
- The Interactive Voice Response (IVR) system is available to answer a variety of inquiries, including claim status, beneficiary eligibility, redetermination status, financial information, and much more.

Information not available on NMP or the IVR can be obtained by contacting the Supplier Contact Center. Customer Service Representatives (CSRs) are available to assist suppliers Monday through Friday from 8 a.m. to 6 p.m. Central Time.

Noridian looks forward to assisting you!

Qualified Medicare Beneficiary (QMB) Program Details Available

On October 2, 2017, Change Request (CR) 9911 modified the Medicare claims processing systems to help providers more readily identify the Qualified Medicare Beneficiary (QMB) status of each patient and to support providers' ability to follow QMB billing requirements. The QMB Program was designed for low income dual eligible beneficiaries and a webpage has been created to assist providers with details and resources regarding the program.

View the Noridian Qualified Medicare Beneficiary (QMB) Program webpage for program details, what can be expected on a Remittance Advice (RA), and access resources.

Self Service Technology Use by Suppliers Required by CMS

CMS requires all Medicare Administrative Contractors (MACs) to refer providers and suppliers to use available self-service technology when inquiring about information that can be obtained through a self-service option when calling the MAC Call Centers. The Customer Service Representatives (CSRs) will instruct providers and suppliers to use the MACs portal or Interactive Voice Response (IVR) System to obtain the information in question.

The Noridian Medicare Portal (NMP) offers a wide variety of claim, remittance and beneficiary information that can be obtained without having to call the call center. View the End User Manual to see all the information available through NMP and step-by-step instructions for obtaining this information. If you are not registered for the NMP, the Registration Guide will assist in the registration process.

Noridian requires the NMP to be used for the following inquires:

NMP Function	Description
Eligibility	View beneficiary Medicare eligibility: Part A, Part B, Managed Care Organization (MCO) and Health Maintenance Organization (HMO), Medicare Secondary Payer (MSP), Home Health, Hospice, End Stage Renal Disease (ESRD)
Claim Status	View status of claims, Medical Review comments and initiate a Self-Service Reopening or Redetermination on finalized claims
Additional Documentation Request (ADR)	If an ADR was sent to supplier and claim is pending, suppliers may view letter and submit supporting documentation
Financials	View pending and finalized check information
Overpayments	View a summary of what claim caused the overpayment and how it is being satisfied
Appeals	Submit an appeal and view the status of previously submitted appeals
Remittance Advice	View a claim specific remittance advice
Same or Similar	View same or similar equipment provided to beneficiary
PMD Prior Authorization Status	View status of Power Mobility Device (PMD) Prior Authorization Request (PAR) status

The specific services for which Noridian requires providers to use the IVR include:

IVR Function	Description
Eligibility	Obtain Beneficiary's Medicare eligibility: Part A, Part B, Managed Care Organization (MCO) and Health Maintenance Organization (HMO), Medicare Secondary Payer (MSP) details, Home Health, Hospice, Inpatient Stay Dates, and Date of Death.
Claim Status	Receive status of claim and overlapping claim information
Financial	Receive Pending and Finalized check information, a financial summary, patient account numbers, date or service and overpayment amounts. A payment floor summary and pricing information is also available
Appeal Status	Inquire on the status of a Reopening or Redetermination.

Full Remittance Advices	Request a duplicate Remittance Advice
Same or Similar	Receive details about same or similar equipment provided to beneficiary. This includes a same to same A-L-V lookup.
PMD PAR Details	Check the status of Power Mobility Device (PMD) Prior Authorization Request (PAR)

The IVR offers both voice and touchtone input options. The IVR Conversion Tool, assists callers in determining the touch-tone data-entry when avoiding the voice recognition option is preferred. The IVR Guide gives step-by-step instructions for using the IVR and provides all information available through the IVR.

The CSRs are available to answer your questions and assist you with learning to use these tools. Ask a CSR today to obtain a better understanding of the Portal and IVR.

Open Enrollment Period for 2018

The 2018 Annual Participation Open Enrollment Period runs mid-November through December 31, 2017. The open enrollment period allows Medicare suppliers to revisit their choice to accept Medicare assignment for claims payment. The participation status only affects how you are reimbursed from Medicare. Changing your status to non-participating does not terminate your Medicare billing privileges.

Do nothing if you do not wish to change your participation status.

To change your status to participating, submit a request on the CMS-460 form signed by the authorized or delegated official as previously reported to the NSC

To change your status to non-participating, submit a request on your company's letterhead signed by the company's authorized or delegated official as previously reported to the NSC

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

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

For more information, contact the National Supplier Clearinghouse (NSC) Customer Service at 866-238-9652, Monday through Friday, 9:00 am to 5:00 pm ET or visit the NSC website, https://www.palmettogba.com/nsc.

Revision to Publication 100-06, Medicare Overpayment Manual, Chapter 3, Section 200 – Limitation on Recoupment – Revised

MLN Matters® Number: MM9815
Related Change Request (CR) #: CR 9815
Related CR Release Date: September 14, 2017
Effective Date: April 2, 2018
Related CR Transmittal #: R293FM
Implementation Date: April 2, 2018

This article was revised on September 15, 2017, to reflect an updated Change Request that corrected format errors in the manual instructions. In the article, the CR release date, transmittal number, and link to the transmittal changed. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9815 updates the Centers for Medicare & Medicaid Services (CMS) "Medicare Financial Management Manual," Chapter 3, Sections 200-200.2.1, Limitation on Recoupment Overpayments. CR9815 is the first of four CRs that are forthcoming and incorporated into this manual. Make sure your billing staffs are aware of these updates that relate to the limitation on recovery of certain overpayments.

Background

Section 1893(f)(2)(a) of the Social Security Act and the provision in the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) prohibits recouping Medicare overpayments from a provider or supplier that seeks a reconsideration from a Qualified Independent Contractor (QIC). This provision changed how interest is to be paid to a provider or supplier whose overpayment is reversed at subsequent administrative or judicial levels of appeal. The final rule defines the overpayments to which the limitation applies, how the limitation works in concert with the appeals process, and the change in our obligation to pay interest to a provider or supplier whose appeal is successful at levels above the QIC. This section also limits recoupment of Medicare overpayments when a provider or supplier seeks a redetermination until a redetermination decision is rendered.

The MAC will cease recoupment or not begin recoupment when the MAC receives a valid redetermination or reconsideration request timely on an overpayment subject to these limitations. The provider has until the appeal deadline to file an appeal (refer to the "Medicare Claims Processing Manual," Chapter 29 at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c29.pdf). If a provider wants to delay recoupment, it must submit the redetermination appeal request within 30 days of the demand letter date. To continue the delayed recoupment, the provider will have 60 days from the redetermination decision to submit a reconsideration request. If the request is received before the appeal deadline but after recoupment has started, the MAC will stop the recoupment. The MAC shall not refund any monies collected back to the provider, unless otherwise directed by the Centers for Medicare & Medicaid Services (CMS). The MAC will be accountable to ensure the debts continue to age and accrue interest until the debt is paid in full.

After the first two levels of appeal are completed, the MAC shall resume recoupment and normal debt collection processes. Whether or not the provider subsequently appeals the overpayment to the Administrative Law Judge (ALJ), or subsequent levels (Department Appeals Board (DAB), or Federal court), the MAC shall initiate recoupment at 100% until the debt is satisfied in full, unless an Extended Repayment Schedule (ERS) is established. If the debt was referred to Treasury and the provider files for an appeal, the MAC shall recall the debt from Treasury while in an appeal status. If the appeal decision is unfavorable to the provider, any outstanding debt will be referred back to Treasury, unless an approved Extended Repayment Schedule (ERS) is established or the provider pays the debt in full.

Additional Information

The official instruction, CR9815, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R293FM.pdf.

Chapter 29 of the "Medicare Claims Processing Manual" is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c29.pdf.

Document History

Date of Change	Description
September 15, 2017	This article was revised to reflect an updated CR that corrected format errors in the manual instructions. In the article, the CR release date, transmittal number, and link to the transmittal changed.
September 1, 2017	Initial article issued.

Common Working File MSP Type for Liability Medicare Set-Aside Arrangements and No-Fault Medicare Set-Aside Arrangements - Rescinded

MLN Matters® Number: MM9893 Rescinded
Related Change Request (CR) #: CR 9893
Effective Date: October 1, 2017
Implementation Date: October 2, 2017
This article was rescinded.

Guidance on Implementing System Edits for Certain DMEPOS – Second Revision

MLN Matters® Number: MM9904 Revised
Related Change Request (CR) #: CR 9904
Related CR Release Date: September 28, 2017
Effective Date: July 1, 2017
Related CR Transmittal #: R1910OTN
Implementation Date: October 2, 2017

This article was revised on September 28, 2017, to reflect an updated CR9904. In the article, the CR Release Date, transmittal number, and the Web address of the CR were revised. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

CR9904 updates CR7333 and CR9371 and informs MACs about changes related to Section 302 of the Medicare Modernization Act of 2003 (MMA). Section 302 added a new paragraph to the Social Security Act (the Act), Section 1834(a)(20) requiring the Secretary to establish and implement quality standards for suppliers of DMEPOS.

All DMEPOS suppliers that furnish such items or services required in the new paragraph, as the Secretary determines appropriate, must comply with the quality standards in order to receive Medicare Part B payments and to retain a supplier billing number. The covered items and services are defined in the Act.

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) added a new subparagraph for implementing quality standards which state the Secretary shall require suppliers furnishing items and services on or after October 1, 2009, directly or as a subcontractor for another entity, to have submitted evidence of accreditation by an accreditation organization designated by the Secretary. Make sure that your billing staffs are aware of these changes.

Background

Pursuant to subparagraph 1834(a)(20)(D) of the Act, the covered items and services are defined in Section 1834(a)(13), Section 1834(h)(4), and Section 1842(s)(2) of the Act. The covered items include:

- DME
- Medical supplies
- Home dialysis supplies and equipment
- Therapeutic shoes
- Parenteral and enteral nutrient, equipment and supplies

- Transfusion medicine
- Devices, prosthetics, and orthotics

Section 154(b) of MIPPA added a new subparagraph (F) to Section 1834(a)(20) of the Act. In implementing quality standards under this paragraph, the Secretary shall require suppliers furnishing items and services on or after October 1, 2009, directly or as a subcontractor for another entity, to have submitted evidence of accreditation by an accreditation organization designated by the Secretary. This subparagraph states that eligible professionals and other persons (defined below) are exempt from meeting the September 30, 2009, accreditation deadline unless the Centers for Medicare & Medicaid Services (CMS) determines that the quality standards are specifically designed to apply to such professionals and persons. The eligible professionals who are exempt from meeting the September 30, 2009, accreditation deadline (as defined in Section 1848(k)(3)(B)) include the following practitioners:

- Physicians (as defined in Section 1861(r) of the Act)
- Physical Therapists
- Occupational Therapists
- Qualified Speech-Language Pathologists
- Physician Assistants
- Clinical Nurse Specialists
- Certified Registered Nurse Anesthetists
- Certified Nurse-Midwives
- Clinical Social Workers
- Clinical Psychologists
- Registered Dietitians
- Nutritional professionals

Section 154(b) of MIPPA allows the Secretary to specify "other persons" that are exempt from meeting the accreditation deadline unless CMS determines that the quality standards are specifically designed to apply to such other persons. At this time, "such other persons" are specifically defined as the following practitioners:

- Orthotists
- Prosthetists
- Opticians
- Audiologists

All supplier types (except those listed above) who furnish items and services requiring accreditation, directly or as a subcontractor for another entity, must have submitted evidence of accreditation by an accreditation organization designated by the Secretary on or after October 1, 2009.

Medicare systems will have edits to check for accreditation on claims with HCPCS codes in the product categories designated by MIPPA as requiring accreditation. The edits will deny claims for these codes unless the DMEPOS supplier has been identified as accredited and verified on their CMS-855S or the DMEPOS supplier is currently exempt from meeting the accreditation requirements.

Denied Claims

MACs will use Claim Adjustment Reason Code (CARC) B7 and Remittance Advice Remark Code (RARC) N211 and RARC N790 for denial:

- CARC B7 - This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- RARC N211 - Alert: You may not appeal this decision.

- RARC N790 - Provider/supplier not accredited for product/service
- Group Code: CO - Contractual Obligation

Additional Information

The official instruction, CR9904, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1925OTN.pdf.

DOCUMENT HISTORY

Date of Change	Description
September 28, 2017	This article was revised to reflect an updated CR. In the article, the CR Release Date, transmittal number, and the Web address of the CR were revised. All other information remains the same.
August 18, 2017	This article was revised to reflect an updated CR. The CR changed the July analysis implementation date and revised the codes used for denied claims. The CR Release Date, transmittal number and link to the CR also changed.
February 17, 2017	Initial article released

QMB Indicator in the Medicare Fee-For-Service Claims Processing System – Third Revision

MLN Matters® Number: MM9911 Revised
Related Change Request (CR) #: CR 9911
Related CR Release Date: November 15, 2017
Effective Date: for claims processed on or after October 2, 2017
Related CR Transmittal #: R3920CP
Implementation Date: October 2, 2017

The article was revised on November 16, 2017, to reflect a revised CR9911 issued on November 15, 2017. In the article, the CR release date, transmittal number, and the Web address of CR9911 are revised. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9911 modifies the Medicare claims processing systems to help providers more readily identify the Qualified Medicare Beneficiary (QMB) status of each patient and to support providers' ability to follow QMB billing requirements. Beneficiaries enrolled in the QMB program are not liable to pay Medicare cost-sharing for all Medicare A/B claims. CR 9911 adds an indicator of QMB status to Medicare's claims processing systems. This system enhancement will trigger notifications to providers (through the Provider Remittance Advice) and to beneficiaries (through the Medicare Summary Notice) to reflect that the beneficiary is enrolled in the QMB program and has no Medicare cost-sharing liability. Make sure that your billing staffs are aware of these changes.

Background

QMB is a Medicaid program that assists low-income beneficiaries with Medicare premiums and cost-sharing. In 2015, 7.2 million persons (more than one out of every ten Medicare beneficiaries) were enrolled in the QMB program.

Federal law bars Medicare providers from billing a QMB individual for Medicare Part A and B deductibles, coinsurance, or copayments, under any circumstances. Sections 1902(n)(3)(B); 1902(n)(3)(C); 1905(p)(3); 1866(a)(1)(A); 1848(g)(3)(A) of the Social Security Act. State Medicaid programs may pay providers

for Medicare deductibles, coinsurance, and copayments. However, as permitted by Federal law, states can limit provider payment for Medicare cost-sharing, under certain circumstances. Regardless, QMB individuals have no legal liability to pay Medicare providers for Medicare Part A or Part B cost-sharing. Providers may seek reimbursement for unpaid Medicare deductible and coinsurance amounts as a Medicare bad debt related to dual eligible beneficiaries under CMS Pub. 15-1, Chapter 3 of the "Provider Reimbursement Manual (PRM)".

CR 9911 aims to support Medicare providers' ability to meet these requirements by modifying the Medicare claims processing system to clearly identify the QMB status of all Medicare patients. Currently, neither the Medicare eligibility systems (the HIPAA Eligibility Transaction System (HETS)), nor the claims processing systems (the FFS Shared Systems), notify providers about their patient's QMB status and lack of Medicare cost-sharing liability. Similarly, Medicare Summary Notices (MSNs) do not inform those enrolled in the QMB program that they do not owe Medicare cost-sharing for covered medical items and services.

CR 9911 includes modifications to the FFS claims processing systems and the "Medicare Claims Processing Manual" to generate notifications to Medicare providers and beneficiaries regarding beneficiary QMB status and lack of liability for cost-sharing.

With the implementation of CR 9911, Medicare's Common Working File (CWF) will obtain QMB indicators so the claims processing systems will have access to this information.

- CWF will provide the claims processing systems the QMB indicators if the dates of service coincide with a QMB coverage period (one of the occurrences) for the following claim types: Part B professional claims; Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) claims; and outpatient institutional Types of Bill (TOB) 012x, 013x, 014x, 022x, 023x, 034x, 071x, 072x, 074x, 075x, 076x, 077x, and 085x); home health claims (TOB 032x) only if the revenue code for the line item is 0274, 029x, or 060x; and Skilled Nursing Facility (SNF) claims (based on occurrence code 50 date for revenue code 0022 lines on TOBs 018x and 021x).
- CWF will provide the claims processing systems the QMB indicator if the "through date" falls within a QMB coverage period (one of the occurrences) for inpatient hospital claims (TOB 011x) and religious non-medical health care institution claims (TOB 041x).

The QMB indicators will initiate new messages on the Remittance Advice that reflect the beneficiary's QMB status and lack of liability for Medicare cost-sharing with three new Remittance Advice Remark Codes (RARC) that are specific to those enrolled in QMB. As appropriate, one or more of the following new codes will be returned:

- N781 – No deductible may be collected as patient is a Medicaid/Qualified Medicare Beneficiary. Review your records for any wrongfully collected coinsurance, deductible or co-payments.
- N782 – No coinsurance may be collected as patient is a Medicaid/Qualified Medicare Beneficiary. Review your records for any wrongfully collected coinsurance, deductible or co-payments.
- N783 – No co-payment may be collected as patient is a Medicaid/Qualified Medicare Beneficiary. Review your records for any wrongfully collected coinsurance, deductible or co-payments.

In addition, the MACs will include a Claim Adjustment Reason Code of 209 ("Per regulatory or other agreement. The provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to patient if collected. (Use only with Group code OA (Other Adjustment)).

Finally, CR 9911 will modify the MSN to inform beneficiaries if they are enrolled in QMB and cannot be billed for Medicare cost-sharing for covered items and services.

Additional Information

The official instruction, CR 9911, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3920CP.pdf.

For more information regarding billing rules applicable to individuals enrolled in the QMB Program, see the MLN Matters article, SE1128, at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se1128.pdf.

DOCUMENT HISTORY

Date of Change	Description
November 16, 2017	The article was revised to reflect a revised CR9911 issued on November 15, 2017. In the article, the CR release date, transmittal number, and the Web address of CR9911 are revised. All other information remains the same.
July 24, 2017	The article was revised to add links to related MLN Matters Articles. SE1128 reminds all Medicare providers that they may not bill beneficiaries enrolled in the QMB program for Medicare cost-sharing. MM9817 states that CR 9817 instructs MACs to issue a compliance letter instructing named providers and suppliers to refund any erroneous charges and recall any past or existing billing with regard to improper QMB billing
June 29, 2017	The article was revised to reflect a revised CR9911 issued on June 28, 2017. In the article, the CR release date, transmittal number, and the Web address of CR9911 are revised. Clarifications were also made to the second paragraph of the Background section.
May 1, 2017	The article was revised to reflect a revised CR9911 issued on April 28, 2017. In the article, the CR release date, transmittal number, and the Web address of CR9911 are revised.
February 3, 2017	Initial article released

PWK Fax/Mail Cover Sheets Revision

MLN Matters Number: MM10124
Related Change Request (CR) Number: 10124
Related CR Release Date: November 9, 2017
Effective Date: April 1, 2018
Related CR Transmittal Number: R1974OTN
Implementation Date: April 2, 2018

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 10124 alerts providers that their MAC will provide revised fax/mail cover sheets via hardcopy and/or electronic download. These revised documents are attached to CR10124. There are three paperwork (PWK) attachments to CR10124: (1) Medicare Part A Fax/Mail Cover Sheet (2) Medicare Part B Fax/Mail Cover Sheet and (3) Medicare DME MAC Fax/Mail Cover Sheet.

BACKGROUND

CR10124 revises the three PWK Fax/Mail Cover Sheets to remove Health Insurance Claim Number (HICN) from the forms and replace it with Medicare ID. HICN is being removed from the forms as part of the Medicare Access and CHIP Re-authorization Act (MACRA) of 2015, which requires removal of the Social Security Number-based HICN from Medicare cards within 4 years of enactment. These Fax/Mail Cover sheets are used so that providers are able to continue to submit electronic claims, which require additional documentation.

ADDITIONAL INFORMATION

The official instruction, CR10124, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1974OTN.pdf.

DOCUMENT HISTORY

Date of Change	Description
November 13, 2017	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.

DMEPOS CBP – January 2018 – Revised

MLN Matters Number: MM10233
Related Change Request (CR) Number: 10233
Related CR Release Date: November 8, 2017
Effective Date: January 1, 2018
Related CR Transmittal Number: R3909CP
Implementation Date: January 2, 2018

This article was revised on November 9, 2017, to reflect a revised CR10233 issued on November 8. In the article, a paragraph was added to the Background section regarding changes to HCPCS codes A4595 and A4557. Also, the CR release date, transmittal number and the Web address for CR10233 are revised. All other information remains the same.

PROVIDER TYPE AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 10233 provides the January 2018 quarterly update for the Medicare DMEPOS fee schedule. The instructions include information, when necessary, to implement fee schedule amounts for new codes and correct any fee schedule amounts for existing codes. The Centers for Medicare & Medicaid Services (CMS) issued CR 10233 to provide the DMEPOS Competitive Bidding Program (CBP) January 2018 quarterly update. CR 10233 provides specific instructions to your DME MAC for implementing updates to the DMEPOS CBP Healthcare Common Procedure Coding System (HCPCS), ZIP code, and Single Payment Amount files. Note that quarterly updates are available on the DMEPOS CBP at https://www.dmecompetitivebid.com/palmetto/cbicrd2recompete.nsf/DocsCat/Quarterly%20Updates.

BACKGROUND

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

The November 8, 2017 revision to CR10233 informs that effective January 1, 2018, the Round 2 Recompete and Round 2017 Single Payment Amount file has been updated to replace HCPCS codes A4595 and A4557 with HCPCS codes A4595KG and A4557KG. This change allows Medicare to accurately process and pay HCPCS code A4595 (Electrical stimulator supplies, 2 lead, per month) and A4557 (Lead wires, (e.g., apnea monitor)) according to competitive bidding payment rules when used in conjunction with a competitive bidding base unit, such as a Transcutaneous Electrical Nerve Stimulation (TENS). When furnishing items described by these codes to a beneficiary residing in a competitive bid area, suppliers should bill without the KG modifier when A4595 and A4557 are used with a NeuroMuscular Electrical Stimulation (NMES) device and with the KG modifier when used with a TENS device.

ADDITIONAL INFORMATION

The official instruction, CR10233, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3909CP.pdf.

The DMEPOS CBP site at https://www.dmecompetitivebid.com/palmetto/cbicrd2recompete.nsf/DocsCat/Home includes information on all rounds of the CBP, including product categories, single payment amounts, and the ZIP codes of areas included in the CBP.

DOCUMENT HISTORY

Date of Change	Description
November 9, 2017	This article was revised to reflect a revised CR10233 issued on November 8. In the article, a paragraph was added to the Background section regarding changes to HCPCS codes A4595 and A4557. Also, the CR release date, transmittal number, and the Web address for CR10233 are revised. All other information remains the same.
September 15, 2017	Initial article released.

HCPCS Drug/Biological Code Changes – October 2017 Update

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

PROVIDER TYPES AFFECTED

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

WHAT YOU NEED TO KNOW

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

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

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

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

ADDITIONAL INFORMATION

The official instruction, CR10234, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3850CP.pdf.

DOCUMENT HISTORY

Date of Change	Description
September 26, 2017	Initial article released.

DMEPOS Fee Schedule October 2017 Quarterly Update

MLN Matters Number: MM10248
Related Change Request (CR) Number: CR 10248
Related CR Release Date: September 8, 2017
Effective Date: October 1, 2017
Related CR Transmittal Number: R3859CP
Implementation Date: October 2, 2017

PROVIDER TYPE AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 10248 provides instructions regarding the October quarterly update for the 2017 DMEPOS and parenteral and enteral nutrition (PEN) fee schedules and the October 2017 DMEPOS Rural ZIP code file containing the Quarter 4, 2017 Rural ZIP code changes. It includes information, when necessary, to implement fee schedule amounts for new codes and correct any fee schedule amounts for existing codes.

BACKGROUND

The DMEPOS fee schedule is updated on a quarterly basis, when necessary, to implement fee schedule amounts for new codes and correct any fee schedule amounts for existing codes, and the quarterly update process for the DMEPOS fee schedule is covered in the Medicare Claims Processing Manual, Chapter 23, Section 60 at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf.

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

Additionally, the Social Security Act (Section 1834(a)(1)(F)(ii)) mandates adjustments to the fee schedule amounts for certain items furnished on or after January 1, 2016, in areas that are not competitive bid areas, based on information from competitive bidding programs (CBPs) for DME. The Social Security Act (Section 1842(s)(3)(B)) provides authority for making adjustments to the fee schedule amount for enteral nutrients, equipment and supplies (enteral nutrition) based on information from CBPs. Also, the adjusted fees apply a rural payment rule. The DMEPOS and PEN fee schedule files contain HCPCS codes that are subject to the adjustments as well as codes that are not subject to the fee schedule adjustments. Additional information on adjustments to the fee schedule amounts based on information from CBPs is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9642.pdf, Transmittal 3551, dated June 23, 2016.

The ZIP code associated with the address used for pricing a DMEPOS claim determines the rural fee schedule payment applicability for codes with rural and non-rural adjusted fee schedule amounts. ZIP codes for non-continental Metropolitan Statistical Areas (MSA) are not included in the DMEPOS Rural ZIP code file. The DMEPOS Rural ZIP code file is updated on a quarterly basis as necessary.

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

The October 2017 DMEPOS Rural ZIP code file public use files (PUFs) will be available for State Medicaid Agencies, managed care organizations, and other interested parties shortly after the release of the data files at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched.

ADDITIONAL INFORMATION

The official instruction, CR10248, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3859CP.pdf.

DOCUMENT HISTORY

Date of Change	Description
September 12, 2017	Initial article released

HCPCS Codes for SNF CB 2018 Annual Update

MLN Matters Number: MM10262
Related Change Request (CR) Number: 10262
Related CR Release Date: September 8, 2017
Effective Date: January 1, 2018
Related CR Transmittal Number: R3857CP
Implementation Date: January 2, 2018

PROVIDER TYPES AFFECTED

This MLN Matters® Article is intended for physicians, other providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs), including Home Health & Hospice (HH&H) MACs and Durable Medical Equipment (DME) MACs, for services provided to Medicare beneficiaries who are in a Part A covered Skilled Nursing Facility (SNF) stay.

PROVIDER ACTION NEEDED

Change Request (CR) 10262 makes changes to Healthcare Common Procedure Coding System (HCPCS) codes and Medicare Physician Fee Schedule designations that will be used to revise Common Working File (CWF) edits to allow A/B MACs to make appropriate payments in accordance with policy for SNF CB in Chapter 6, Section 110.4.1 and Chapter 6, Section 20.6 in the "Medicare Claims Processing Manual."

BACKGROUND

The Common Working File (CWF) currently has edits in place for claims received for beneficiaries in a Part A covered SNF stay as well as for beneficiaries in a non-covered stay. These edits allow only those services that are excluded from consolidated billing to be separately paid. Barring any delay in the Medicare Physician Fee Schedule, the new code files will be provided to CWF by November 1, 2017.

By the first week in December 2017, new code files will be posted at http://www.cms.gov/SNFConsolidatedBilling/. The files will be applicable to claims with dates of service on or after January 1, 2018, through December 31, 2018. It is important and necessary for the provider/contractor community to view the "General Explanation of the Major Categories" file located at the bottom of each year's update in order to understand the Major Categories including additional exclusions not driven by HCPCS codes.

ADDITIONAL INFORMATION

The official instruction, CR10262, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3857CP.pdf.

DOCUMENT HISTORY

Date of Change	Description
September 8, 2017	Initial article released.

ICD-10 and Other Coding Revisions to NCDs

MLN Matters Number: MM10318

Related Change Request (CR) Number: 10318

Related CR Release Date: November 9, 2017

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

Related CR Transmittal Number: R19750TN

Implementation Date: December 29, 2017 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

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/2017Downloads/R1975OTN.pdf.

DOCUMENT HISTORY

Date of Change	Description
November 16, 2017	Initial article released.

ASP Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files – January 2018

MLN Matters Number: MM10320
Related Change Request (CR) Number: 10320
Related CR Release Date: October 6, 2017
Effective Date: January 1, 2018
Related CR Transmittal Number: R3878CP
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) for Medicare Part B drugs provided to Medicare beneficiaries.

WHAT YOU NEED TO KNOW

Change Request (CR) 10320 instructs MACs to download and implement the January 2018 and, if released, the revised October 2017, July 2017, April 2017, and January 2017, Average Sales Price (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 January 2, 2018, with dates of service January 1, 2018, through March 31, 2018. Make sure your billing staffs are aware of these changes.

BACKGROUND

The Average Sales Price (ASP) methodology is based on quarterly data that manufacturers submit to the CMS. CMS supplies the 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 in Chapter 4, Section 50 of the "Internet Only Manual" (IOM) which is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf.

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

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

For any drug or biological not listed in the ASP or NOC drug-pricing files that is billed with the KD modifier, 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 (DME) on or after January 1, 2017, associated with the passage of the 21st Century Cures Act.

ADDITIONAL INFORMATION

The official instruction, CR10320, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3878CP.pdf.

DOCUMENT HISTORY

Date of Change	Description
October 6, 2017	Initial article released.

IVIG Demonstration: Payment Update for 2018 – Revised

MLN Matters Number: MM10343 Revised
Related Change Request (CR) Number: 10343
Related CR Release Date: November 22, 2017
Effective Date: October 1, 2017
Related CR Transmittal Number: R186DEMO
Implementation Date: January 2, 2018

This article was revised on November 22, 2017, to reflect the revised CR10343 issued on November 22. In the article, the CR release date, transmittal number, and the Web address of the CR are revised. All other information remains the same.

PROVIDER TYPE AFFECTED

This MLN Matters Article is intended for suppliers billing Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for Intravenous Immune Globulin (IVIG) services provided to Medicare beneficiaries under the IVIG Demonstration.

PROVIDER ACTION NEEDED

Change Request (CR) 10343 specifies the payment rate for 2018 and allows for continued payments from October 1, 2017 - December 31, 2017, at the current 2017 payment rate. The original demonstration end date was September 30, 2017. The IVIG demonstration was extended by law through December 31, 2020.

- The payment rate for Q2052: "Services, Supplies and Accessories Used in the Home under the Medicare IVIG Demonstration" for October 1, 2017 - December 31, 2017 shall be $354.60. This same rate was paid for services rendered January 1, 2017 - September 31, 2017.
- The payment rate for services rendered January 1, 2018 - December 31, 2018, shall be $358.50.

Be sure your billing staff is aware of these changes.

BACKGROUND

The "Medicare Intravenous Immune Globulin (IVIG) Access and Strengthening Medicare and Repaying Taxpayers Act of 2012" authorizes a 3-year demonstration under Part B of Title XVIII of the Social Security Act to evaluate the benefits of providing payment for items and services needed for the in-home administration of IVIG for the treatment of Primary Immunodeficiency Disease (PIDD).

In accordance with the original legislation, the demonstration was scheduled to end on September 30, 2017 and CR 9746 specified that claims for services after that date should not be paid. However, on September 28, 2017, Congress passed the Disaster Tax Relief and Airport and Airway Extension Act of 2017. Title III, section 302 of this legislation extended the IVIG demonstration through December 31, 2020. CR 10343 authorizes the continued payment of claims for the remainder of 2017 at the current payment rate and specifies a new payment rate for services rendered in 2018.

ADDITIONAL INFORMATION

The official instruction, CR10343, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R185DEMO.pdf.

DOCUMENT HISTORY

Date of Change	Description
November 22, 2017	The article was revised to reflect the revised CR10343 issued on November 22. In the article, the CR release date, transmittal number and the Web address of the CR are revised. All other information remains the same.
November 3, 2017	Initial article released

Home Health Consolidated Billing Enforcement HCPCS Codes Quarterly Update

MLN Matters Number: MM10374
Related Change Request (CR) Number: 10374
Related CR Release Date: November 17, 2017
Effective Date: April 1, 2018
Related CR Transmittal Number: R3923CP
Implementation Date: April 2, 2018

PROVIDER TYPES AFFECTED

This MLN Matters Article is intended for Home Health Agencies (HHAs) and other providers submitting claims to Medicare Administrative Contractors (MACs) for home health services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

This article is based on Change Request (CR) 10374, which provides the quarterly update of HCPCS codes used for HH consolidated billing effective April 1, 2018. Make sure that your billing staffs are aware of these changes.

BACKGROUND

Section 1842(b)(6) of the Social Security Act requires that payment for home health services provided under a home health plan of care is made to the home health agency. This requirement is in Medicare regulations at 42 CFR 409.100 and in Medicare instructions provided in Chapter 10, Section 20 of the Medicare Claims Processing Manual.

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of HCPCS codes that are subject to the consolidated billing provision of the Home Health Prospective Payment System (HH PPS). With the exception of therapies performed by physicians, supplies incidental to physician services and supplies used in institutional settings, services appearing on this list that are submitted on claims to your MAC will not be paid separately on dates when a beneficiary for whom such a service is being billed is in a home health episode (that is, under a home health plan of care administered by an HHA).

Medicare will only directly reimburse the primary HHAs that have opened such episodes during the episode periods. Therapies performed by physicians, supplies incidental to physician services, and supplies used in institutional settings are not subject to HH consolidated billing.

The HH consolidated billing code lists are updated annually to reflect changes to the HCPCS code set itself. Additional updates may occur as frequently as quarterly in order to reflect the creation of temporary HCPCS codes (for example, 'K' codes) throughout the calendar year. The new coding identified in each update describes the same services that were used to determine the applicable HH PPS payment rates. No additional services will be added by these updates; that is, new updates are required by changes to the coding system, not because the services subject to HH consolidated billing are being redefined.

Effective April 1, 2018, the following HCPCS code is added to the HH consolidated billing non-routine supply code list as a result of CR10374:

- A4575 Topical hyperbaric oxygen chamber, disposable (Hyperbaric o2 chamber disps)

No HCPCS codes are added to the HH consolidated billing therapy code list in this update.

ADDITIONAL INFORMATION

The official instruction, CR 10374, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3923CP.pdf.

DOCUMENT HISTORY

Date of Change	Description
November 17, 2017	Initial article released.

Prohibition on Billing Dually Eligible Individuals Enrolled in the QMB Program - Sixth Revision

MLN Matter® Number: SE1128 Revised

Related Date of Revised Article: November 3, 2017

The article was revised to show the HETS QMB release will be in November 2017. Previously, the article was revised on October 18, 2017, to indicate that the Provider Remittance Advice and the Medicare Summary Notice for beneficiaries identifies the QMB status of beneficiaries and exemption from cost-sharing for Part A and B claims processed on or after October 2, 2017, and to recommend how providers can use these and other upcoming system changes to promote compliance with QMB billing requirements. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

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

Look for new information and messages in CMS' HIPAA Eligibility Transaction System (HETS) (effective November 2017) and the Provider Remittance Advice (RA) (effective October 2, 2017), to identify patients' QMB status and exemption from cost-sharing prior to billing. If you are an MA provider, contact the MA plan for more information about verifying the QMB status of plan members.

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

Background

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

Billing of QMBs Is Prohibited by Federal Law

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

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

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

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

Inappropriate Billing of QMB Individuals Persists

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

Ways to Promote Compliance with QMB Billing Rules

Take the following steps to ensure compliance with QMB billing prohibitions:

1. Establish processes to routinely identify the QMB status of your Medicare patients prior to billing for items and services.

- Beginning in November 2017, providers and suppliers can use Medicare eligibility data provided to Medicare providers, suppliers, and their authorized billing agents (including clearinghouses and third-party vendors) by CMS' HETS to verify a patient's QMB status and exemption from cost-sharing charges. For more information on HETS, visit https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/index.html.
- Original Medicare providers and suppliers can readily identify the QMB status of patients and billing prohibitions on the Medicare Provider RA, which will contain new notifications and information about a patient's QMB status for Part A and B claims processed on or after October 2, 2017. Refer to Qualified Medicare Beneficiary Indicator in the Medicare Fee-For-Service Claims Processing System for more information about these improvements.
- MA providers and suppliers should also contact the MA plan to learn the best way to identify the QMB status of plan members.

2. Providers and suppliers may also verify patient's QMB status through State online Medicaid eligibility systems or by asking patients for other proof such as their Medicaid identification card or a copy of their Medicare Summary Notice, the quarterly summary of claims sent to Original Medicare beneficiaries that reflects, among other things, the patients' QMB status for Part A and B claims processed on or after October 2, 2017. Ensure that billing procedures and third-party vendors exempt individuals enrolled in the QMB program from Medicare charges and that you remedy billing problems should they occur. If you have erroneously billed individuals enrolled in the QMB program, recall the charges (including referrals to collection agencies) and refund the invalid charges they paid.

3. Determine the billing processes that apply to seeking payment for Medicare cost-sharing from the States in which you operate. Different processes may apply to Original Medicare and MA services provided to individuals enrolled in the QMB program. For Original Medicare claims, nearly all States have electronic crossover processes through

the Medicare Benefits Coordination & Recovery Center (BCRC) to automatically receive Medicare-adjudicated claims.

- If a claim is automatically crossed over to another payer, such as Medicaid, it is customarily noted on the Medicare RA.
- Understand the processes you need to follow to request payment for Medicare cost-sharing amounts if they are owed by your State. You may need to complete a State Provider Registration Process and be entered into the State payment system to bill the State.

Important Reminders Concerning QMB Billing Requirements

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

- All Original Medicare and MA providers and suppliers–not only those that accept Medicaid–must abide by the billing prohibitions.

- Individuals enrolled in the QMB program retain their protection from billing when they cross State lines to receive care. Providers and suppliers cannot charge individuals enrolled in QMB even if their QMB benefit is provided by a different State than the State in which care is rendered.
- Note that individuals enrolled in QMB cannot choose to "waive" their QMB status and pay Medicare cost-sharing. The Federal statute referenced above supersedes Section 3490.14 of the State Medicaid Manual, which is no longer in effect.

QMB Eligibility and Benefits

Program	Income Criteria*	Resources Criteria*	Medicare Part A and Part B Enrollment	Other Criteria	Benefits
QMB Only	≤100% of Federal Poverty Line (FPL)	≤3 times SSI resource limit, adjusted annually in accordance with increases in Consumer Price Index	Part A***	Not Applicable	Medicaid pays for Part A (if any) and Part B premiums, and may pay for deductibles, coinsurance, and copayments for Medicare services furnished by Medicare providers to the extent consistent with the Medicaid State Plan (even if payment is not available under the State plan for these charges, QMBs are not liable for them)
QMB Plus	≤100% of FPL	Determined by State	Part A***	Meets financial and other criteria for full Medicaid benefits	Full Medicaid Coverage Medicaid pays for Part A (if any) and Part B premiums, and may pay for deductibles, coinsurance, and copayments to the extent consistent with the Medicaid State Plan (even if payment is not available under the State plan for these charges, QMBs are not liable for them)

* States can effectively raise these Federal income and resources criteria under Section 1902(r)(2) of the Act.

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

Additional Information

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

Document History

Date of Change	Description
November 3, 2017	Article revised to show the HETS QMB release will be in November 2017. All other information remains the same.

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

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

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

What is not accepted as a Telephone Reopening?	The following will not be accepted as a Telephone Reopening and must be submitted as a redetermination with supporting documentation.
	• Overutilization denials that require supporting medical records
	• Certificate of Medical Necessity (CMN) and Durable Medical Equipment Information Form (DIF) issues. Please see the article posted March 21, 2013
	• Oxygen break in service (BIS) issues
	• Some manual wheelchairs and all power mobility devices (PMDs) – HCPCS K0005 and higher
	• Overpayments or reductions in payment
	• Medicare Secondary Payer (MSP) issues
	• Claims denied for timely filing
	• Reopenings past one year from the initial determination
	• Complex Medical Reviews or Additional Documentation Requests
	• Advance Beneficiary Notice of Noncoverage (ABN) issues and other liability issues
	• Repair and labor claims
	• Miscellaneous HCPCS codes and all HCPCS codes that require manual pricing
	• The following modifier changes or additions:
	  • A1 through A9
	  • K0 through K4
	  • GA
	  • GY
	  • GZ
	  • KX
	  • EY
	  • KG
	  • RA
	  • RB
	  • RP
	• Certain HCPCS codes (not all-inclusive list)
	  • A4450 through A4452
	  • E0194
	  • E0748
	  • E1028
	  • J1559
	  • J1561
	  • J1562
	  • K0108
	  • K0462

What do I do when I have a large amount of corrections?	If a supplier has more than 50 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 and provide further direction how to submit the request If a supplier has a least 10 DOS, the supplier can request a phone appointment for a 30-minute interval. A Telephone Reopenings representative will call the supplier at the designated time and will complete as many reopenings as possible in that time.
Where can I find more information on Telephone Reopenings?	Supplier Manual Chapter 13 Appeals Section on the Noridian DME website IOM Publication 100-04, Chapter 34
Additional assistance available	Suppliers can email questions and concerns regarding reopenings and redeterminations to dmeredeterminations@noridian.com. Please note, emails containing Protected Health Information (PHI) will be returned as unprocessable.

CERT Documentation

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

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

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

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

Mail all requested documentation to:

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

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

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

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

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

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

Ankle-Foot/Knee-Ankle-Foot Orthosis (HCPCS L4361) Final Edit Effectiveness Results of Service Specific Prepayment Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code L4361. The final edit effectiveness results from April 2017 through September 2017 are as follows:

- The L4361 review involved 781 claims, of which 521 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 67%.

Top Denial Reasons

- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Proof of Delivery (POD) was not received.
- Documentation does not support coverage criteria.
- Claim is the same or similar to another claim on file.

For complete detail see, Ankle-Foot/Knee-Ankle-Foot Orthosis (HCPCS L4361) Final Edit Effectiveness Results of Service Specific Prepayment Review.

Ankle-Foot Orthosis Final Edit Effectiveness Results of Service Specific Prepayment Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code L1900, L1906, L1910, L1920, L1930, L1932, L1940, L1945, L1950, L1951, L1960, L1970, L1971, L1980, L1990, L2106, L2108, L2112, L2114 and L2116. The final edit effectiveness results from January 2017 through September 2017 are as follows:

- The AFO review involved 237 claims, of which 207 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 85%.

Top Denial Reasons

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

For complete detail see, Ankle-Foot Orthosis Final Edit Effectiveness Results of Service Specific Prepayment Review.

Ankle-Foot Orthosis (HCPCS L1960, L1970, & L4360) Final Edit Effectiveness Results of Service Specific Prepayment Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code L1960, L1970 and L4360. The final edit effectiveness results from March 2017 through August 2017 are as follows:

- The L1960 review involved 270 claims, of which 194 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 71%.
- The L1970 review involved 493 claims, of which 352 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 70%.
- The L4360 review involved 442 claims, of which 432 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 98%.

Top Denial Reasons

- Documentation does not support coverage criteria.
- Documentation does not support custom fit criteria.
- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Proof of Delivery (POD) was not received.

For further detail see, Ankle-Foot Orthosis (HCPCS L1960, L1970, & L4360) Final Edit Effectiveness Results of Service Specific Prepayment Review.

Ankle-Foot Orthosis Walking Boot (HCPCS L4360, L4361, L4370, L4386, L4387, L4398, L4631) Final Edit Effectiveness Results of Service Specific Prepayment Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code L4360, L4361, L4370, L4386, L4387, L4398, L4631. The final edit effectiveness results from January 2017 through September 2017 are as follows:

- The AFO Walking Boot review involved 258 claims, of which 244 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 83%.

Top Denial Reasons

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

For complete details see, Ankle-Foot Orthosis Walking Boot (HCPCS L4360, L4361, L4370, L4386, L4387, L4398, L4631) Final Edit Effectiveness Results of Service Specific Prepayment Review.

Ankle Orthosis (HCPCS L1902, L1904, L1907, L4350) Final Edit Effectiveness Results of Service Specific Prepayment Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code L1902, L1904, L1907 and L4350. The final edit effectiveness results from January 2017 through September 2017 are as follows:

- The AO review involved 237 claims, of which 228 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 92%.

Top Denial Reasons

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

For complete detail see, Ankle Orthosis (HCPCS L1902, L1904, L1907, L4350) Final Edit Effectiveness Results of Service Specific Prepayment Review.

External Infusion Pumps (HCPCS J1817) Final Edit Effectiveness Results of Service Specific Prepayment Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code J1817. The final edit effectiveness results from December 2016 through September 2017 are as follows:

- The J1817 review involved 15 claims, of which 15 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 100%.

Top Denial Reasons

- Medical documentation was not received.
- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Detailed Written Order (DWO) is incomplete or missing elements.
- Proof of Delivery (POD) was not received.

For complete detail see, External Infusion Pumps (HCPCS J1817) Final Edit Effectiveness Results of Service Specific Prepayment Review.

External Infusion Pumps (HCPCS J2260) Final Edit Effectiveness Results of Service Specific Prepayment Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code J2260. The final edit effectiveness results from January 2017 through August 2017 are as follows:

- The J2260 review involved 57 claims, of which 31 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 48%.

Top Denial Reasons

- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Proof of Delivery (POD) is dated prior to the date of service of the claim.
- Documentation does not support coverage criteria.
- Refill request was not received.

For further detail see, External Infusion Pumps (HCPCS J2260) Final Edit Effectiveness Results of Service Specific Prepayment Review.

Glucose Monitors (HCPCS A4253) Final Edit Effectiveness Results of Service Specific Prepayment Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code A4253. The final edit effectiveness results from April 2017 through September 2017 are as follows:

- The A4253 review involved 571 claims, of which 546 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 90%.

Top Denial Reasons

- Medical documentation was not received.
- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Documentation does not support high utilization.
- An incorrect modifier was billed on the claim.

For further detail see, Glucose Monitors (HCPCS A4253) Final Edit Effectiveness Results of Service Specific Prepayment Review.

Hospital Beds (HCPCS E0250) Final Edit Effectiveness Results of Service Specific Prepayment Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code E0250. The final edit effectiveness results from January 2017 through April 2017 are as follows:

- The E0250 review involved 109 claims, of which 54 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 56%.

Top Denial Reasons

- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Documentation does not support coverage criteria for a fixed height hospital bed.
- Proof of Delivery (POD) is dated prior to the date of service of the claim.
- Claim is a duplicate to a previously submitted claim.

For complete detail see, Hospital Beds (HCPCS E0250) Final Edit Effectiveness Results of Service Specific Prepayment Review.

Knee-Ankle-Foot Orthosis Final Edit Effectiveness Results of Service Specific Prepayment Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code L2000, L2005, L2010, L2020, L2030, L2034, L2035, L2036, L2037, L2038, L2126, L2128, L2132, L2134 and L2136. The final edit effectiveness results from January 2017 through September 2017 are as follows:

- The KAFO review involved 8 claims, of which 7 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 67%.

Top Denial Reasons

- Claim is the same or similar to another claim on file.
- The documentation does not include verification that the equipment was lost, stolen, or irreparably damaged in a specific incident.
- Proof of Delivery (POD) was not received.
- Claim is a duplicate to a previously submitted claim.

For complete detail see, Knee-Ankle-Foot Orthosis Final Edit Effectiveness Results of Service Specific Prepayment Review.

Knee Orthoses Final Edit Effectiveness Results of Service Specific Prepayment Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code L1810, L1812, L1820, L1830, L1831, L1832, L1833, L1834, L1836, L1840, L1843, L1844, L1845, L1846, L1847, L1848, L1850, L1851, L1852 and L1860. The final edit effectiveness results from April 2017 through September 2017 are as follows:

- The KO review involved 946 claims, of which 886 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 94%.

Top Denial Reasons

- The documentation does not include verification that the equipment was lost, stolen, or irreparably damaged in a specific incident.
- Claim is the same or similar to another claim on file.

- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Documentation does not support coverage criteria.

For complete detail see, Knee Orthoses Final Edit Effectiveness Results of Service Specific Prepayment Review.

Knee Orthosis (HCPCS L1832, L1843) Final Edit Effectiveness Results of Service Specific Prepayment Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code L1832 and L1843. The final edit effectiveness results from April 2017 through August 2017 are as follows:

- The L1832 review involved 158 claims, of which 157 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 99%.
- The L1843 review involved 158 claims, of which 155 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 97%.

Top Denial Reasons

- Documentation does not support custom fit criteria.
- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Documentation does not support coverage criteria.
- Proof of Delivery (POD) is incomplete or missing elements.

For further detail see, Knee Orthosis (HCPCS L1832, L1843) Final Edit Effectiveness Results of Service Specific Prepayment Review.

Knee Orthosis (HCPCS L1833) Final Edit Effectiveness Results of Service Specific Prepayment Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code L1833. The final edit effectiveness results from March 2017 through September 2017 are as follows:

- The L1833 review involved 1,822 claims, of which 1,519 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 85%.

Top Denial Reasons

- Documentation does not support coverage criteria.
- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Proof of Delivery (POD) is incomplete or missing elements.
- Medical documentation was not received.

For further detail see, Knee Orthosis (HCPCS L1833) Final Edit Effectiveness Results of Service Specific Prepayment Review.

Manual Wheelchairs (HCPCS K0001, K0003) Final Edit Effectiveness Results of Service Specific Prepayment Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code K0001 and K0003. The final edit effectiveness results from April 2017 through August 2017 are as follows:

- The K0001 review involved 1,454 claims, of which 731 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 46%.
- The K0003 review involved 343 claims, of which 240 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 65%.

Top Denial Reasons

- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Documentation does not support coverage criteria.
- Documentation does not support coverage criteria for a lightweight wheelchair.
- Written Order Prior to Delivery (WOPD) was not received.

For complete detail see, Manual Wheelchairs (HCPCS K0001, K0003) Final Edit Effectiveness Results of Service Specific Prepayment Review.

Nebulizer (HCPCS J7682) Final Edit Effectiveness Results of Service Specific Prepayment Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code J7682. The final edit effectiveness results from February 2017 through September 2017 are as follows:

- The J7682 review involved 54 claims, of which 33 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 51%.

Top Denial Reasons

- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Medical documentation was not received.
- Refill request was not received.
- Detailed Written Order (DWO) was signed after the date of service and dispensing order was not received.

For complete detail see, Nebulizer (HCPCS J7682) Final Edit Effectiveness Results of Service Specific Prepayment Review.

Oxygen and Oxygen Equipment (HCPCS E0431) Final Edit Effectiveness Results of Service Specific Prepayment Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code E0431. The final edit effectiveness results from February 2017 through August 2017 are as follows:

- The E0431 review involved 887 claims, of which 461 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 54%.

Top Denial Reasons

- Documentation does not support coverage criteria.
- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Documentation does not support a qualifying blood gas study.
- Written Order Prior to Delivery (WOPD) was not received.

For complete detail see, Oxygen and Oxygen Equipment (HCPCS E0431) Final Edit Effectiveness Results of Service Specific Prepayment Review.

Oxygen and Oxygen Equipment (HCPCS E0439 and E0434) Final Edit Effectiveness Results of Service Specific Prepayment Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code E0439 and E0434. The final edit effectiveness results from January 2017 through September 2017 are as follows:

- The E0439 review involved 153 claims, of which 71 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 47%.
- The E0434 review involved 136 claims, of which 61 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 36%.

Top Denial Reasons

- Documentation does not support coverage criteria.
- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Documentation does not support a qualifying blood gas study.
- Proof of Delivery (POD) is dated after the date of service of the claim.

For complete detail see, Oxygen and Oxygen Equipment (HCPCS E0439 and E0434) Final Edit Effectiveness Results of Service Specific Prepayment Review.

Oxygen and Oxygen Equipment (HCPCS E0439 and E0434) Final Edit Effectiveness Results of Service Specific Prepayment Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code E0439 and E0434. The final edit effectiveness results from June 2017 through August 2017 are as follows:

- The E0439 review involved 24 claims, of which 8 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 30%.
- The E0434 review involved 37 claims, of which 12 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 20%.

Top Denial Reasons

- Written Order Prior to Delivery (WOPD) was not received.
- Documentation does not support coverage criteria.

- Proof of Delivery (POD) was not received.
- Documentation was not received in response to the Additional Documentation Request (ADR) letter.

For further details see, Oxygen and Oxygen Equipment (HCPCS E0439 and E0434) Final Edit Effectiveness Results of Service Specific Prepayment Review.

Oxygen and Oxygen Equipment (HCPCS E1390) Final Edit Effectiveness Results of Service Specific Prepayment Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code E1390. The final edit effectiveness results from March 2017 through September 2017 are as follows:

- The E1390 review involved 5,587 claims, of which 2,623 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 48%.

Top Denial Reasons

- Documentation does not support coverage criteria.
- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Documentation does not support a qualifying blood gas study.
- Medical record documentation was not authenticated (handwritten or electronic) by the author.

For complete detail see, Oxygen and Oxygen Equipment (HCPCS E1390) Final Edit Effectiveness Results of Service Specific Prepayment Review.

Pressure Reducing Support Surface-Group 1 (HCPCS E0181 E0185) Final Edit Effectiveness Results of Service Specific Prepayment Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code E0181 and E185. The final edit effectiveness results from February 2017 through September 2017 are as follows:

- The E0181 review involved 221 claims, of which 100 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 59%.
- The E0185 review involved 321 claims, of which 96 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 33%.

Top Denial Reasons

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

For complete detail see, Pressure Reducing Support Surface-Group 1 (HCPCS E0181 E0185) Final Edit Effectiveness Results of Service Specific Prepayment Review.

Pressure Reducing Support Surface-Group 1 (HCPCS E0181 E0185) Final Edit Effectiveness Results of Service Specific Prepayment Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code E0181 and E185. The final edit effectiveness results from May 2017 through August 2017 are as follows:

- The E0181 review involved 44 claims, of which 20 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 64%.
- The E0185 review involved 50 claims, of which 17 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 34%.

Top Denial Reasons

- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Documentation does not support coverage criteria.
- Medical documentation was not received.
- Proof of Delivery (POD) is incomplete or missing elements.

For complete detail see, Pressure Reducing Support Surface-Group 1 (HCPCS E0181 E0185) Final Edit Effectiveness Results of Service Specific Prepayment Review.

Spinal Orthoses (HCPCS L0631, L0637) Final Edit Effectiveness Results of Service Specific Prepayment Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code L0631 and L0637. The final edit effectiveness results from March 2017 through August 2017 are as follows:

- The L0631 review involved 159 claims, of which 156 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 98%.
- The L0637 review involved 169 claims, of which 162 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 96%.

Top Denial Reasons

Documentation does not support custom fit criteria.

Documentation was not received in response to the Additional Documentation Request (ADR) letter.

Documentation does not support PDAC approval.

Documentation does not support coverage criteria.

For further detail see, Spinal Orthoses (HCPCS L0631, L0637) Final Edit Effectiveness Results of Service Specific Prepayment Review.

Spinal Orthosis Final Edit Effectiveness Results of Service Specific Prepayment Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code L0450, L0452, L0454-L0458, L0460, L0462, L0464, L0466-L0470, L0472, L0480, L0482, L0484, L0486, L0488, L0490-L0492, L0621, L0623, L0625-L0643 and L0648-L0651. The final edit effectiveness results from February 2017 through September 2017 are as follows:

- The TLSO review involved 63 claims, of which 61 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 97%.
- The LSO review involved 962 claims, of which 948 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 100%.
- The SO review involved 18 claims, of which 16 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 90%.
- The LO review involved 232 claims, of which 231 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 99%.

Top Denial Reasons

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

For complete detail see, Spinal Orthosis Final Edit Effectiveness Results of Service Specific Prepayment Review.

Spinal Orthosis (HCPCS L0648, L0650) Final Edit Effectiveness Results of Service Specific Prepayment Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code L0648 and L0650. The final edit effectiveness results from April 2017 through August 2017 are as follows:

- The L0648 review involved 477 claims, of which 353 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 74%.
- The L0650 review involved 1,695 claims, of which 1,219 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 72%.

Top Denial Reasons

- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Documentation does not support coverage criteria.
- Proof of Delivery (POD) is incomplete or missing elements.
- Medical documentation was not received.

For further detail see, Spinal Orthosis (HCPCS L0648, L0650) Final Edit Effectiveness Results of Service Specific Prepayment Review.

Targeted Probe and Educate (TPE) Reminder

Beginning July 3, 2017, CMS has authorized Jurisdiction D to conduct the TPE review process. TPE will include up to three rounds of supplier-specific prepayment probe review with a focus on one-on-one education throughout the process to improve identified errors. The goal of TPE is to improve the claims payment error rate and reduce the volume of appeals through claim review and education.

If a high error rate persists following three rounds of review and education, Noridian will refer the supplier to CMS for possible further action. In addition, discontinuation of TPE may occur at the conclusion of any round if sufficient improvement is achieved through claim review.

For complete details see the Targeted Probe and Educate (TPE) webpage.

Transcutaneous Electrical Nerve Stimulator (TENS) (HCPCS E0730) Final Edit Effectiveness Results of Service Specific Prepayment Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code E0730. The final edit effectiveness results from February 2017 through September 2017 are as follows:

- The E0730 review involved 27 claims, of which 24 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 92%.

Top Denial Reasons

- Certificate of Medical Necessity (CMN) was incomplete or missing elements.
- Documentation does not meet the trial rental period general requirements.
- Proof of Delivery (POD) is illegible.
- Documentation does not demonstrate chronic, intractable pain other than chronic low back pain.

For complete detail see, Transcutaneous Electrical Nerve Stimulator (TENS) (HCPCS E0730) Final Edit Effectiveness Results of Service Specific Prepayment Review.

Therapeutic Shoes (HCPCS A5500) Final Edit Effectiveness Results of Service Specific Prepayment Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code A5500. The final edit effectiveness results from March 2017 through August 2017 are as follows:

- The A5500 review involved 4,114 claims, of which 2,679 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 64%.

Top Denial Reasons

- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Documentation does not support coverage criteria.
- Medical documentation was not received.
- Documentation received is illegible.

For complete detail see, Therapeutic Shoes (HCPCS A5500) Final Edit Effectiveness Results of Service Specific Prepayment Review.

Urological Supplies (HCPCS A4351, A4353, A4358) Final Edit Effectiveness Results of Service Specific Prepayment Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code A4351, A4353 and A4358. The final edit effectiveness results from April 2017 through September 2017 are as follows:

- The A4351 review involved 1,442 claims, of which 656 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 43%.
- The A4353 review involved 188 claims, of which 131 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 60%.
- The A4358 review involved 1,382 claims, of which 906 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 60%.

Top Denial Reasons

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

For complete detail see, Urological Supplies (HCPCS A4351, A4353, A4358) Final Edit Effectiveness Results of Service Specific Prepayment Review.

RT and LT Modifiers on the Same Claim Line for Capped Rental Items – Update

Effective July 3, 2017 the Common Electronic Data Interchange (CEDI) has removed the claim editing requirement for the RT and LT modifiers to be included in the second and third position on the claim line for bilateral Capped Rental items when two units of service are billed.

This change will impact codes that need to be submitted with more than four modifiers on the same claim line. As a result of this change, the RT and LT modifier should be included in the narrative field and the applicable pricing and informational modifiers should be on the claim line.

All codes requiring more than four modifiers must list the 99 modifier in the fourth position on the claim line with additional modifiers reported in the narrative field.

An example of modifiers included for a bilateral capped rental repair replacement code billed with two units are as follows:

Claim line = NU KH KX 99

Narrative = RB RT LT (and all other applicable modifiers)

Remember to continue billing with two units of service for these types of claims. For additional information, visit the following pages on the Noridian website.

- Modifiers
- Power Mobility Devices (PMDs)
- Capped Rental Items

Claim Status Category Codes and Claim Status Codes Update

MLN Matters Number: MM10271
Related Change Request (CR) Number: 10271
Related CR Release Date: November 9, 2017
Effective Date: April 1, 2018
Related CR Transmittal Number: R3916CP
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 services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

Change Request (CR) 10271 informs MACs about system changes to update, as needed, the Claim Status Codes and Claim Status Category Codes used for the Accredited Standards Committee (ASC) X12 276/277 Health Care Claim Status Request and Response and ASC X12 277 Health Care Claim Acknowledgment transactions. Make sure your billing staffs are aware of these changes.

BACKGROUND

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires all covered entities to use only Claim Status Category Codes and Claim Status Codes approved by the National Code Maintenance Committee in the ASC X12 276/277 Health Care Claim Status Request and Response transaction standards adopted under HIPAA for electronically submitting health care claims status requests and responses. These codes explain the status of submitted claim(s). Proprietary codes may not be used in the ASC X12 276/277 transactions to report claim status.

The National Code Maintenance Committee meets at the beginning of each ASC X12 trimester meeting (January/February, June, and September/October) and makes decisions about additions, modifications, and retirement of existing codes. The National Code Maintenance Committee has decided to allow the industry 6 months for implementation of newly added or changed codes.

The codes sets are available at http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-category-codes/ and http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-codes/.

Included in the code lists are specific details, including the date when a code was added, changed, or deleted. All code changes approved during the January 2018 committee meeting will be posted on these sites on or about February 1, 2018.

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

These code changes are to be used in editing of all ASC X12 276 transactions processed on or after the date of implementation and to be reflected in the ASC X12 277 transactions issued on and after the date of implementation of Change Request (CR) 10271.

Note: References in CR 10271 to "277 responses" and "claim status responses" encompass both the ASC X12 277 Health Care Claim Status Response and the ASC X12 277 Healthcare Claim Acknowledgment transactions.

ADDITIONAL INFORMATION

The official instruction, CR10271, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3916CP.pdf.

DOCUMENT HISTORY

Date of Change	Description
November 13, 2017	Initial article released.

MSP Liability Insurance Billing Situations

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

PROVIDER TYPE AFFECTED

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

PROVIDER ACTION NEEDED

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

BACKGROUND

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

The options when seeking payment from the liability insurance, and the obligations and restrictions that accompany them, are discussed with more specificity in the "Internet Only Medicare Secondary Payer

Manual" (Pub 100-05), Chapter 2, Section 40.2 found at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/msp105c02.pdf. See also, MLN Matters Article MM7355 "Clarification of Medicare Conditional Payment Policy and Billing Procedures for Liability, No-Fault, and Workers' Compensation (WC) Medicare Secondary Payer (MSP) Claims". This article is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7355.pdf. (Although not the subject of this article, the instructions for situations involving no-fault insurance or workers' compensation benefits can be found in Chapter 3 of the MSP Manual.)

FAQs for Liability Insurance (Including Self-Insurance) Billing

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

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

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

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

Q3. What is the Oregon rule?

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

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

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

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

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

- All such claims/liens must be withdrawn (except for claims related to items or services not covered by Medicare and for Medicare deductibles and co-insurance) when the provider, physician, or other supplier bills Medicare or when Medicare's timely filing period has expired – whichever occurs first.
- If there is a settlement, judgment, award, or other payment before the timely filing period expires, the provider, physician, or supplier may maintain its claim/lien despite the expiration of the timely filing period.
- All such claims/liens are limited by state lien laws/requirements. The MSP provisions do not create lien rights when those rights do not exist under state law.
- Under the Oregon rule all such claims/liens must be withdrawn following the expiration of the applicable 120 day period.

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

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

- Is limited to the Medicare approved amount (limiting charge when non-assigned) once they have billed Medicare, even if they return any payment received from Medicare.
- May charge actual charges but is limited to the amount available from the settlement less applicable procurement costs (for example, attorney fees, other litigation costs).
- May only bill for non-covered services, or co-insurance and deductibles, if Medicare timely filing has expired before payment or settlement. (In this context, non-covered services are the program exclusions such as measuring of eye refractions or services rendered to family members. Medical necessity denials are not included and are not billable in the example.)
- May not collect from the beneficiary until the proceeds are available to the beneficiary.

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

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

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

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

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

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

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

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

ADDITIONAL INFORMATION

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

DOCUMENT HISTORY

Date of Change	Description
September 19, 2017	Initial article released.

Submit KE Modifier Claims to Written Reopenings Now

KE modifier claims may now be submitted to written reopenings for the Cures Act Adjustments. Noridian notified suppliers on August 25 that the Cures Act adjustments have all been initiated and most claims are finalized so we are ready to accept KE modifier reopening requests.

For more information on submitting KE modifier written reopening requests, see the CR9968 CURES Act Fee Schedule Adjustments webpage.

New Claim Situations for Cures Act Adjustments

Noridian has identified some claim processing situations that we wanted to bring to our supplier's attention.

Oxygen Concentrators: Some claims adjusted for the Cures Act adjustments are denying with code N370 (Billing exceeds the rental months covered/approved by the payer) rather than paying the last month of rental, i.e. only 35 rental payments were made. Noridian is aware of this system issue and is working with the system maintainer for resolution. In the interim, we will adjust claims brought to our attention. Call the Contact Center to report these instances for correction.

Temporary Replacement of Beneficiary Owned Equipment (K0462): Noridian reviews this code to assure that accurate payment has been made by suspending each claim for manual review. If you feel the claim was underpaid or denied in error, the next step is to submit an appeal.

Heated Humidifier (E0562): This inexpensive and routinely purchased (IRP) item when billed as a rental, in some cases, did not process appropriately during the adjustment. Any IRP item billed as a rental will pay up to the fee schedule allowance. If the rental began prior to July 1, 2016, no additional payments will be made on claims for July 1, 2016, through December 31, 2016 dates of service because the fee schedule amount was already in effect. Noridian is reviewing the claim adjustments to verify accurate payment. If claims need to be adjusted again, Noridian will handle the adjustments.

Wheelchair Accessories Codes Changed to E1399 for Cures Act Adjustments

In order to process wheelchair accessories claims adjusted by the Cures Act, in some cases, Noridian may need to change the submitted HCPCS code to E1399 with a "cc" modifier (code change). This step is needed to pay the correct amount. There are various billing and modifier rules that cannot be accommodated with the limitation of four modifiers for pricing and system edits on the submitted wheelchair accessory HCPCS. The best solution is to change the HCPCS to E1399 with a "cc" modifier.

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

MLN Matters Number: SE17021 Revised

Article Release Date: November 28, 2017

This article was revised on November 28, 2017, to advise providers that the public health emergency declaration and Section 1135 waiver authority expired on November 24, 2017. All other information remains the same.

PROVIDER TYPES AFFECTED

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

PROVIDER INFORMATION AVAILABLE

On August 28, 2017, pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act, President Trump declared that, as a result of the effects of Tropical Storm Harvey, an emergency exists in the State of Louisiana, retroactive to August 27, 2017. Also on August 28, 2017, Secretary Price of the Department of Health & Human Services declared that a public health emergency exists in the State of Louisiana and authorized waivers and modifications under Section 1135 of the Social Security Act (the Act), retroactive to August 27, 2017. The Public Health Emergency declaration and Social Security Act waivers including the Section 1135 waiver authority expired on November 24, 2017.

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

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

BACKGROUND

Section 1135 and Section 1812(f) Waivers

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

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

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

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

effective August 27, 2017, for Louisiana.

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

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 **Louisiana**. Individual facilities do not need to apply for the following approved blanket waivers:

Skilled Nursing Facilities

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

Home Health Agencies

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

Critical Access Hospitals

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

Housing Acute Care Patients In Excluded Distinct Part Units

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

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

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

For more information refer to the Emergency 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.

Application Deadline Extended for Reclassifications Submission to MGCRB

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

Deadline Extended for IPPS Wage Index Requests

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

Facilities Quality Reporting

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

Medicare-dependent small, rural hospitals (MDHs)

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

Low-volume hospital

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

Appeal Administrative Relief for Areas Affected by Tropical Storm Harvey

If you were affected by Tropical Storm Harvey and are unable to file an appeal within 120 days from the date of receipt of the Remittance Advice (RA) that lists the initial determination or will have an extended

period of non-receipt of remittance advices that will impact your ability to file an appeal, please contact your Medicare Administrative Contractor.

Replacement Prescription Fills

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
November 28, 2017	The article was revised to advise providers that the public health emergency declaration and Section 1135 waiver authority expired on November 24, 2017. All other information remains the same.
September 19, 2017	The article was revised to include information regarding replacement prescription fills of covered Part B drugs. All other information remains the same.
September 7, 2017	The article was revised to include additional waiver information about emergency durable medical equipment, prosthetics, orthotics, and supplies for Medicare beneficiaries impacted by Hurricane Harvey. All other information remains the same.
September 5, 2017	The article was revised on September 5, 2017, to include additional information about housing acute care patients in excluded distinct part units. In addition, information has been added to the Facilities Quality Reporting Section on page 4 and the second paragraph of the Provider Information Available section is modified to clarify that waivers prevent gaps in access to care.
September 1, 2017	The article was revised to include additional waiver information for Medicare-dependent small, rural hospitals and for low-volume hospitals. Information regarding administrative relief related to timely filing of appeals was added. All other information remained the same.
August 31, 2017	Initial article released.

Hurricane Harvey and Medicare Disaster Related Texas Claims – Fifth Revision

MLN Matters Number: SE17020 Revised
Article Release Date: November 28, 2017

This article was revised on November 28, 2017, to advise providers that the public health emergency declaration and Section 1135 waiver authority expired on November 22, 2017. All other information remains the same.

PROVIDER TYPE AFFECTED

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

PROVIDER INFORMATION AVAILABLE

On August 26, 2017, pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act, President Trump declared that, as a result of the effects of Hurricane Harvey, an emergency exists in the State of Texas, retroactive to August 25, 2017. Also on August 26, 2017, Secretary Price of the Department of Health & Human Services declared that a public health emergency exists in the State of Texas and authorized waivers and modifications under Section 1135 of the Social Security Act (the Act), retroactive to August 25, 2017. The Public Health Emergency declaration and Social Security Act waivers including the Section 1135 waiver authority expired on November 22, 2017.

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

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

BACKGROUND

Section 1135 and Section 1812(f) Waivers

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

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

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

- The first listed file addresses policies and procedures that are applicable without any Section 1135 or other formal waiver. These policies are always applicable in any kind of emergency or disaster, including the current emergency in Texas.
- The second file addresses policies and procedures that are applicable only with approved Section 1135 waivers or, when applicable, approved Section 1812(f) waivers. These Q&As are applicable for approved Section 1135 blanket waivers and approved individual 1135 waivers requested by providers and are effective August 25, 2017, for Texas.

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

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 **Texas**. Individual facilities do not need to apply for the following approved blanket waivers:

Skilled Nursing Facilities

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

Home Health Agencies

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

Critical Access Hospitals

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

Housing Acute Care Patients In Excluded Distinct Part Units

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

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

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

For more information refer to the Emergency 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.

Application Deadline Extended for Reclassifications Submission to MGCRB

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

Deadline Extended for IPPS Wage Index Requests

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

Facilities Quality Reporting

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

Medicare-dependent small, rural hospitals (MDHs)

In accordance with Waivers or Modifications of Requirements under Section 1135 of the Social Security Act issued August 26, 2017 by Secretary Price, CMS is modifying the September 1, 2017 deadline for Medicare-dependent small, rural hospitals (MDHs) to apply for sole community hospital (SCH) status in advance of the expiration of the MDH program with an effective date of an approval of SCH status that is the day following the expiration date of the MDH program (that is, September 30, 2017 under current law). CMS is currently granting a 31-day extension to the deadline at § 412.92(b)(2)(v) for the State of Texas. If a hospital located in these areas that is classified as an MDH applies for classification as an SCH under the provisions of § 412.92(b)(2)(v), and that hospital's SCH status is approved, the effective date of approval of SCH status will be the day following the expiration date of the MDH program if such hospital applies for classification as a SCH not later than October 2, 2017.

Low-volume hospital

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

Appeal Administrative Relief for Areas Affected by Hurricane Harvey

If you were affected by Hurricane Harvey and are unable to file an appeal within 120 days from the date of receipt of the Remittance Advice (RA) that lists the initial determination or will have an extended period

of non-receipt of remittance advices that will impact your ability to file an appeal, please contact your Medicare Administrative Contractor.

Replacement Prescription Fills

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

Moratoria on Part B Non-emergency Ambulance Suppliers

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

Requesting an 1135 Waiver

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

ADDITIONAL INFORMATION

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

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
November 28, 2017	The article was revised to advise providers that the public health emergency declaration and Section 1135 waiver authority expired on November 22, 2017. All other information remains the same.
September 19, 2017	The article was revised to include information about replacement prescription fills of covered Part B drugs. All other information remains the same.
September 7, 2017	The article was revised to include additional waiver information about emergency durable medical equipment, prosthetics, orthotics, and supplies for Medicare beneficiaries impacted
September 5, 2017	The article was revised on September 5, 2017, to include additional information about housing acute care patients in excluded distinct part units and lifting the temporary enrollment moratoria on Part B non-emergency ambulance suppliers in Texas. In addition, information has been added to the Facilities Quality Reporting Section and the second paragraph of the Provider Information Available section is modified to clarify that waivers prevent gaps in access to care.
September 1, 2017	The article was revised to include additional waiver information for Medicare-dependent small, rural hospitals and for low-volume hospitals. Information regarding administrative relief related to timely filing of appeals was added. All other information remained the same.
August 31, 2017	Initial article released.

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

MLN Matters Number: SE17022 Revised

Article Release Date: September 19, 2017

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

PROVIDER TYPE AFFECTED

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

PROVIDER INFORMATION AVAILABLE

On September 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.

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

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

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

BACKGROUND

Section 1135 and Section 1812(f) Waivers

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

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

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

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

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

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

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

Blanket Waivers Issued by CMS

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

Skilled Nursing Facilities

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

Home Health Agencies

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

Critical Access Hospitals

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

Housing Acute Care Patients In Excluded Distinct Part Units

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

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

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

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

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

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

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

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 – This information added on September 19, 2017.

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

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

Requesting an 1135 Waiver

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

ADDITIONAL INFORMATION

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

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
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 – Second Revision

MLN Matters Number: SE17024 Revised
Article Release Date: September 19, 2017

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

PROVIDER TYPES AFFECTED

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

PROVIDER INFORMATION AVAILABLE

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

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

Under Section 1135 or 1812(f) of the Social Security Act, the CMS has issued several blanket waivers in the impacted counties and geographical areas of the States of South Carolina and Georgia. These waivers will prevent gaps in access to care for beneficiaries impacted by the emergency. Providers do not need to apply

for an individual waiver if a blanket waiver has been issued. Providers can request an individual Section 1135 waiver, if there is no blanket waiver, by following the instructions available at https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Requesting-an-1135-Waiver-Updated-11-16-2016.pdf.

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

BACKGROUND

Section 1135 and Section 1812(f) Waivers

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

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

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

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

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

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

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

Blanket Waivers Issued by CMS

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

Skilled Nursing Facilities

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

Home Health Agencies

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

Critical Access Hospitals

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

Housing Acute Care Patients In Excluded Distinct Part Units

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

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

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

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

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

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

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

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 – This information added on September 19, 2017.

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

Requesting an 1135 Waiver

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

ADDITIONAL INFORMATION

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

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
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 Maria and Medicare Disaster Related United States Virgin Islands and Commonwealth of Puerto Rico Claims - Revised

MLN Matters Number: SE17028 Revised

Article Release Date: October 2, 2017

The article was updated on October 2, 2017, to include the section on Applicability of Reporting Requirements for Inpatient Psychiatric Facilities, Skilled Nursing Facilities, Home Health Agencies, Hospices, Inpatient Rehabilitation Facilities, Ambulatory Surgical Centers, and Renal Dialysis Facilities Affected by Hurricane Maria. 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 and the Commonwealth of Puerto Rico who were affected by Hurricane Maria.

PROVIDER INFORMATION AVAILABLE

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

On September 19, 2017, the Administrator of the Centers for Medicare & Medicaid Services (CMS) authorized waivers under Section 1812(f) of the Social Security Act for the United States Virgin Islands

and the Commonwealth of Puerto Rico, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of Hurricane Maria in 2017.

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

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

BACKGROUND

Section 1135 and Section 1812(f) Waivers

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

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

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

- One file addresses policies and procedures that are applicable without any Section 1135 or other formal waiver. These policies are always applicable in any kind of emergency or disaster, including the current emergency in the United States Virgin Islands and the Commonwealth of Puerto Rico.
- Another file addresses policies and procedures that are applicable only with approved Section 1135 waivers or, when applicable, approved Section 1812(f) These Q&As are applicable for approved Section 1135 blanket waivers and approved individual 1135 waivers requested by providers and are effective September 16, 2017, for the United States Virgin Islands and September 17, 2017, or the Commonwealth of Puerto Rico.

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

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

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

Blanket Waivers Issued by CMS

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

Skilled Nursing Facilities

- Section 1812(f): Waiver of the requirement for a 3-day prior hospitalization for coverage of a skilled nursing facility (SNF) stay provides temporary emergency coverage of SNF services without a qualifying hospital stay, for those people who are evacuated, transferred, or otherwise dislocated as a result of

the effect of Hurricane Maria in the United States Virgin Islands and the Commonwealth of Puerto Rico in 2017. In addition, for certain beneficiaries who recently exhausted their SNF benefits, it authorizes renewed SNF coverage without first having to start a new benefit period. (Blanket waiver for all impacted facilities)

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

Home Health Agencies

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

Critical Access Hospitals

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

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

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

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

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

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 Maria

If you were affected by Hurricane Maria 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.

Applicability of Reporting Requirements for Inpatient Psychiatric Facilities, Skilled Nursing Facilities, Home Health Agencies, Hospices, Inpatient Rehabilitation Facilities, Ambulatory Surgical Centers, and Renal Dialysis Facilities Affected by Hurricane Maria – This information added on October 2, 2017.

CMS is granting exceptions under certain Medicare quality reporting and value-based purchasing programs to inpatient psychiatric facilities, skilled nursing facilities, home health agencies, hospices, inpatient rehabilitation facilities, renal dialysis facilities, and ambulatory surgical centers located in areas affected by Hurricane Maria due to the devastating impact of the storm. These providers will be granted exceptions without having to submit an Extraordinary Circumstances Exceptions (ECE) request if they are located in one of the 78 Puerto Rico municipios or one of the three U.S. Virgin Islands county-equivalents, all of which have been designated by the Federal Emergency Management Agency (FEMA) as a major disaster municipio or county-equivalent.

The scope and duration of the exception under each Medicare quality reporting program is described in the memorandum that CMS posted on September 25, 2017, however, all of the exceptions are being granted to assist these providers while they direct their resources toward caring for their patients and repairing structural damages to facilities.

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
October 2, 2017	The article was updated to include the section on Applicability of Reporting Requirements for Inpatient Psychiatric Facilities, Skilled Nursing Facilities, Home Health Agencies, Hospices, Inpatient Rehabilitation Facilities, Ambulatory Surgical Centers, and Renal Dialysis Facilities Affected by Hurricane Maria. All other information remains the same.
September 21, 2017	Initial article released.

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

MLN Matters Number: SE17034

Article Release Date: October 11, 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 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.

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) 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 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
October 11, 2017	Initial article released.

Medicare FFS Response to the 2017 California Wildfires - Revised

MLN Matters Number: SE17035 Revised

Article Revised Date: November 1, 2017

This article was revised on November 1, 2017, to add information regarding the exceptions granted for certain Medicare quality reporting and value-based purchasing programs. All other information is unchanged.

PROVIDER TYPES AFFECTED

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

PROVIDER INFORMATION AVAILABLE

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

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

On October 17, 2017, the Administrator of the Centers for Medicare & Medicaid Services (CMS) authorized waivers under §1812(f) of the Social Security Act for the State of California retroactive to October 8, 2017 for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of wildfires. Providers can request an individual Section 1135 waiver by following the instructions available at https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Requesting-an-1135-Waiver-Updated-11-16-2016.pdf.

BACKGROUND

Section 1135 and Section 1812(f) Waivers

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

Change Request (CR) 6451 (Transmittal 1784, Publication 100-04) issued on July 31, 2009, applies to items and services furnished to Medicare beneficiaries within the State of California retroactive to October 8, 2017, for the duration of the emergency. In accordance with CR6451, use of the "DR" condition code and the "CR" modifier are mandatory on claims for items and services for which Medicare payment is conditioned on the presence of a "formal waiver" including, but not necessarily limited to, waivers granted under either Section 1135 or Section 1812(f) of the Act.

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

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

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

Another file addresses policies and procedures that are applicable only with approved Section 1135 waivers or, when applicable, approved Section 1812(f) waivers. These Q&As are applicable for approved individual 1135 waivers requested by providers for California.

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

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

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

Waiver for California

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

Skilled Nursing Facilities

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

Administrative Relief

Appeal Administrative Relief for Areas Affected by California Wildfires

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

Requesting an 1135 Waiver

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

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

Medicare Quality Reporting and Value-based Purchasing Programs

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

DOCUMENT HISTORY

Date of Change	Description
November 1, 2017	This article was revised to add information regarding the exceptions granted for certain Medicare quality reporting and value-based purchasing programs.
October 18, 2017	Initial article released.

Immunosuppressive Drugs Billing Clarification

MLN Matters Number: MM10235
Related Change Request (CR) Number: 10235
Related CR Release Date: September 1, 2017
Related CR Transmittal Number: R3856CP
Effective Date: October 2, 2017
Implementation Date: October 2, 2017

PROVIDER TYPE AFFECTED

This MLN Matters Article is intended for suppliers billing Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

Change Request (CR) 10235 updates language in the "Medicare Claims Processing Manual,"

Chapter 17 (Drugs and Biologicals), Section 80.3 (Billing for Immunosuppressive Drugs), to remove a double negative statement and provide clear guidance to suppliers for when you may bill Medicare for immunosuppressive drugs. It provides no change in policy.

BACKGROUND

This section provides details to the updated manual section, which is a part of CR10235.

Following a beneficiary's organ transplant, Medicare covers their immunosuppressive drugs in accordance with 1861(s)(2)(J) of the Social Security Act (the Act); which states that Medicare covers "prescription drugs used in immunosuppressive therapy furnished to an individual who receives an organ transplant for which payment is made under this title."

In the billing for immunosuppressive drugs, there are circumstances in which Medicare cannot locate, in Medicare's claims database, the claim that would have confirmed that Medicare paid for the transplant. The claim may not appear in the database for reasons such as:

- At the time of the transplant, the beneficiary was enrolled in a Medicare Advantage plan that paid for the transplant. (Medicare Advantage data is not included in the Medicare Fee-For-Service (FFS) claims database). Although some encounter data may be available, it may be incomplete or may not contain coding information sufficient to identify a transplant claim.
- There may be instances in which claims related to a transplant are old and may not be identifiable in the claims database despite Medicare's payment for the claim.

In these circumstances, your submission of the KX modifier (Specific Required Documentation on File) in the claim permits Medicare to make a reasonable assumption that: 1) You have documentation on file that indicates the date of the transplant, 2) The services furnished are medically necessary, and 3) Medicare paid for the transplant in accordance with the statute.

The use of the KX modifier is not required, but you should be aware that your DME MACs will accept claims for immunosuppressive drugs, received on and after July, 2008, without a KX modifier; but will deny the claim if the Centers for Medicare & Medicaid Services (CMS) cannot identify a record of a claim indicating that the transplant was paid for by Medicare FFS.

Further, if you furnish an immunosuppressive drug to a Medicare beneficiary, prescribed because the beneficiary had undergone an organ transplant; and, on and after July 1, 2008, submit a claim for this service that contains the KX modifier, you must:

- Secure from the prescriber the date of such organ transplant and retain documentation of such transplant date in your files.
- Attest that you have documentation on file that the beneficiary was eligible to receive Medicare Part A benefits at the particular date of the transplant and retain the documentation in your files.
- Retain such documentation of the beneficiary's transplant date, Medicare Part A eligibility, and that such transplant date precedes the Date of Service (DOS) for furnishing the drug.

ADDITIONAL INFORMATION

The official instruction, CR10235, issued to your MAC regarding this change, is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3856CP.pdf.

Pharmacy Billing of Immunosuppressive Drugs

MLN Matters Number: SE17032

Article Release Date: October 17, 2017

PROVIDER TYPES AFFECTED

This MLN Matters Special Edition (SE) Article is intended for pharmacies billing Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for immunosuppressive drugs provided to Medicare beneficiaries who received an organ transplant that was paid for by Medicare.

PROVIDER ACTION NEEDED

Change Request (CR) 10235 highlighted updated language in the Medicare Claims Processing Manual, Chapter 17, Section 80.3. (Billing for Immunosuppressive Drugs) regarding the use of the KX modifier for certain claims for immunosuppressive drugs. See the related MLN Matters article (MM10235) at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network- MLN/MLNMattersArticles/Downloads/MM10235.pdf. CR10235 also provided guidance to the MACs to abide by the updated language on processing claims for immunosuppressive drugs.

This article reminds pharmacy billing staff of the appropriate process for billing Medicare for immunosuppressive drugs using the KX modifier. This is especially important for pharmacies as the Health and Human Services Office of the Inspector General (OIG) recently determined that pharmacies did not comply with parts of this policy on a significant percentage of related claims. Be sure your staff is aware of the proper policy as summarized in the Background Section of this article.

BACKGROUND

Medicare covers a beneficiary's immunosuppressive drugs following a transplant in accordance with 1861(s)(2)(J) of the Social Security Act (the Act), which states that Medicare covers "prescription drugs used in immunosuppressive therapy furnished to an individual who receives an organ transplant for which payment is made under this title."

The OIG reviewed a sample of 2014 claims and their objective was to determine whether Part B should have paid for immunosuppressive drugs billed with a KX modifier for beneficiaries for whom Medicare did not have a transplant record.

Medicare Part B (Part B) covers immunosuppressive drugs for beneficiaries who receive an organ transplant for which Medicare payment was made. When Medicare Fee-For-Service (FFS) pays for a transplant, a record of the transplant claim should be maintained in Medicare's claim history. However, to accommodate certain circumstances in which Medicare cannot locate an FFS claim for a transplant in the beneficiary's Medicare FFS claims database that would confirm that Medicare paid for the transplant, **a pharmacy can submit an immunosuppressive drug claim with a KX modifier.**

In the billing for immunosuppressive drugs, there are circumstances in which Medicare cannot locate, in Medicare's claims database, the claim that would have confirmed that Medicare paid for the transplant. The claim may not appear in the database for reasons such as:

1. At the time of the transplant, the beneficiary was enrolled in a Medicare Advantage plan that paid for the transplant. (Medicare Advantage data is not included in the Medicare FFS claims database). Although some encounter data may be available, it may be incomplete or may not contain coding information sufficient to identify a transplant claim.

2. There may be instances in which claims related to a transplant are old and may not be identifiable in the claims database despite Medicare's payment for the claim.

In these circumstances, your submission of the KX modifier (Specific Required Documentation on File) in the claim permits Medicare to make a reasonable assumption that:

- You have documentation on file that indicates the date of the transplant
- The services furnished are medically necessary, and
- Medicare paid for the transplant in accordance with the statute.

The use of the KX modifier is not required, but you should be aware that your DME MACs will accept claims for immunosuppressive drugs, received on and after July, 2008, without a KX modifier; but will deny the claim if the Centers for Medicare & Medicaid Services (CMS) cannot identify a record of a claim indicating that the transplant was paid for by Medicare FFS.

Further, if you furnish an immunosuppressive drug to a Medicare beneficiary, prescribed because the beneficiary had undergone an organ transplant; and, on and after July 1, 2008, submit a claim for this service that contains the KX modifier, you must:

- Secure from the prescriber the date of such organ transplant and retain documentation of such transplant date in your files.
- Attest that you have documentation on file that the beneficiary was eligible to receive Medicare Part A benefits at the particular date of the transplant and retain the documentation in your files.
- Retain such documentation of the beneficiary's transplant date, Medicare Part A eligibility, and that such transplant date precedes the Date of Service (DOS) for furnishing the drug.

ADDITIONAL INFORMATION

To review MM 10235 visit: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10235.pdf

A report on the OIG review referenced above is available at https://oig.hhs.gov/oas/reports/region6/61500018.pdf.

DOCUMENT HISTORY

Date of Change	Description
October 17, 2017	Initial article released.

Billing Instruction - Blinatumomab (Blincyto) – Revised

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Billing Instruction - Blinatumomab (Blincyto) - Revised" is now available on our (Noridian) website.

View the complete Billing Instruction - Blinatumomab (Blincyto®) - Revised webpage.

Correct Coding - 2018 HCPCS Code Annual Update

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Correct Coding - 2018 HCPCS Code Annual Update" is now available on our (Noridian) website.

View the complete Correct Coding - 2018 HCPCS Code Annual Update webpage.

Correct Coding of CUVITRU – Revised

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Correct Coding of CUVITRU - Revised" is now available on our (Noridian) website.

View the complete Correct Coding of CUVITRU™ - Revised webpage.

Correct Coding - Full Length Rocker Soles Added to Therapeutic Shoes

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Correct Coding - Full Length Rocker Soles Added to Therapeutic Shoes" is now available on our (Noridian) website.

View the complete Correct Coding - Full Length Rocker Soles Added to Therapeutic Shoes webpage.

Correct Coding - HCPCS Coding of Surgical Dressings - Components to Report on the PDAC HCPCS Code Verification Application

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Correct Coding - HCPCS Coding of Surgical Dressings - Components to Report on the PDAC HCPCS Code Verification Application" is now available on our (Noridian) website.

View the complete Correct Coding – HCPCS Coding of Surgical Dressings - Components to Report on the PDAC HCPCS Code Verification Application webpage.

Correct Coding - Hygienic Cleansers, Diapers, and Under-pads

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Correct Coding - Hygienic Cleansers, Diapers, and Under-pads" is now available on our (Noridian) website.

View the complete Correct Coding - Hygienic Cleansers, Diapers, and Under-pads webpage.

Correct Coding - Hygienic Items, Wash Cloths, and Cleansing Wipes

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Correct Coding - Hygienic Items, Wash Cloths, and Cleansing Wipes" is now available on our (Noridian) website.

View the complete Correct Coding - Hygienic Items, Wash Cloths, and Cleansing Wipes webpage.

Correct Coding - Insulin Used with Continuous External Insulin Infusion Pumps

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Correct Coding - Insulin Used with Continuous External Insulin Infusion Pumps" is now available on our (Noridian) website.

View the complete Correct Coding - Insulin Used with Continuous External Insulin Infusion Pumps webpage.

Correct Coding - Lithium Batteries – Revised

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Correct Coding - Lithium Batteries – Revised" has been updated.

Summary of changes: Revised to include PMD codes for which E2397 may be used.

View the complete Correct Coding - Lithium Batteries – Revised webpage.

Correct Coding - PRO-FLEX Prosthetic Foot (Össur)

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Correct Coding - PRO-FLEX® Prosthetic Foot (Össur)" is now available on our (Noridian) website.

View the complete Correct Coding – PRO-FLEX® Prosthetic Foot (Össur) webpage.

Correct Coding - Urinary Drainage Tube Adapter

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Correct Coding - Urinary Drainage Tube Adapter" is now available on our (Noridian) website.

View the complete Correct Coding - Urinary Drainage Tube Adapter webpage.

LCD and Policy Article Revisions Summary for October 26, 2017

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "LCD and Policy Article Revisions Summary for October 26, 2017" is now available on our (Noridian) website.

View the complete LCD and Policy Article Revisions Summary for October 26, 2017 webpage.

LCD and Policy Article Revisions Summary for November 30, 2017

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "LCD and Policy Article Revisions Summary for November 30, 2017" is now available on our (Noridian) website.

View the complete LCD and Policy Article Revisions Summary for November 30, 2017 webpage.

LCD Revision Summary for October 19, 2017

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "LCD Revision Summary for October 19, 2017" is now available on our (Noridian) website.

View the complete LCD Revision Summary for October 19, 2017 webpage.

Local Coverage Determination (LCD) Revisions Summary for September 7, 2017

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Local Coverage Determination (LCD) Revisions Summary for September 7, 2017" is now available on our (Noridian) website.

View the complete Local Coverage Determination (LCD) Revisions Summary for September 7, 2017 webpage.

Policy Article Revision Summary for October 12, 2017

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Policy Article Revision Summary for October 12, 2017" is now available on our (Noridian) website.

View the complete Policy Article Revision Summary for October 12, 2017 webpage.

Policy Article Revision Summary for November 16, 2017

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Policy Article Revision Summary for November 16, 2017" is now available on our (Noridian) website.

View the complete Policy Article Revision Summary for November 16, 2017 webpage.

Request for Information - Topical Oxygen Therapy Used for Wound Care

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Request for Information – Topical Oxygen Therapy Used for Wound Care" is now available on our (Noridian) website.

View the complete Request for Information – Topical Oxygen Therapy Used for Wound Care webpage.

Surgical Dressings Comments and Response Summary – Revised

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Surgical Dressings Comments and Response Summary – Revised" has been updated.

Summary of changes: Correspondence was received that indicated that in the "Response to Comments and Response Summary" erroneously stated that there was no change in coverage requirements for hydrogel dressings. The response to the section "Restricting Usage of Dressings to Stage 3 and 4 Ulcers" has been revised to better explain the non-coverage statement of hydrogel for stage II wounds in this version of the LCD.

View the complete Surgical Dressings Comments and Response Summary – Revised webpage.

MLN Connects Special Edition – September 1, 2017

- Hurricane Harvey and Medicare Disaster Related Texas Claims MLN Matters Article — Updated
- Tropical Storm Harvey and Medicare Disaster Related Louisiana Claims MLN Matters Article — Updated

Hurricane Harvey and Medicare Disaster Related Texas Claims MLN Matters Article — Updated

The MLN Matters Special Edition Article on Hurricane Harvey and Medicare Disaster Related Texas Claims has been updated. The article was revised to include additional waiver information for Medicare-dependent small, rural hospitals and for low-volume hospitals. Information regarding administrative relief related to timely filing of appeals was also added. All other information remained the same.

Tropical Storm Harvey and Medicare Disaster Related Louisiana Claims MLN Matters Article — Updated

The MLN Matters Special Edition Article on Tropical Storm Harvey and Medicare Disaster Related Louisiana Claims has been updated. The article was revised to include additional waiver information for Medicare-dependent small, rural hospitals and for low-volume hospitals. Information regarding administrative relief related to timely filing of appeals was also added. All other information remained the same.

MLN Connects Special Edition – September 5, 2017

- Hurricane Harvey and Medicare Disaster Related Texas Claims MLN Matters Article — Updated
- Tropical Storm Harvey and Medicare Disaster Related Louisiana Claims MLN Matters Article — Updated

Hurricane Harvey and Medicare Disaster Related Texas Claims MLN Matters Article — Updated

The MLN Matters Special Edition Article on Hurricane Harvey and Medicare Disaster Related Texas Claims has been updated. The article was revised to include additional waiver information about housing acute care patients in excluded distinct part units and lifting the temporary enrollment moratoria on Part B non-emergency ambulance suppliers in Texas. Information regarding the Facilities Quality Reporting was also added. All other information remains the same.

Tropical Storm Harvey and Medicare Disaster Related Louisiana Claims MLN Matters Article — Updated

The MLN Matters Special Edition Article on Tropical Storm Harvey and Medicare Disaster Related Louisiana Claims has been updated. The article was revised to include additional waiver information about housing acute care patients in excluded distinct part units. Information regarding the Facilities Quality Reporting was also added. All other information remains the same.

MLN Connects Special Edition – September 7, 2017

- Hurricane Harvey and Medicare Disaster Related Texas Claims MLN Matters Article — Updated
- Tropical Storm Harvey and Medicare Disaster Related Louisiana Claims MLN Matters Article — Updated

Hurricane Harvey and Medicare Disaster Related Texas Claims MLN Matters Article — Updated

The MLN Matters Special Edition Article on Hurricane Harvey and Medicare Disaster Related Texas Claims has been updated. This article was revised to include additional waiver information about emergency durable medical equipment, prosthetics, orthotics, and supplies for Medicare beneficiaries impacted by Hurricane Harvey. All other information remains the same.

Tropical Storm Harvey and Medicare Disaster Related Louisiana Claims MLN Matters Article — Updated

The MLN Matters Special Edition Article on Tropical Storm Harvey and Medicare Disaster Related Louisiana Claims has been updated. This article was revised to include additional waiver information about emergency durable medical equipment, prosthetics, orthotics, and supplies for Medicare beneficiaries impacted by Hurricane Harvey. All other information remains the same.

MLN Connects – September 7, 2017

MLN Connects® for Thursday, September 7, 2017

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News & Announcements

- Hospice Provider Preview Reports Available through September 28
- IRF and LTCH Provider Preview Reports: Review by September 30
- IRF and LTCH Compare Quarterly Refresh
- Mapping Medicare Disparities Tool: 2017 Enhancements Released
- 2015 Inpatient and Outpatient Hospital Utilization and Payment Data Available
- Healthy Aging® Month: Discuss Preventive Services with your Patients

Provider Compliance

- Lumbar Spinal Fusion CMS Provider Minute Video — Reminder

Claims, Pricers & Codes

- October 2017 Average Sales Price Files Available

Upcoming Events

- Overview of MIPS for Small, Rural, and Underserved Practices Webinar — September 8
- New Medicare Card Project: Clearinghouses and Vendors Special Open Door Forum — September 12
- Qualified Medicare Beneficiary Program Billing Requirements Call — September 19
- Reporting Hospice Quality Data: Tips for Compliance Call — September 20
- PQRS: Feedback Reports and Informal Review Process for PY 2016 Results Call — September 26
- Physician Compare Call — September 28

Medicare Learning Network Publications & Multimedia

- Medicare Diabetes Prevention Program: Audio Recording and Transcript — New

MLN Connects Special Edition – September 11, 2017

Hurricane Irma and Medicare Disaster Related United States Virgin Islands, Commonwealth of Puerto Rico and State of Florida Claims MLN Matters Article — New

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

Check the Hurricanes webpage for current information on temporary emergency policies and waivers. Additional waiver requests are being reviewed, and the webpage will be updated as decisions are made.

MLN Connects Special Edition – September 11, 2017

Hurricane Irma and Medicare Disaster Related South Carolina and Georgia Claims MLN Matters Article — New

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

Check the Hurricanes webpage for current information on temporary emergency policies and waivers.

MLN Connects – September 14, 2017

MLN Connects® for Thursday, September 14, 2017

View this edition as a PDF

News & Announcements

- Quality Payment Program: New Resources Available
- September is Prostate Cancer Awareness Month

Provider Compliance

- Billing for Ambulance Transports — Reminder

Upcoming Events

- Qualified Medicare Beneficiary Program Billing Requirements Call — September 19
- Reporting Hospice Quality Data: Tips for Compliance Call — September 20
- PQRS: Feedback Reports and Informal Review Process for PY 2016 Results Call — September 26
- Physician Compare Call — September 28

Medicare Learning Network Publications & Multimedia

- Office of Inspector General Reports Highlight Hospital Billing Issues MLN Matters® Article — New
- PECOS for DMEPOS Suppliers Booklet — Reminder
- Medicare Enrollment Resources Educational Tool — Reminder

MLN Connects Special Edition – September 21, 2017

Hurricane Maria and Medicare Disaster Related United States Virgin Islands and Commonwealth of Puerto Rico Claims MLN Matters Article — New

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

Check the Hurricanes webpage for current information on temporary emergency policies and waivers.

MLN Connects – September 21, 2017

MLN Connects® for Thursday, September 21, 2017

View this edition as a PDF

News & Announcements

- Transition to New Medicare Numbers and Cards
- 2016 PQRS Feedback Reports and Annual QRURs Available
- Hospice Provider Preview Reports Available through September 28
- IRF and LTCH Provider Preview Reports: Review by September 30
- CMS Innovation Center New Direction RFI: Submit Comments by November 20
- DME Appeals Demonstration: Respond to Reopening Document Request Letters
- Chronic Care Management: Connected Care Videos
- Quality Payment Program: Hardship Exception Application for 2017 Transition Year Available
- Hospital Quality Reporting Programs: eCQM Value Set Addendum Available

Provider Compliance

- Medicare Hospital Claims: Avoid Coding Errors

Upcoming Events

- PQRS: Feedback Reports and Informal Review Process for PY 2016 Results Call — September 26
- Physician Compare Call — September 28
- IMPACT Act and Improving Care Coordination: Special Open Door Forum — September 28
- SNF QRP: Claims-Based Measures Confidential Feedback Report Webinar — September 28
- Home Health Agencies: Quality of Patient Care Star Rating Algorithm Call — October 10
- 2016 Annual QRURs Webcast — October 19

Medicare Learning Network Publications & Multimedia

- IMPACT Act Call: Audio Recording and Transcript — New
- Hurricane Harvey and Medicare Disaster Related Texas Claims MLN Matters Article — Updated
- Tropical Storm Harvey and Medicare Disaster Related Louisiana Claims MLN Matters Article — Updated
- Hurricane Irma and Medicare Disaster Related United States Virgin Islands, Commonwealth of Puerto Rico and State of Florida Claims MLN Matters Article — Updated
- Hurricane Irma and Medicare Disaster Related South Carolina and Georgia Claims MLN Matters Article — Updated
- Prohibition on Billing Dually Eligible Individuals Enrolled in the QMB Program MLN Matters Article — Revised
- Global Surgery Fact Sheet — Revised

MLN Connects – September 28, 2017

MLN Connects® for Thursday, September 28, 2017

View this edition as a PDF

News & Announcements

- Medicare Clinical Laboratory Fee Schedule: Preliminary CY 2018 Payment Rates
- 2016 PQRS Feedback Reports and Annual QRURs Updates
- Quality Payment Program: New Resources Available
- Quality Payment Program: View Recordings of Recent Webinars
- MIPS Eligible Measure Applicability: New Resources Available
- National Cholesterol Education Month and World Heart Day

Provider Compliance

- Psychiatry and Psychotherapy CMS Provider Minute Video — Reminder

Claims, Pricers & Codes

- Clinicians: Medicare Part B Crossover Claims Issue Tied to Error Code H51082

Upcoming Events

- Home Health Agencies: Quality of Patient Care Star Rating Algorithm Call — October 10
- 2016 Annual QRURs Webcast — October 19

Medicare Learning Network Publications & Multimedia

- 2017-2018 Influenza Resources for Health Care Professionals MLN Matters® Article — New
- Billing in Medicare Secondary Payer Liability Insurance Situations MLN Matters Article — New
- Accepting Payment from Patients with Set-Aside Arrangements MLN Matters Article — New
- Clarification of Billing and Payment Policies for Negative Pressure Wound Therapy Using a Disposable Device MLN Matters Article — New
- Transition to New Medicare Numbers and Cards Fact Sheet — New
- Nursing Home Call: Audio Recording and Transcript — New
- SNF Consolidated Billing Web-Based Training Course — Reminder
- Remittance Advice Resources and FAQs Fact Sheet — Reminder
- Medicare Enrollment Guidelines for Ordering/Referring Providers Booklet — Reminder

MLN Connects – October 5, 2017

MLN Connects® for Thursday, October 5, 2017

View this edition as a PDF

News & Announcements

- National Partnership to Improve Dementia Care Achieves Goals to Reduce Unnecessary Antipsychotic Medications in Nursing Homes
- 2018 eCQM Value Set Addendum Available
- 2018 eCQM Logic Flows Available
- Health Services Research Health Equity Issue: Submit Abstracts by November 1
- Extension of Medicare IVIG Demonstration through December 31, 2020

- October is National Breast Cancer Awareness Month

Provider Compliance

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

Claims, Pricers & Codes

- FY 2018 IPPS and LTCH PPS Claims Hold

Upcoming Events

- 2016 Annual QRURs Webcast — October 19
- Definition of a Hospital: Primarily Engaged Requirement Call — November 2

Medicare Learning Network Publications & Multimedia

- Medicare Basics: Parts A and B Appeals Overview Video — New
- Updates to Medicare's Cost Report Worksheet S-10 to Capture Uncompensated Care Data MLN Matters Article — New
- Qualified Medicare Beneficiary Program Call: Audio Recording and Transcript — New
- Hospice Quality Reporting Program Call: Audio Recording and Transcript — New
- Hurricane Maria and Medicare Disaster Related United States Virgin Islands and Commonwealth of Puerto Rico Claims MLN Matters Article — Updated
- Reading a Professional Remittance Advice Booklet — Reminder
- Reading an Institutional Remittance Advice Booklet — Reminder

MLN Connects – October 12, 2017

MLN Connects® for Thursday, October 12, 2017

View this edition as a PDF

News & Announcements

- New Medicare Card Web Updates
- 2018 Medicare EHR Incentive Program Payment Adjustment Fact Sheet for Hospitals
- Qualifying APM Participant Look-Up Tool
- Hospice Quality Reporting Program: New and Updated Resources
- SNF Quality Reporting Program: Quick Reference Guide
- Protect Your Patients from Influenza this Season

Provider Compliance

- Cochlear Devices Replaced Without Cost: Bill Correctly — Reminder

Claims, Pricers & Codes

- Home Health Claims Will Be Returned When No OASIS Is Found

Upcoming Events

- 2016 Annual QRURs Webcast — October 19
- Definition of a Hospital: Primarily Engaged Requirement Call — November 2

Medicare Learning Network Publications & Multimedia

- PQRS Call: Audio Recording and Transcript — New

MLN Connects - October 19, 2017

MLN Connects® for Thursday, October 19 ,2017

View this edition as a PDF

News & Announcements

- Preview Draft eCQM Specifications through November 13
- MIPS Virtual Group Election Period Ends December 1
- Quality Payment Program: New Resources
- SNF Quality Reporting Program Confidential Feedback Reports for Claims-Based Measures
- SNF Review and Correct Report Update
- Post-Acute Care Quality Reporting Programs FY 2018 APU: Successful Facilities
- New CMS Legionella Requirement for Hospitals, Critical Access Hospitals, and Nursing Homes

Provider Compliance

- Coudé Tip Catheters CMS Provider Minute Video - Reminder

Claims, Pricers & Codes

- October 2017 OPPS Pricer File
- Outpatient Claims: Correcting Deductible and Coinsurance for Code G0473

Upcoming Events

- Definition of a Hospital: Primarily Engaged Requirement Call - November 2
- New Medicare Card Project Special Open Door Forum - November 9
- SNF Value-Based Purchasing Program FY 2018 Final Rule Call - November 16

Medicare Learning Network Publications & Multimedia

- Medicare FFS Response to the 2017 California Wildfires MLN Matters Article - New
- Hurricane Nate and Medicare Disaster Related Alabama, Florida, Louisiana and Mississippi Claims MLN Matters Article - New
- Medicare Quarterly Provider Compliance Newsletter Educational Tool - New
- Physician Compare Call: Audio Recording and Transcript - New
- Prohibition on Billing Dually Eligible Individuals Enrolled in the QMB Program MLN Matters Article - Revised
- Critical Access Hospital Booklet - Revised

MLN Connects – October 26, 2017

MLN Connects® for Thursday, October 26, 2017

View this edition as a PDF

News & Announcements

- New Medicare Numbers/Cards: Coordination of Benefits
- Hospice QRP: Register for HEART Pilot Study by October 31
- MIPS: Participate in Field Testing of Episode-Based Cost Measures by November 15
- Physician Compare Preview Period Closes November 17

Provider Compliance

- Reporting Changes in Ownership — Reminder

Upcoming Events

- Definition of a Hospital: Primarily Engaged Requirement Call — November 2
- Preventive Care and Health Screenings for Persons with Disabilities Webinar — November 2
- SNF Value-Based Purchasing Program FY 2018 Final Rule Call — November 16
- Comparative Billing Report on Emergency Department Services Webinar — December 13

Medicare Learning Network Publications & Multimedia

- Quality Payment Program in 2017: MIPS APMs Web-Based Training Course —New
- HHA Star Rating Call: Audio Recording and Transcript — New
- Prohibition on Billing Dually Eligible Individuals Enrolled in the QMB Program MLN Matters Article — Revised
- General Equivalence Mappings FAQs Booklet — Revised
- Medicare Fraud & Abuse: Prevention, Detection, and Reporting Web-Based Training Course — Reminder

MLN Connects Special Edition – November 2, 2017

- Physician Fee Schedule Final Policy, Payment, and Quality Provisions for CY 2018
- Hospital OPPS and ASC Payment System and Quality Reporting Programs Changes for 2018
- HHAs: Payment Changes for 2018
- Quality Payment Program Rule for Year 2

Physician Fee Schedule Final Policy, Payment, and Quality Provisions for CY 2018

On November 2, CMS issued a final rule that includes updates to payment policies, payment rates, and quality provisions for services furnished under the Medicare Physician Fee Schedule (PFS) on or after January 1, 2018.

The overall update to payments under the PFS based on the finalized CY 2018 rates will be +0.41 percent. This update reflects the +0.50 percent update established under the Medicare Access and CHIP Reauthorization Act of 2015, reduced by 0.09 percent, due to the misvalued code target recapture amount, required under the Achieving a Better Life Experience Act of 2014. After applying these adjustments, and the budget neutrality adjustment to account for changes in Relative Value Units, all required by law, the final 2018 PFS conversion factor is $35.99, an increase to the 2017 PFS conversion factor of $35.89.

The Final Rule Includes:

- Patients over Paperwork Initiative
- Changes in valuation for specific services
- Payment rates for nonexcepted off-campus provider-based hospital departments
- Medicare telehealth services
- Malpractice relative value units
- Care management services
- Improvement of payment rates for office-based behavioral health services
- Evaluation and management comment solicitation
- Emergency department visits comment solicitation

- Solicitation of public comments on initial data collection and reporting periods for Clinical Laboratory Fee Schedule
- Part B drugs: Payment for biosimilar biological products
- Part B drug payment: Infusion drugs furnished through an item of durable medical equipment
- New care coordination services and payment for rural health clinics and federally-qualified health centers
- Appropriate use criteria for advanced diagnostic imaging
- Medicare Diabetes Prevention Program expanded model
- Physician Quality Reporting System
- Patient relationship codes
- Medicare Shared Savings Program
- 2018 Value Modifier

For More Information:

- Final Rule
- Press Release: CMS Finalizes Policies that Reduce Provider Burden, Lower Drug Prices

See the full text of this excerpted CMS Fact Sheet (issued November 2).

Hospital OPPS and ASC Payment System and Quality Reporting Programs Changes for 2018

On November 1, CMS issued the CY 2018 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System final rule with comment period, which includes updates to the 2018 rates and quality provisions and other policy changes. CMS adopted a number of policies that will support care delivery; reduce burdens for health care providers, especially in rural areas; lower beneficiary out of pocket drug costs for certain drugs; enhance the patient-doctor relationship; and promote flexibility in healthcare.

CMS is increasing the OPPS payment rates by 1.35 percent for 2018. The change is based on the hospital market basket increase of 2.7 percent minus both a 0.6 percentage point adjustment for multi-factor productivity and a 0.75 percentage point adjustment required by law. After considering all other policy changes under the final rule, including estimated spending for pass-through payments, CMS estimates an overall impact of 1.4 percent payment increase for providers paid under the OPPS in CY 2018.

CMS updates ASC payments annually by the percentage increase in the Consumer Price Index for all urban consumers (CPI-U). The Medicare statute specifies a Multi-Factor Productivity (MFP) adjustment to the ASC annual update. For CY 2018, the CPI-U update is 1.7 percent. The MFP adjustment is 0.5 percent, resulting in a CY 2018 MFP-adjusted CPI-U update factor of 1.2 percent. Including enrollment, case-mix, and utilization changes, total ASC payments are projected to increase approximately 3 percent in 2018.

The Final Rule Includes:

- Patients over Paperwork Initiative
- Payment for drugs and biologicals purchased through the 340B drug pricing program
- Supervision of hospital outpatient therapeutic services
- Packaging of low-cost drug administration services
- Inpatient only list
- High cost/low cost threshold for packaged skin substitutes
- Revisions to the laboratory date of service policy
- Partial Hospitalization Program rate setting
- Comment solicitation on ASC payment reform
- ASC covered procedures list
- Hospital Outpatient Quality Reporting Program

- Ambulatory Surgical Center Quality Reporting Program

For More Information:

- Final Rule
- Press Release: CMS Finalizes Policies that Lower Out-of-Pocket Drug Costs and Increase Access to High-Quality Care

See the full text of this excerpted CMS Fact Sheet (issued November 1).

HHAs: Payment Changes for 2018

On November 1, CMS issued a final rule that updates the CY 2018 Medicare payment rates and the wage index for Home Health Agencies (HHAs) serving Medicare beneficiaries. The rule also finalizes proposals for the Home Health Value-Based Purchasing Model and the Home Health Quality Reporting Program.

CMS projects that Medicare payments to HHAs in CY 2018 will be reduced by 0.4 percent, or $80 million, based on the finalized policies. This decrease reflects the effects of a one percent home health payment update percentage ($190 million increase); a -0.97 percent adjustment to the national, standardized 60-day episode payment rate to account for nominal case-mix growth for an impact of -0.9 percent ($170 million decrease); and the sunset of the rural add-on provision ($100 million decrease).

The Final Rule Includes:

- Patients over Paperwork Initiative
- Annual home health payment update percentage
- Adjustment to reflect nominal case-mix growth
- Sunset of the rural add-on provision

For More Information:

- Final Rule
- Press Release: CMS Finalizes Policies that Lower Out-of-Pocket Drug Costs and Increase Access to High-Quality Care

See the full text of this excerpted CMS Fact Sheet (issued November 1).

Quality Payment Program Rule for Year 2

On November 2, CMS issued the final rule with comment for the second year of the Quality Payment Program (CY 2018), as required by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), as well as an interim final rule with comment. We finalized policies for Year 2 of the Quality Payment Program to further reduce your burden and give you more ways to participate successfully. We are keeping many of our transition year policies and making some minor changes.

The Final Rule Includes:

- Weighting the Merit-based Incentive Payment System (MIPS) Cost performance category to 10% of your total MIPS final score, and the Quality performance category to 50%
- Raising the MIPS performance threshold to 15 points in Year 2
- Allowing the use of 2014 Edition and/or 2015 Certified Electronic Health Record Technology (CEHRT) in Year 2 for the Advancing Care Information performance category, and giving a bonus for using only 2015 CEHRT
- Awarding up to 5 bonus points on your MIPS final score for treatment of complex patients
- Automatically weighting the Quality, Advancing Care Information, and Improvement Activities performance categories at 0% of the MIPS final score for clinicians impacted by Hurricanes Irma, Harvey and Maria and other natural disasters
- Adding 5 bonus points to the MIPS final scores of small practices
- Adding Virtual Groups as a participation option for MIPS

- Issuing an interim final rule with comment for extreme and uncontrollable circumstances where clinicians can be automatically exempt from these categories in the transition year without submitting a hardship exception application
- Decreasing the number of doctors and clinicians required to participate as a way to provide further flexibility by excluding individual MIPS eligible clinicians or groups with ≤$90,000 in Part B allowed charges or ≤200 Medicare Part B beneficiaries
- Providing more detail on how eligible clinicians participating in selected Advanced Alternative Payment Models (APMs) will be assessed under the APM scoring standard
- Creating additional flexibilities and pathways to allow clinicians to be successful under the All Payer Combination Option

For More Information:

- Final Rule
- Fact Sheet
- Executive Summary
- Press Release: CMS Finalizes Policies that Reduce Provider Burden, Lower Drug Prices
- Quality Payment Program website
- Register for a webinar on November 14

MLN Connects – November 2, 2017

MLN Connects® for Thursday, November 2, 2017

View this edition as a PDF

News & Announcements

- ESRD PPS: Updates to Policies and Payment Rates
- New Medicare Card: Provider Ombudsman Announced
- IRF and LTCH Quality Reporting Programs Submission Deadline: November 15
- Physician Compare Preview Period Extended to December 1
- Hospitals: Take Action before Meaningful Use Attestation Beginning January 2
- SNF Quality Reporting Program Submission Deadline Extended to May 15
- eCQM Value Set Addendum: Updated Technical Release Notes
- Administrative Simplification Enforcement and Testing Tool
- Antipsychotic Drug use in Nursing Homes: Trend Update
- CMS Offers Medicare Enrollment Relief for Americans Affected by Recent Disasters
- November is Home Care and Hospice Month

Provider Compliance

- Advanced Life Support Ambulance Services: Insufficient Documentation — Reminder

Claims, Pricers & Codes

- Outpatient Claims: Correcting Deductible and Coinsurance for Code G0473

Upcoming Events

- SNF Value-Based Purchasing Program FY 2018 Final Rule Call — November 16

Medicare Learning Network Publications & Multimedia

- QRUR Webcast: Audio Recording and Transcript — New

- ICD-10-CM/PCS the Next Generation of Coding Booklet — Revised
- Diagnosis Coding: Using the ICD-10-CM Web-Based Training Course — Reminder
- Medicare Home Health Benefit Web-Based Training Course — Reminder
- Dual Eligible Beneficiaries under Medicare and Medicaid Booklet — Reminder
- Resources for Medicare Beneficiaries Booklet — Reminder
- Medicare Ambulance Transports Booklet — Reminder
- SNF Billing Reference Booklet — Reminder
- Items and Services Not Covered under Medicare Booklet — Reminder
- Guidelines for Teaching Physicians, Interns, and Residents Fact Sheet — Reminder

MLN Connects – November 9, 2017

MLN Connects® for Thursday, November 9, 2017

View this edition as a PDF

News & Announcements

- New Medicare Card: Help Notify Your Patients
- Medicare Diabetes Prevention Program Expanded Model Implementation
- Hospital Value-Based Purchasing Program Results for FY 2018
- Low Volume Appeals Settlements
- Hospice Item Set Data Freeze: November 15
- Draft 2018 CMS QRDA III Implementation Guide: Submit Comments by November 17
- CMS Innovation Center New Direction RFI: Submit Comments by November 20
- Therapeutic Shoe Inserts: Comment on DMEPOS Quality Standards through December 11
- Quality Payment Program Resources in New Location
- Post-Acute Care: Quality Reporting Program Quick Reference Guides Available
- Provider and Pharmacy Access during Public Health Emergencies
- Raising Awareness of Diabetes in November

Provider Compliance

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

Upcoming Events

- Quality Payment Program Year 2 Overview Webinar — November 14
- SNF Value-Based Purchasing Program FY 2018 Final Rule Call — November 16
- Quality Payment Program Virtual Groups Train-the-Trainer Webinar — November 17
- Quality Payment Program Year 2 Final Rule Call — November 30
- Medicare Diabetes Prevention Program Model Expansion Call — December 5
- LTCH Quality Reporting Program In-Person Training — December 6 and 7

Medicare Learning Network Publications & Multimedia

- Quality Payment Program in 2017: Advanced Alternative Payment Models Web-Based Training Course — New
- Medicare FFS Response to the 2017 California Wildfires MLN Matters Article — Updated

- Prohibition on Billing Dually Eligible Individuals Enrolled in the QMB Program MLN Matters Article— Revised
- Transition to New Medicare Numbers and Cards Fact Sheet — Revised
- Hospital-Acquired Conditions and Present on Admission Indicator Reporting Provision Fact Sheet — Revised
- Remittance Advice Information: An Overview Booklet — Reminder

MLN Connects – November 16, 2017

MLN Connects® for Thursday, November 16, 2017

View this edition as a PDF

News & Announcements

- New Medicare Card: New Webpage Information
- CAHs: Deadline to Apply for a Hardship Exception is November 30
- Virtual Group for MIPS in 2018: Apply by December 31
- QMB Remittance Advice Issue
- IRF/LTCH Quality Measure Reports: Measures Added
- Hospice Quality Reporting Program: Quarterly Update
- Physician Compare: How to Update Your Listing
- Recognizing Lung Cancer Awareness Month and the Great American Smokeout

Provider Compliance

- Evaluation and Management: Correct Coding — Reminder

Upcoming Events

- Quality Payment Program Year 2 Final Rule Call — November 30
- Medicare Diabetes Prevention Program Model Expansion Call — December 5
- National Partnership to Improve Dementia Care and QAPI Call — December 14

Medicare Learning Network Publications & Multimedia

- Hospital Call: Audio Recording and Transcript — New
- Medicare and Medicaid Basics Booklet — Revised
- Looking for Educational Materials?

MLN Connects – November 22, 2017

MLN Connects® for Wednesday, November 22, 2017

View this edition as a PDF

News & Announcements

- Medicare Clinical Laboratory Fee Schedule: Final CY 2018 Payment Rates
- National Rural Health Day
- 2017 Medicare FFS Improper Payment Rate Below 10 Percent for First Time Since 2013
- CMS Measures Inventory Tool
- 2016 PQRS Feedback Reports and Annual QRURs: Informal Review Period Ends December 1
- Hospice Compare: Guidance on Updating Demographic Data
- Hospice Compare Refresh Delayed
- Submit Suggestions for Precedential Medicare Appeals Council Decisions
- IPPS Hospitals: Review FY 2014 and FY 2015 Worksheet S-10 Cost Report Data
- Recommend Influenza Vaccination: Each Office Visit is an Opportunity

Provider Compliance

- OIG Video: Reporting Fraud to the Office of the Inspector General — Reminder

Upcoming Events

- Revisions to DMEPOS Quality Standards for Therapeutic Shoe Inserts Special Open Door Forum — November 28
- Quality Payment Program Year 2 Final Rule Call — November 30
- Medicare Diabetes Prevention Program Model Expansion Call — December 5
- SNF QRP: Assessment-Based Measures Confidential Feedback Report Webinar — December 6
- LTCH Quality Reporting Program In-Person Training — December 6 and 7
- IMPACT Act Special Open Door Forum — December 12
- National Partnership to Improve Dementia Care and QAPI Call — December 14

Medicare Learning Network Publications & Multimedia

- Medicare Fraud & Abuse Poster — New
- Medicare Fraud & Abuse: Prevention, Detection, and Reporting Booklet — Revised
- Medicare Disproportionate Share Hospital Fact Sheet — Revised
- ABCs of the Initial Preventive Physical Examination Educational Tool — Reminder

MLN Connects – November 30, 2017

MLN Connects® for Thursday, November 30, 2017

View this edition as a PDF

News & Announcements

- QRDA III Implementation Guide for CY 2018 Performance Period
- DMEPOS: Traveling Beneficiary Clarification
- Hospice Compare Search Function
- World AIDS Day is December 1

Provider Compliance

- Billing for Stem Cell Transplants — Reminder

Upcoming Events

- Medicare Diabetes Prevention Program Model Expansion Call — December 5
- Interdisciplinary Care Teams for Older Adults Webinar — December 7
- National Partnership to Improve Dementia Care and QAPI Call — December 14

Medicare Learning Network Publications & Multimedia

- Quality Payment Program 2017: MIPS ACI Performance Category Web-Based Training Course — New
- SNF Value-Based Purchasing Program Call: Audio Recording and Transcript — New
- Hurricane Harvey and Medicare Disaster Related Texas Claims MLN Matters Article — Updated
- Tropical Storm Harvey and Medicare Disaster Related Louisiana Claims MLN Matters Article — Updated
- SBIRT Services Booklet — Reminder

Eligibility Details Expanded in Portal – Now Including QMB Details

Qualified Medicare Beneficiaries (QMB)

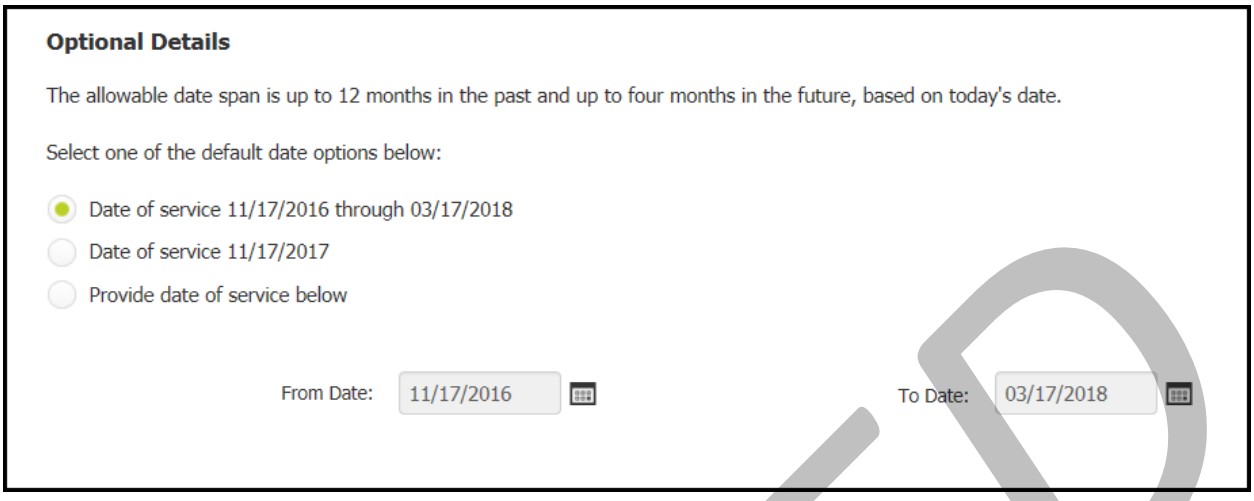
Effective November 19, 2017, the Noridian Medicare Portal (NMP) offers Qualified Medicare Beneficiary (QMB) information on an eligibility inquiry. Low- income beneficiaries receive assistance with their Medicare premiums and cost-sharing through the QMB program. NMP will now display if the beneficiary is enrolled in this program.

If a beneficiary is a QMB, additional benefit information will be displayed on a green line in the Eligibility response.

Since Medicare providers cannot charge QMBs for any cost sharing, the portal will not display the Preventive Services or Next Eligible Date on the Preventive tab.

Date of Service Options for Eligibility Inquiry

Users now have three options to choose from for Date of Service under "Optional Details" when performing an Eligibility inquiry. The inquiry will default to a date range of 12 months if no other option is selected. The current date or a specific date range may be chosen to narrow down the results.



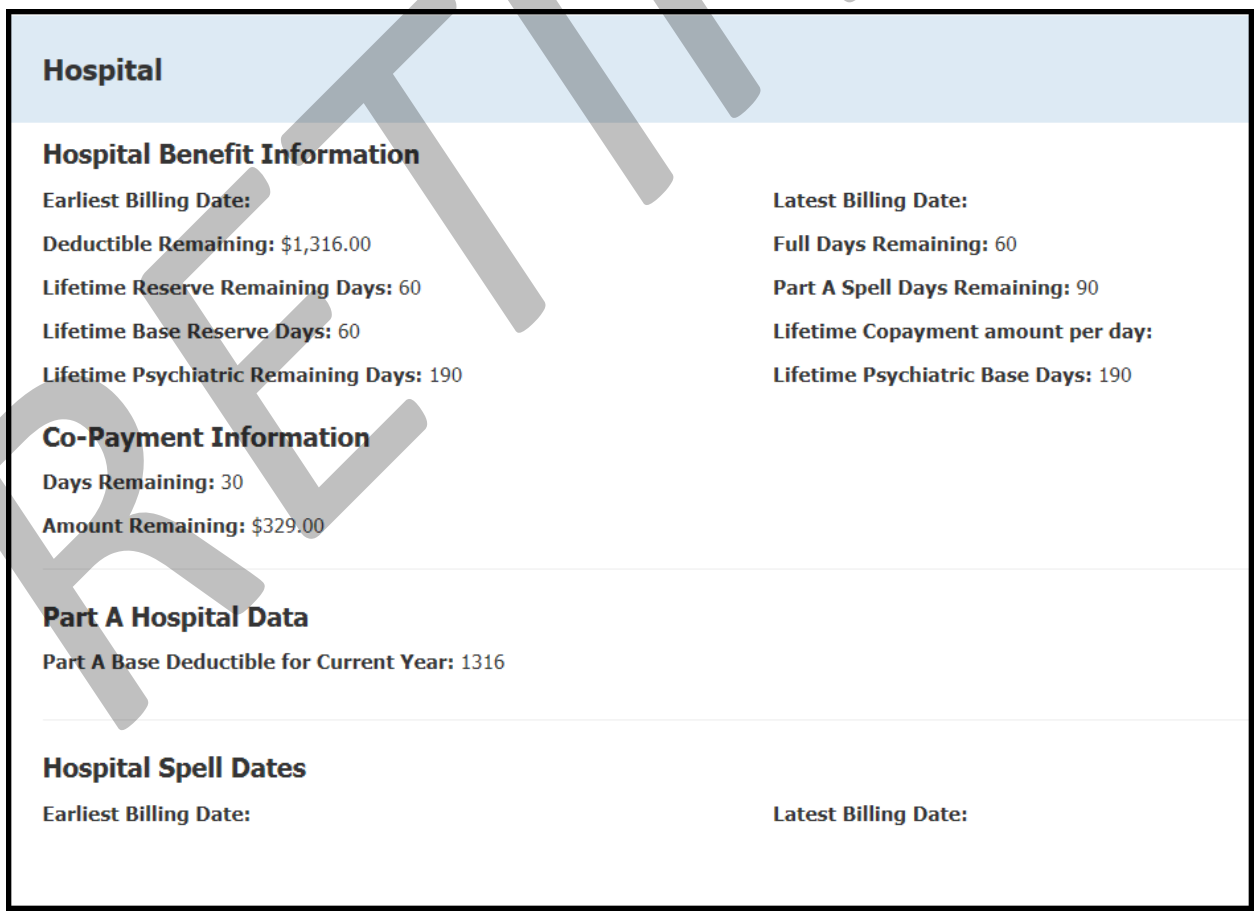
These updates are an addition to the previously published enhancements below.

Effective November 5, 2017, the Noridian Medicare Portal (NMP) offers additional beneficiary eligibility information including hospital spell dates, Part D enrollment, preventive service expanded for colorectal, alcohol and rehabilitation services, and Hospice occurrence counts. Noridian recommends entering 'From' and 'To Dates' when performing an Eligibility inquiry to receive the most accurate entitlement information.

Below is a brief description and screen shot to show where these enhancements can be seen.

Hospital Benefit Information

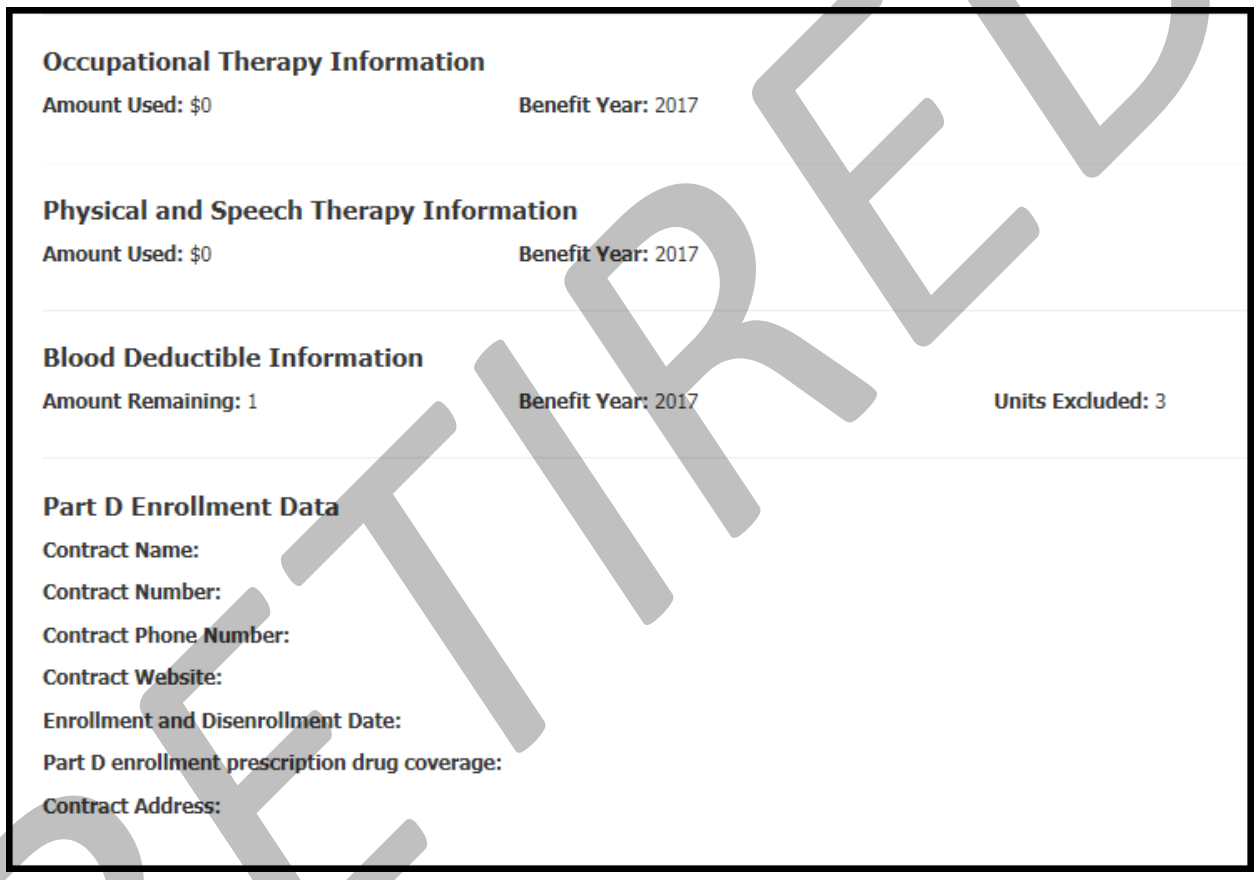
Hospital Benefits will offer the current years Part A Base Deductible, Part A Spell days remaining and the Earliest and Latest Billing Dates for Hospital spells.



Part D Enrollment Data

The following items for Part D Enrollment are available under the Eligibility tab of the response. If the beneficiary is not enrolled in Part D, these fields will remain blank.

- Contract Name
- Contract Number
- Contract Phone Number
- Contract Website
- Enrollment and Disenrollment Date
- Part D Enrollment Prescription Drug Coverage
- Contract Address



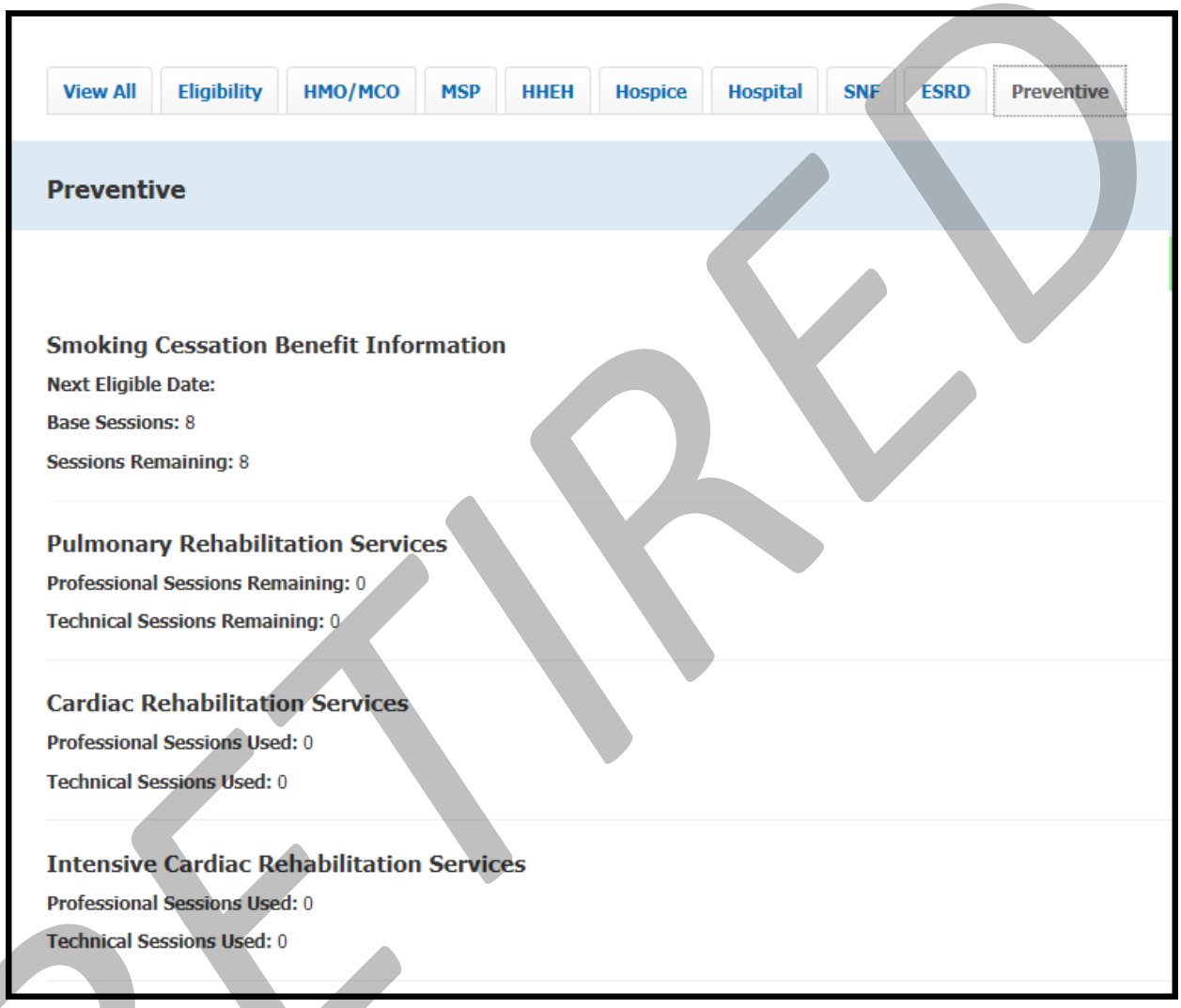
Preventive Services

The following Preventive Services CPT/HCPCS codes will be listed on the Preventive Services tab and provide the date the beneficiary is next eligible for that service.

- 81528
- G0297
- G0442
- G0443
- G0472
- G0473
- G0475

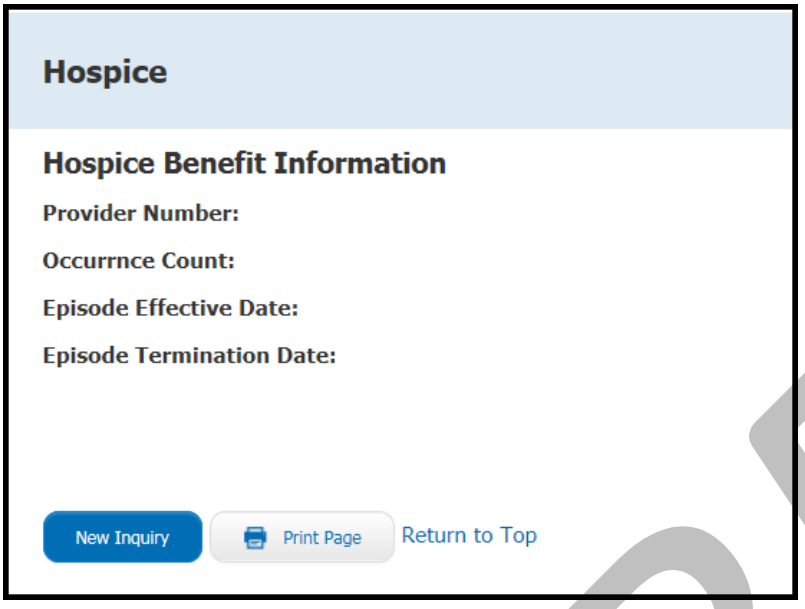
The Preventive Services tab now offers Pulmonary, Cardiac and Intensive Cardiac Rehabilitation Services. The following information is available:

- Professional Sessions Remaining
- Technical Sessions Remaining
- Professional Sessions Used
- Technical Sessions Used



Hospice Benefits

The Hospice Benefit has also been expanded to provide the Occurrence Count of each Hospice episode.



The CMS HIPAA Eligibility Transaction System (HETS) is the authoritative source for all eligibility inquires performed in the portal (and IVR). Noridian hopes you find these enhancements valuable. We encourage you to complete the website satisfaction survey each time it is presented to you so we may continue to improve our portal services.

NMP Appeals Documentation Size Increase

Noridian has listened to provider concerns when attaching Appeals documentation. The file size providers were previously able to attach was up to 10MB. Now, providers can attach documents up to 70MB in size. Noridian is not able to provide a page count to equate to the file size, as it depends on formatting, images, and other factors that can quickly increase the size of a document.

EFT - Less Paper and Faster Payments

Are you still manually depositing your Medicare payments? Why not switch to Electronic Funds Transfer (EFT) and have Medicare payments sent directly to your financial institution. All Medicare suppliers are eligible for EFT if your claims are submitted electronically or on paper.

EFT is the required method of Medicare payment for all suppliers entering the Medicare program for the first time and for existing suppliers that are submitting a change to their existing enrollment record but are not currently enrolled in EFT.

Benefits of switching to EFT include:

- Safe alternative to paper checks
- Faster access to funds
- Eliminating risk of paper check being lost or stolen

To get started, complete the Electronic Funds Transfer (EFT) Authorization Agreement Form and return to your DME MAC. Once received, the process takes about two weeks to complete.

For more information on EFT, visit the Electronic Funds Transfer page on the Noridian website or the CMS resources below.

- Electronic Funds Transfer
- Internet Only Manual, Publication 100-04, Medicare Claims Processing Manual, Chapter 24

Learn How Easy It Is to Get Payments Electronically

Medicare can send payments directly to your financial institution and all it takes is a few minutes of your time to get started. Electronic Funds Transfer (EFT) is the method and it eliminates that extra step of having to physically deposit a check. For more information, please review the article on EFT – Less Paper and Faster Payments. Don't delay, start saving time and money today!

Resources

- Electronic Funds Transfer (EFT) Noridian

Receive Your Medicare Payment Information Faster!

Would you like to receive faster payment notification from Medicare? What if we could eliminate mail and deposit time of your Medicare checks? The solution to both questions are just a few easy steps away. Sign up for Electronic Remittance Advices (ERAs) and Electronic Funds Transfer (EFT)!

ERAs are the recommended method for suppliers to receive their remittance advices and there are many benefits to switching to electronic:

- Faster communication and payment notification
- Faster account reconciliation through electronic posting
- Ability to create various reports
- Ability to search for information on claims
- Ability to print the remittance advice with the free software, Medicare Remit Easy Print (MREP), provided by Centers for Medicare & Medicaid Services (CMS)

Switching to ERAs is as easy as 1, 2, 3:

1. Verify you are capable of receiving the 835-transaction file.

- If you are a self-biller, verify this information with your software vendor
- If you are using a 3rd party biller, verify the information with your billing service/clearinghouse

2. Once the capability is confirmed, you will need to complete the required enrollment located on the CEDI Web site and follow the guided enrollment process.

3. You will receive an e-mail confirmation once your request has been completed.

Once you have signed up to receive electronic remittance notices, consider signing up for electronic funds transfer as well! The EFTs are the most convenient method to receive your Medicare payments. EFT is the process through which payment on Medicare claims is electronically transferred directly to your bank account. This process eliminates mail and deposit time and is available to all DME POS suppliers at no cost. Other benefits of the EFT process include:

- Quicker payment
- Assurance of timely payment in the bank
- Prevention of lost or delayed checks
- Easier bank reconciliation
- Administration efficiency

To sign up for EFT, you or your authorized representative must complete the Authorization for Electronic Funds Transfer agreement form and send to your local Durable Medical Equipment Medicare Administrative Contractor (DME MAC).

ERAs and EFTs are a perfect way to ensure you receive your payments and your payment information as quickly as possible! For additional information, review the resources provided below.

Resources

- Remittance Advice Information: An Overview
- Medicare Remit Easy Print (MREP)
- CEDI
- Electronic Funds Transfer (EFT) Noridian
- Electronic Remittance Advice (ERA) Noridian

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

MLN Matters Number: MM10268
Related Change Request (CR) Number: 10268
Related CR Release Date: November 9, 2017
Effective Date: April 1, 2018
Related CR Transmittal Number: R3915CP
Implementation Date: April 2, 2018

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 10268 instructs MACs and Shared System Maintainers (SSMs) to update systems based on the CORE 360 Uniform Use of Claims Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC), and Claim Adjustment Group Code (CAGC) Rule publication. These system updates are based on the Committee on Operating Rules for Information Exchange (CORE) Code Combination List to be published on or about February 1, 2018. Make sure that your billing staff is aware of these changes.

BACKGROUND

The Department of Health and Human Services (DHHS) adopted the Phase III Council for Affordable Quality Healthcare (CAQH) CORE, EFT, and ERA Operating Rule Set that was implemented on January 1, 2014 under the Affordable Care Act.

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

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. CR10268 deals with the regular update in CAQH CORE defined code combinations per Operating Rule 360 - Uniform Use of CARC and RARC (835) Rule.

CAQH CORE will publish the next version of the Code Combination List on or about February 1, 2018. This update is based on the CARC and RARC updates as posted at the Washington Publishing Company (WPC) website on or about November 1, 2017. This will also include updates based on Market Based Review that CAQH CORE conducts once a year to accommodate code combinations that are currently being used by Health Plans including Medicare as the industry needs them. You can find CARC and RARC updates at http://www.wpc-edi.com/reference and CAQH CORE defined code combination updates at http://www.caqh.org/CORECodeCombinations.php.

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 CR10268, the MACs and the SSMs must get the complete list for both CARCs and RARCs from the WPC website to obtain the comprehensive lists for both code sets and determine the changes included on the code list since the last code update CR (CR10140).

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

ADDITIONAL INFORMATION

The official instruction, CR10268, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3915CP.pdf.

DOCUMENT HISTORY

Date of Change	Description
November 13, 2017	Initial article released.

RARC, CARC, MREP and PC Print Update

MLN Matters Number: MM10270
Related Change Request (CR) Number: 10270
Related CR Release Date: November 9, 2017
Effective Date: April 1, 2018
Related CR Transmittal Number: R3910CP
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

Change Request (CR) 10270 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 staffs are aware of these changes and obtain the updated MREP and PC Print software if they use that software.

BACKGROUND

The Health Insurance Portability and Accountability Act of 1986 (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.

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 later than the implementation date specified in CR10270, 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.

ADDITIONAL INFORMATION

The official instruction, CR10270, issued to your MAC regarding this change, is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3910CP.pdf.

DOCUMENT HISTORY

Date of Change	Description
November 13, 2017	Initial Article Released

Accepting Payment from Patients with a Medicare Set-Aside Arrangement – Reissued

MLN Matters Number: SE17019 Reissued

Article Release Date: **November 8, 2017**

This article was reissued on November 8, 2017, to clarify information. The title of the article was also changed to better reflect the information.

PROVIDER TYPE AFFECTED

This MLN Matters® Article is intended for providers, physicians, and other suppliers who are told by patients that they must pay the bill themselves because they have a Medicare Set-Aside Arrangement (MSA).

WHAT YOU NEED TO KNOW

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

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

BACKGROUND

Medicare is always a secondary payer to liability insurance (including self-insurance), no-fault insurance, and workers' compensation benefits. The law precludes Medicare payment for services to the extent that payment has been made, or can reasonably be expected to be made promptly. When future medical care is claimed, or a settlement, judgment, award, or other payment releases (or has the effect of releasing) claims for future medical care, it can reasonably be expected that the monies from the settlement, judgment, award, or other payment are available to pay for future medical items and services which are otherwise covered and reimbursable by Medicare.

Medicare should not be billed for future medical services until those funds are exhausted by payments to providers for services that would otherwise be covered and reimbursable by Medicare.

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

Medicare beneficiaries are advised that before receiving treatment for services to be paid by their MSA, they should advise their health care provider about the existence of the MSA. They are also notified that their health care providers should bill them directly, and that they should pay those charges out of the MSA if:

- The treatment or prescription is related to what was claimed or the settlement, judgment, award, or other payment had the effect of releasing AND
- The treatment or prescription is something Medicare would cover.

The obligation to protect the Medicare trust funds exists regardless of whether or not there is a formal CMS approved MSA amount. A Medicare beneficiary may or may not have documentation they can provide the physician, provider, or supplier from Medicare approving a Medicare Set-Aside amount.

PROVIDER ACTION NEEDED

Where a patient who is a Medicare beneficiary states that he/she is required to use funds from the settlement, judgment, award, or other payment to pay for the items or services related to what was

claimed or which the settlement, judgment, award, or other payment, it is appropriate for you to document your records with that information and accept payment directly from the patient for such services.

DOCUMENT HISTORY

Date of Change	Description
November 8, 2017	The article was reissued to clarify information in the initial release. The title of the article was also changed to better reflect the information.
October 3, 2017	Rescinded
September 19, 2017	Initial article issued

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