DME Happenings

Jurisdiction A

September 2018

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APPEALS

CLAIM REVIEWS

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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Noridian Healthcare Solutions, LLC

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Jurisdiction A 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

Documentation Education on Demand Now Available

All Medicare Administrative Contractors (MACs) have collaborated on a joint Education on Demand tutorial. This tutorial will provide clarification on documentation requirements for any entity involved in the ordering or provision of Durable Medical Equipment, Prosthetics, Orthotics and Supply (DMEPOS) items to Medicare beneficiaries. This education is being provided in an effort to bring both suppliers and providers relevant information that is required by the Medicare program which will assist in better serving the Medicare population.

Education on Demands are self-paced tutorial that viewers can access from any device (smart phone, tablet, desktop, etc.) and include both an audio and visual component. Follow the links below to view the Education on Demand tutorial directly, or access it through YouTube.

Interactive Voice Response (IVR) Authentication

Providers and third-party representatives are required to authenticate the facility or provider they're inquiring about, even when calling to speak with a Noridian Contact Center Customer Service Representative (CSR). Callers must enter authentication information into the phone using the keypad or speaking aloud.

Authentication information entered into the IVR will display for the CSR allowing him/her to be ready to assist the caller with inquiries.

- National Provider Identifier (NPI);
- Provider Transaction Access Number (PTAN); and
- Last five digits of TIN (Tax Identification Number)

Note: If unable to authenticate via the IVR, ensure the correct line of business has been selected when asking for General Inquiries.

- Select Part B when submitting claims via CMS-1500 or electronic equivalent

Information obtained through the IVR may also be found in the Noridian Medicare Portal (NMP). View the NMP Advantages Over the IVR article to learn more about the NMP benefits.

View the IVR webpage for availability, authentication details, guide, and conversion tool.

QMB CMS Audio Recording and Transcript Available

An audio recording and transcript are available for the June 6 CMS call on Qualified Medicare Beneficiary (QMB) Program Billing Requirements. Find out about the July 2018 re-launch of changes to the remittance advice and November 2017 changes to the HIPAA Eligibility Transaction System (HETS) to identify the QMB status of your patients and exemption from cost-sharing. Also, learn key steps to promote compliance.

This is a national CMS educational resource advertised via the CMS MLN Connects dated June 21, 2018.

Rural and Non-Contiguous Areas: Adjusted Fee Schedule Rates and KE Modifier – Revised

This article, originally published on June 25, 2018, has been revised and is being republished to update verbiage regarding the KE modifier.

The interim final rule with comment period (CMS-1687-IFC) entitled "Transitional 50/50 Blended Rates to Provide Relief in Rural Areas and Non-Contiguous Areas" was published in the Federal Register on Friday, May 11, 2018. The IFC amends the regulations to increase the fee schedule amounts for items furnished from June 1, 2018 - December 31, 2018, in rural areas and non-contiguous areas (Alaska, Hawaii, and United States territories) not subject to the Competitive Bidding Program.

Effective June 1, 2018:

- This change requires new 2018 rural and non-contiguous fee schedules be calculated for certain Durable Medical Equipment (DME) and Parenteral and Enteral Nutrition (PEN) Healthcare Common Procedure Coding System (HCPCS) codes adjusted using competitive bidding information
  - New rural and non-contiguous fee schedule amounts are based on a blend of 50 percent of adjusted fee schedule amount and 50 percent of unadjusted fee schedule amounts updated by covered item updates specified in sections 1834(a)(14) and 1842(s)(B) of the Act. Access updated fee schedules and applicable zip code lists from CMS Interim Final Rule with Comment Period (CMS-1687-IFC) Durable Medical Equipment Fee Schedule webpage
- Suppliers should append KE modifier to accessory codes included in Competitive Bid Program (CBP) when furnished for use with base equipment that was not included in 2008 CBP when beneficiaries reside in rural or non-contiguous, non-competitive bid areas (Alaska, Hawaii, and United States territories) furnished June 1, 2018 – December 31, 2018
  - If KE modifier is not submitted, accessory will not price correctly

See the CMS Medicare Learning Network (MLN) Matters (MM)6270 for background information and a list of the applicable KE HCPCS codes.

HCPCS Drug/Biological Code Changes – July 2018 Update – Third Revision

MLN Matters Number: MM10624 Revised
Related Change Request (CR) Number: 10624
Related CR Release Date: July 5, 2018
Effective Date: July 1, 2018
Related CR Transmittal Number: R4083CP
Implementation Date: July 2, 2018

This article was revised on July 6, 2018, to reflect a revised CR issued on July 5. The article is revised to show the Type of Service Code for CPT code 90739 remains as V. Also, the CR release date, transmittal number, and the Web address of the CR are revised. All other information is the same.

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 10624 informs MACs of updated drug/biological HCPCS codes. The HCPCS code set is updated on a quarterly basis. The July 2018 HCPCS file includes six new HCPCS codes: Q9991, Q9992, Q9993, Q9995, Q5105, and Q5106. Please make sure your billing staffs are aware of these updates.

BACKGROUND

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

Q9991

- Short Description: Buprenorph xr 100 mg or less
- Long Description: Injection, buprenorphine extended-release (sublocade), less than or equal to 100 mg
- Type of Service (TOS) Code: 1
- Medicare Physician Fee Schedule Data Base (MPFSDB) Status Indicator: E

Q9992

- Short Description: Buprenorphine xr over 100 mg
- Long Description: Injection, buprenorphine extended-release (sublocade), greater than 100 mg
- TOS Code: 1
- MPFSDB Status Indicator: E

Q9993

- Short Description: Inj., triamcinolone ext rel
- Long Description: Injection, triamcinolone acetonide, preservative-free, extended-release, microsphere formulation, 1 mg
- TOS Code: 1,P
- MPFSDB Status Indicator: E

Q9995

- Short Description: Inj. emicizumab-kxwh, 0.5 mg
- Long Description: Injection, emicizumab-kxwh, 0.5 mg
- TOS Code: 1
- MPFSDB Status Indicator: E

Q5105

- Short Description: Inj Retacrit esrd on dialysi
- Long Description: Injection, epoetin alfa, biosimilar, (Retacrit) (for esrd on dialysis), 100 units
- TOS Code: 1, L
- MPFSDB Status Indicator: E

Q5106

- Short Description: Inj Retacrit non-esrd use
- Long Description: Injection, epoetin alfa, biosimilar, (Retacrit) (for non-esrd use), 1000 units
- TOS Code: 9
- MPFSDB Status Indicator: E

In addition to the new codes, the TOS code for CPT Code 90739 remains as V.

ADDITIONAL INFORMATION

The official instruction, CR 10624, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4083CP.pdf.

DOCUMENT HISTORY

Date of Change	Description
July 6, 2018	The article was revised to reflect a revised CR issued on July 5. The article is revised to show the Type of Service Code for CPT code 90739 remains as V. Also, the CR release date, transmittal number, and the Web address of the CR are revised. All other information is the same.
June 26, 2018	The article was revised to reflect a revised CR issued on June 26. In the article, the new codes of Q5105 and Q5106 are added. The Type of Service Code for CPT code 90739 is updated to 1, V. Also, the CR release date, transmittal number, and the Web address of the CR are revised. All other information is the same.

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

Q Code for In-Line Cartridge Containing Digestive Enzyme(s)

MLN Matters Number: MM10626
Related Change Request (CR) Number: 10626
Related CR Release Date: June 1, 2018
Effective Date: July 1, 2018
Related CR Transmittal Number: R4063CP
Implementation Date: July 2, 2018

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 10626 instructs MACS to add Healthcare Common Procedure Coding System (HCPCS) code Q9994 to the Level II HCPCS code set effective July 1, 2018. Make sure your billing staffs are aware of these changes.

BACKGROUND

The HCPCS is divided into two principal subsystems, referred to as Level I and Level II. Level I is comprised of the Current Procedural Terminology (CPT), a numeric coding system maintained by the American Medical Association (AMA) to identify medical services and procedures furnished by physicians and other health care professionals. The Level II HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes.

Policy Change

Q9994 is added to the Level II HCPCS code set effective July 1, 2018:

- Long Description: In-line cartridge containing digestive enzyme(s) for enteral feeding, each
- Short Description: Enzyme cartridge enteral nut

The billing jurisdiction for this code will be DME MAC.

ADDITIONAL INFORMATION

The official instruction, CR 10626, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4063CP.pdf.

DOCUMENT HISTORY

Date of Change	Description
June 1, 2018	Initial article released.

DMEPOS Fee Schedule – July 2018 Update

MLN Matters Number: MM10707
Related Change Request (CR) Number: 10707
Related CR Release Date: June 8, 2018
Related CR Transmittal Number: R4072CP
Effective Date: January 1, 2018 for fees for code Q0477, June 1, 2018 for CMS-1687-IFC-related rural and blended fees, July 1, 2018 for all other changes
Implementation Date: July 2, 2018

PROVIDER TYPE AFFECTED

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

Medical Equipment Medicare Administrative Contractors (DME MACs) for DME, Prosthetics, Orthotics, and Supplies (DMEPOS) items or services paid under the DMEPOS fee schedule.

PROVIDER ACTION NEEDED

Change Request (CR) 10707 provides the July 2018 Medicare DMEPOS fee schedule quarterly update listing fee schedule amounts for non-rural and rural areas. Additionally, the Parenteral and Enteral Nutrition (PEN) fee schedule file includes state fee schedule amounts for enteral nutrition items and national fee schedule amounts for parental nutrition items. Also, the files for this update include the July 2018 DMEPOS Rural ZIP code file containing the Third Quarter 2018 Rural ZIP code changes.

BACKGROUND

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

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

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

Additional information on adjustments to the fee schedule amounts based on information from CBPs is available in Transmittal 3551, CR 9642, dated June 23, 2016 and Transmittal 3416, CR9431, dated November 23, 2015. You can find the MLN Matters articles associated with these CRs at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9642.pdf and https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network- MLN/MLNMattersArticles/Downloads/MM9431.pdf respectively.

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

Key changes in this update are as follows:

Interim Final Rule with Comment Period (CMS-1687-IFC)

The interim final rule with comment period (CMS-1687-IFC) entitled "Transitional 50/50 Blended Rates to Provide Relief in Rural Areas and Non-Contiguous Areas" was published in the Federal Register on Friday, May 11, 2018. The IFC amends the regulations to increase the fee schedule amounts for items

furnished from June 1, 2018 through December 31, 2018, in rural areas and non-contiguous areas (Alaska, Hawaii, and United States territories) not subject to the CBP. This change requires new 2018 rural and non-contiguous fee schedules be calculated for HCPCS codes for certain DME and PEN adjusted using competitive bidding information effective June 1, 2018. The new rural and non-contiguous fee schedule amounts are based on a blend of 50 percent of the adjusted fee schedule amount and 50 percent of the unadjusted fee schedule amounts updated by the covered item updates specified in sections 1834(a)(14) and 1842(s)(B) of the Act. For areas other than rural or non-continuous areas, the fee schedules for DME and PEN codes with adjusted fee schedule amounts will continue to be based on 100 percent of the adjusted fee schedule amounts from June 1, 2018 through December 31, 2018.

Because the revised rural and non-contiguous fee schedule amounts are based in part on unadjusted fee schedule amounts, the fees for certain items included in the 2008 Original Round One CBP, denoted with the HCPCS pricing modifier, are added back to the fee schedule file only for items furnished in rural and non-contiguous areas. Background information and a list of the applicable KE HCPCS codes was issued in Transmittal 1630, CR 6270, dated November 7, 2008. (See the related MLN Matters article MM6270 at https://www.cms.gov/Outreach-and- Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6270.pdf.) Beginning June 1, 2018 through December 31, 2018, the rural and non-contiguous KE fee schedule amounts will be based on a blend of 50 percent of the adjusted fee schedule amount and 50 percent of the unadjusted KE fee schedule amount updated by the covered item updates specified in sections 1834(a)(14) and 1842(s)(B) of the Act. The non-rural fees for these KE codes will be populated with zeros on the fee schedule file since KE is not a valid option for areas without blended fees.

For certain accessories used with base equipment included in the CBP in 2008 (for example, power wheelchairs, walkers, and negative pressure wound therapy pumps), the unadjusted fee schedule amounts include a 9.5 percent reduction in accordance with Federal law if these accessories were also included in the 2008 CBP. The 9.5 percent fee reduction only applies to these accessories when they are furnished for use with the base equipment included in the 2008 CBP. Beginning June 1, 2018, in cases where accessories included in the 2008 CBP are furnished for use with base equipment that was not included in the 2008 CBP (for example, manual wheelchairs, canes and aspirators), for beneficiaries residing in rural or non-contiguous, non-competitive bid areas, suppliers should append the KE modifier to the HCPCS code for the accessory. Suppliers should not use the KE modifier with accessories that were included in the 2008 CBP and furnished for use with base equipment that was not included in the 2008 CBP when these accessories are furnished to beneficiaries residing in non-rural, non-competitive bid areas.

Also, because the IFC results in a change to the 2018 fee schedule amounts for the various classes of oxygen and oxygen equipment, the annual oxygen budget neutrality adjustment for 2018 is recomputed and the adjustments to the stationary oxygen equipment, mandated by regulations at section 414.226(c)(6), will be applied to the fees on the June 1, 2018 file.

DMEPOS and PEN fee schedule files containing the revised rural and non-contiguous 50/50 blend fees were transmitted in May to the Part B and DME MACs for the June 1, 2018 implementation. However, the DMEPOS Institutional Claim (FI) fee schedule file was not updated with the revised rural and non-contiguous 50/50 blend in June. The July 2018 DMEPOS fee schedule FI file will incorporate the 50/50 blend rural and non-contiguous fees with a June 1, 2018 effective date. As part of the July 2018 DMEPOS fee schedule file update, HHHMACs shall adjust any impacted 50/50 blend claims processed for dates of service between June 1, 2018 and June 30, 2018 that are brought to their attention by the supplier.

MACs will not search for and adjust claims for HCPCS codes with revised 50/50 blend fees appearing on the July 2018 DMEPOS FI file with effective dates of June 1, 2018 for dates of service June 1, 2018 through June 30, 2018. However, they will adjust these claims when you bring them to their attention for dates of service June 1, 2018 through June 30, 2018.

Other Changes

As part of this update, the fee schedules for HCPCS code Q0477 (Power Module Patient Cable for Use with Electric or Electric/Pneumatic Ventricular Assist Device, Replacement Only) are revised and effective for dates of service on or after January 1, 2018. If you resubmit impacted claims, MACs will adjust previously processed claims for code Q0477 with dates of service on or after January 1, 2018.

The fee schedules Public Use Files (PUFs) will be available for State Medicaid Agencies, managed care organizations, and other interested parties shortly after the release of the data files at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html.

ADDITIONAL INFORMATION

The official instruction, CR10707, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4072CP.pdf.

DOCUMENT HISTORY

Date of Change	Description
June 11, 2018	Initial article released.

Claim Status Category and Claim Status Codes Update

MLN Matters Number: MM10777
Related Change Request (CR) Number: 10777
Related CR Release Date: June 1, 2018
Effective Date: October 1, 2018
Related CR Transmittal Number: R4066CP
Implementation Date: October 1, 2018

PROVIDER TYPE AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 10777 updates, as needed, the Claim Status and Claim Status Category Codes used for the Accredited Standards Committee (ASC) X12 276/277 Health Care Claim Status Request and Response and ASC X12 277 Health Care Claim Acknowledgment transactions. Make sure your billing staffs are aware of these updates.

BACKGROUND

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires all covered entities to use only Claim Status Category Codes and Claim Status Codes approved by the National Code Maintenance Committee in the ASC X12 276/277 Health Care Claim Status Request and Response transaction standards adopted under HIPAA for electronically submitting health care claims status requests and responses. These codes explain the status of submitted claim(s). Proprietary codes may not be used in the ASC X12 276/277 transactions to report claim status. The National Code Maintenance Committee meets at the beginning of each ASC X12 trimester meeting (January/February, June, and September/October) and makes decisions about additions, modifications, and retirement of existing codes. The Committee allows 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 June 2018 committee meeting shall be posted on these sites on or about July 1, 2018.

The Centers for Medicare & Medicaid Services (CMS) will issue future updates to these codes, as needed. MACs must update their claims systems to ensure that the current version of these codes is used in their claim status responses.

These code changes are 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 CR 10777.

The CMS' Medicare contractors must comply with the requirements contained in the current standards adopted under HIPAA for electronically submitting certain health care transactions, among them the ASC X12 276/277 Health Care Claim Status Request and Response. These contractors must use valid Claim Status Category Codes and Claim Status Codes when sending ASC X12 277 Health Care Claim Status Responses. They must also use valid Claim Status Category Codes and Claim Status Codes when sending ASC X12 277 Healthcare Claim Acknowledgments. References in CR 10777 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, CR10777, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and- Guidance/Guidance/Transmittals/2018Downloads/R4066CP.pdf.

DOCMENT HISTORY

Date of Change	Description
June 1, 2018	Initial article released.

HCPCS Drug/Biological Code Changes – October 2018 Update

MLN Matters Number: MM10834
Related Change Request (CR) Number: 10834
Related CR Release Date: August 10, 2018
Effective Date: July 12, 2018
Related CR Transmittal Number: R4114CP
Implementation Date: October 1, 2018

PROVIDER TYPES AFFECTED

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

WHAT YOU NEED TO KNOW

The HCPCS code set is updated on a quarterly basis. Change Request (CR) 10834 informs MACs of the October 2018 addition of one new HCPCS code. Effective with dates of service on or after July 12, 2018, the Q5108 is payable by Medicare. The short descriptor for Q5108 is Injection, fulphila and the long descriptor is Injection, pegfilgrastim-jmdb, biosimilar, (fulphila), 0.5 mg. The Type of Service (TOS) Codes for Q5108 are 1, P and the Medicare Physician Fee Schedule Database (MPFSDB) Status Indicator is E. Note that MACs should hold claims for Q5108 until CR10834 is implemented.

ADDITIONAL INFORMATION

The official instruction, CR 10834, issued to your MAC regarding this change, is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4114CP.pdf.

DOCUMENT HISTORY

Date of Change	Description
August 10, 2018	Initial article released.

HPTCs Code Set – October 2018 Update

MLN Matters Number: MM10857
Related Change Request (CR) Number: 10857
Related CR Release Date: August 24, 2018
Effective Date: January 1, 2019
Related CR Transmittal Number: R4116CP
Implementation Date: No later than January 7, 2019

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 10857 directs MACs to obtain the most recent Healthcare Provider Taxonomy Codes (HPTCs) code set and use it to update their internal HPTC tables and/or reference files. Make sure your billing staffs are aware of these updates.

BACKGROUND

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

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

You should note that:

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

Although the NUCC generally posts their updates on the Washington Publishing Company (WPC) website 3 months prior to the effective date, changes are not effective until April 1 or October 1 as indicated in each update. The changes to the code set include the addition of a new code and addition of definitions to existing codes. When reviewing the Health Care Provider Taxonomy code set online, revisions made since the last release are identified.

Note: MACs having the capability to do so will update the HPTC table, such that claims received on and after October 1, 2018, will be validated against the October 1, 2018, HPTC set. MACs lacking the capability to implement the updated October 2018 HPTC set, for claims received on or after October 1, 2018, will implement the October 2018 HPTC update as soon as possible after October 1, 2018, but no later than January 7, 2019.

ADDITIONAL INFORMATION

The official instruction, CR10857, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4116CP.pdf.

DOCUMENT HISTORY

Date of Change	Description
August 24, 2018	Initial article released.

Medicare Claims Processing Manual, Chapter 24, ASCA Waiver Review Form of Letters, Exhibits A-H Updates

MLN Matters Number: MM10858
Related Change Request (CR) Number: CR 10858
Related CR Release Date: August 3, 2018
Effective Date: January 1, 2019
Related CR Transmittal Number: R4102CP
Implementation Date: January 7, 2019

PROVIDER TYPE AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 10858 provides an update to the language contained in the Form Letters the MACs use to inform certain providers of Administrative Simplification Compliance Act (ASCA) waiver reviews. The CR gives you clear directions for communicating with your MACs regarding ASCA waiver review-related questions when you receive a review Form Letter. Make sure your billing staffs are aware of these directions.

BACKGROUND

Section 3 of the ASCA, PL107-105, and the implementing regulation at 42 CFR 424.32, requires that you, on or after October 16, 2003, submit electronically (with limited exceptions); all of your initial claims for reimbursement under Medicare. You should be aware that Medicare cannot pay for claims: 1) That do not meet the limited exception criteria; and 2) Which you submit non-electronically. The issuance of waivers under this limited exception criteria to providers has been delegated to the MACs by the Centers for Medicare & Medicaid Services (CMS). Refer to https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm3440.pdf or additional information about this requirement, including a list of these exception criteria.

Based on discussions with MACs to streamline the communication process with your MACs, CMS has made minor modifications to the ASCA waiver review letters that will improve this communication. CR10858 provides these modifications; specifically, the addition of the statement: "If you have questions, please contact your MAC Customer Service."

You will find the updated Claims Processing Manual, Chapter 24 (General EDI and EDI Support Requirements, Electronic Claims, and Mandatory Electronic Filing of Medicare Claims), as an attachment to CR10858. It documents the changes mentioned above for the waiver review Exhibits of Form Letters (A-H).

ADDITIONAL INFORMATION

The official instruction, CR10858, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4102cp.pdf.

DOCUMENT HISTORY

Date of Change	Description
August 3, 2018	Initial article released.

ICD-10 and Other Coding Revisions to NCDs

MLN Matters Number: MM10859
Related CR Number: 10859
Related CR Release Date: August 10, 2018
Effective Date: January 1, 2019
Related CR Transmittal Number: R2122OTN
Implementation Date: January 7, 2019, shared edits, September 28, 2018, local edits

PROVIDER TYPE AFFECTED

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

PROVIDER ACTION NEEDED

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

BACKGROUND

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

Coding (as well as payment) are separate and distinct areas of the Medicare Program from coverage policy/criteria. Revisions to codes within an NCD are carefully and thoroughly reviewed and vetted by the Centers for Medicare & Medicaid Services 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.

CR10859 makes coding and clarifying adjustments to the following NCDs:

- NCD80.11 Vitrectomy
- NCD110.21 Erythropoiesis-Stimulating Agents (ESAs) for Cancer
- NCD190.3 Cytogenetics
- NCD190.11 Home Prothrombin Time (PT)/International Normalized Ratio (INR)
- NCD220.6.17 Positron Emission Tomography (PET) for Oncologic Conditions
- NCD270.3 Blood-Derived Products for Chronic, Non-Healing Wounds
- NCD260.1 Adult Liver Transplantation
- NCD110.18 Aprepitant for Chemo-Induced Emesis
- NCD270.1 Electrical Stimulation, Electromagnetic Therapy for Wounds

Note/Clarification: A/B MACs shall use default Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) messages where appropriate: Remittance Advice Remark Codes (RARC) N386 with Claim Adjustment Reason Code (CARC) 50, 96, and/or 119. See latest CAQH CORE update. When denying claims associated with the NCDs referenced in CR10859, except where otherwise indicated, A/B MACs shall use:

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

ADDITIONAL INFORMATION

The official instruction, CR10859, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R2122OTN.pdf.

DOCUMENT HISTORY

Date of Change	Description
August 14, 2018	Initial article released.

DMEPOS Fee Schedule – October 2018 Update

MLN Matters Number: MM10881
Related Change Request (CR) Number: 10881
Related CR Release Date: August 10, 2018
Effective Date: October 1, 2018
Related CR Transmittal Number: R4108CP
Implementation Date: October 1, 2018

PROVIDER TYPE AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 10881 informs DME MACs about the changes to the DMEPOS fee schedule which 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. Make sure that your billing staffs are aware of these changes.

BACKGROUND

The DMEPOS fee schedules are updated on a quarterly basis, when necessary, in order to implement fee schedule amounts for new and existing codes, as applicable, and apply changes in payment policies. The update process for the DMEPOS fee schedule is located in the Medicare Claims Processing Manual, Chapter 23, Section 60.

Payment on a fee schedule basis is required for Durable Medical Equipment (DME), prosthetic devices, orthotics, prosthetics and surgical dressings by Section 1834(a), (h), and (i) of the Social Security Act (the Act). Additionally, payment on a fee schedule basis is a regulatory requirement at 42 Code of Federal Regulations (CFR) 414.102 for Parenteral and Enteral Nutrition (PEN), splints, casts and Intraocular Lenses (IOLs) inserted in a physician's office.

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

authority for making adjustments to the fee schedule amount for enteral nutrients, equipment and supplies (enteral nutrition) based on information from CBPs.

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

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.

October quarterly updates are only required for the DMEPOS Rural Zip code file containing the Quarter 4 2018 Rural ZIP code changes. An October update to the 2018 DMEPOS and PEN fee schedule files is not required.

The October 2018 DMEPOS Rural Zip file (PUF) 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/DMEPOS-Fee-Schedule.html.

ADDITIONAL INFORMATION

The official instruction, CR10881, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4108CP.pdf.

DOCUMENT HISTORY

Date of Change	Description
August 10, 2018	Initial article released.

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

MLN Matters Number: MM10899
Related Change Request (CR) Number: 10899
Related CR Release Date: August 3, 2018
Effective Date: October 1, 2018
Related CR Transmittal Number: R4107CP
Implementation Date: October 1, 2018

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 10899 provides the quarterly update for Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to the prior quarterly pricing files. CR 10899 instructs MACs to download and implement the October 2018 and, if released, the revised July 2018, April 2018, January 2018, and October 2017 ASP drug pricing files for Medicare Part B drugs. Medicare shall use the October 2018 ASP and Not Otherwise Classified (NOC) drug pricing files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after October 1, 2018 with dates of service October 1, 2018, through December 31, 2018. Make sure your billing staffs are aware of these updates.

BACKGROUND

The ASP methodology is based on quarterly data that manufacturers submit to the Centers for Medicare & Medicaid Services (CMS). CMS supplies MACs with the ASP and NOC drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the Outpatient Prospective Payment System (OPPS) are incorporated into the Outpatient Code Editor (OCE) through separate instructions available in Chapter 4, Section 50 of the Medicare Claims Processing Manual at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf.

- File: October 2018 ASP and ASP NOC – effective dates of service: October 1, 2018, through December 31, 2018;
- File: July 2018 ASP and ASP NOC – effective dates of service: July 1, 2018, through September 30, 2018;
- File: April 2018 ASP and ASP NOC – effective dates of April 1, 2018, through June 30, 2018;
- File: January 2018 ASP and ASP NOC – effective dates of service: January 1, 2018, through March 31, 2018; and
- File: October 2017 ASP and ASP NOC – effective dates of service: October 1, 2017, through December 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 Chapter 17, Section 20.1.3 of the Medicare Claims Processing Manual at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c17.pdf.

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

MACs will not search and adjust claims that have already been processed unless you bring such claims to your MAC's attention.

ADDITIONAL INFORMATION

The official instruction, CR 10899, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4107CP.pdf.

DOCUMENT HISTORY

Date of Change	Description
August 3, 2018	Initial article released.

Claim Status Category and Claim Status Codes Update

MLN Matters Number: MM10925
Related Change Request (CR) Number: 10925
Related CR Release Date: August 24, 2018
Effective Date: January 1, 2019
Related CR Transmittal Number: R4115CP
Implementation Date: January 7, 2019

PROVIDER TYPE AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 10925 updates, as needed, the Claim Status and Claim Status Category Codes used for the Accredited Standards Committee (ASC) X12 276/277 Health Care Claim Status Request and Response and ASC X12 277 Health Care Claim Acknowledgment transactions. Make sure your billing staffs are aware of these updates.

BACKGROUND

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

The National Code Maintenance Committee meets at the beginning of each ASC X12 trimester meeting (January/February, June, and September/October) and makes decisions about additions, modifications, and retirement of existing codes. The Committee allows 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 September/October 2018 committee meeting shall be posted on these sites on or about November 1, 2018.

The Centers for Medicare & Medicaid Services (CMS) will issue future updates to these codes, as needed. MACs must update their claims systems to ensure that the current version of these codes is used in their claim status responses.

These code changes are 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 CR 10925.

The CMS' Medicare contractors must comply with the requirements contained in the current standards adopted under HIPAA for electronically submitting certain health care transactions, among them the ASC X12 276/277 Health Care Claim Status Request and Response. These contractors must use valid Claim Status Category Codes and Claim Status Codes when sending ASC X12 277 Health Care Claim Status Responses. They must also use valid Claim Status Category Codes and Claim Status Codes when sending ASC X12 277 Healthcare Claim Acknowledgments. References in CR 10925 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, CR10925, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4115CP.pdf.

DOCUMENT HISTORY

Date of Change	Description
August 24, 2018	Initial article released.

Prohibition Billing Dually Eligible Individuals Enrolled in the QMB Program – Ninth Revision

MLN Matters Number: SE1128 Revised

Article Release Date: June 26, 2018

This article was revised on June 26, 2018, to clarify the description of the QMB program. It also adds that starting July 2018 the Medicare Summary Notice (MSN) is another way for providers to verify the QMB status of beneficiaries for Medicare Fee-For-Service (FFS) claims. All other information remains the same.

PROVIDER TYPES AFFECTED

This article pertains to all Medicare providers and suppliers, including pharmacies that serve beneficiaries enrolled in Original Medicare or a Medicare Advantage (MA) plan.

PROVIDER ACTION NEEDED

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

Implement key measures to ensure compliance with QMB billing requirements. Use the Medicare 270/271 HIPAA Eligibility Transaction System (HETS) (effective November 2017), CMS' eligibility-verification system, and the provider Remittance Advice (RA) (July 2018) to identify beneficiaries' QMB status and exemption from cost-sharing prior to billing. Starting July 2018, look for QMB alerts messages in the RA for FFS claims to verify QMB after claims processing. Work with your office staff and vendors to make sure your insurance verification and billing systems are ready to incorporate these QMB updates. Refer to the Background and Additional Information Sections below for further details and important steps to promote compliance.

BACKGROUND

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

Billing of QMBs Is Prohibited by Federal Law

Federal law bars Medicare providers and suppliers from billing an individual enrolled in the QMB program for Medicare Part A and Part B cost-sharing under any circumstances (see Sections 1902(n)(3)(B), 1902(n)(3)(C), 1905(p)(3), 1866(a)(1)(A), and 1848(g)(3)(A) of the Social Security Act [the Act]). The QMB program provides Medicaid coverage of Medicare Part A and Part B premiums and cost sharing to low income Medicare beneficiaries. QMB is an eligibility category under the Medicare Savings Programs. In 2016, 7.5 million individuals (more than one out of eight beneficiaries) were enrolled in the QMB program.

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

Note that certain types of providers may seek reimbursement for unpaid Medicare deductible and coinsurance amounts as a Medicare bad debt. For more information about bad debt, refer to Chapter 3 of the Provider Reimbursement Manual (Pub.15-1).

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

Inappropriate Billing of QMB Individuals Persists

Despite Federal law, providers and suppliers continue to improperly bill individuals enrolled in the QMB

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

Ways to Promote Compliance with QMB Billing Rules

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

- Establish processes to routinely identify the QMB status of Medicare beneficiaries prior to billing for items and services. Use the Medicare 270/271 HETS data provided to Medicare providers, suppliers, and their authorized billing agents (including clearinghouses and third party vendors) (effective November 2017) to verify a beneficiary's QMB status and exemption from cost-sharing charges. Ask your third party eligibility-verification vendors how their products reflect the new QMB information from HETS. For more information, visit the HETS website.
    - In July 2018, CMS will reintroduce QMB information in the Medicare RA that Original Medicare providers and suppliers can use to identify the QMB status of beneficiaries. Refer to the Additional Information section below for educational materials on recent changes that impact RAs for Medicare FFS QMB claims.
    - MA providers and suppliers should also contact the MA plan to learn the best way to identify the QMB status of plan members both before and after claims submission.
    - Providers and suppliers may also verify beneficiaries' QMB status through automated Medicaid eligibility-verification systems in the State in which the person is a resident or by asking beneficiaries for other proof, such as their Medicaid identification card, MSN (starting July 2018) or other documentation of their QMB status.
- Ensurethat 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.
- Determine the billing processes that apply to seeking payment for Medicare cost-sharing from the States in which the beneficiaries you serve reside. Different processes may apply to Original Medicare and MA services provided to individuals enrolled in the QMB program. For Original Medicare claims, nearly all States have electronic crossover processes through the Medicare Benefits Coordination & Recovery Center (BCRC) to automatically receive Medicare-adjudicated claims.
    - If a claim is automatically crossed over to another payer, such as Medicaid, it is customarily noted on the Medicare RA.
    - States require all providers, including Medicare providers, to enroll in their Medicaid system for provider claims review, processing, and issuance of the Medicaid RA. Providers should contact the State Medicaid Agency for additional information regarding Medicaid provider enrollment.

Important Reminders Concerning QMB Billing Requirements

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

1. All Original Medicare and MA providers and suppliers–not only those that accept Medicaid–must not charge individuals enrolled in the QMB program for Medicare cost-sharing.

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

3. Note that individuals enrolled in QMB **cannot** elect to pay Medicare deductibles, coinsurance, and copays, but may have a small Medicaid copay.

ADDITIONAL INFORMATION

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

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

- MLN Matters Article MM9911, discusses the claims processing system modifications implemented on October 2, 2017, to generate QMB information in the RAs and MSNs.
- On December 8, 2017, the claims processing system modifications made on October 2, 2017, were temporarily suspended due to unintended issues that affected processing QMB cost-sharing claims by States and other payers secondary to Medicare. For more information, refer to QMB Remittance Advice Issue.
- MLN Matters Article 10494 describes how Medicare Administrative Contractors (MACs) will issue replacement RAs for QMB claims paid on or after October 2, 2017, through December 31, 2017, that have not been voided or replaced. MACs will issue replacement RAs by December 11, 2018, for Part B claims and by September 12, 2018, for Part A/Durable Medical Equipment C claims.
- MLN Matters Article MM10433 discusses how CMS will reintroduce QMB information in the RA starting July 2018 and modify to CR 9911 to avoid disrupting claims processing by secondary payers.

For more information about dual eligibles under Medicare and Medicaid, please visit https://www.medicaid.gov/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
June 26, 2018	This article was revised to clarify the description of the QMB program. It also adds that starting July 2018 the Medicare Summary Notice (MSN) is another way for providers to verify the QMB status of beneficiaries for Medicare Fee-For-Service (FFS) claims. All other information remains the same.
March 22, 2018	The article was revised to indicate that CMS will reintroduce QMB information in the Medicare Remittance Advice (RA) and Medicare Summary Notice (MSN) for all claims processed on or after July 2, 2018. CMS initially included QMB information in RAs and MSNs for claims processed on or after October 2, 2017, but suspended those changes on December 8, 2017, to address unforeseen issues preventing the processing of QMB cost-sharing claims by States and other secondary payers outside of the Coordination of Benefits Agreement (COBA) process. All other information remains the same.
December 4, 2017	The article was revised to indicate that on December 8, 2017, CMS will suspend modifications to the Provider Remittance Advice and the Medicare Summary Notice for QMB claims made on October 2, 2017. The article was also revised to show the HETS QMB release was implemented in November 2017. Finally, the article was changed to clarify that QMBs cannot elect to pay Medicare cost-sharing but may need to pay a small Medicaid copay in certain circumstances. All other information remains the same.
November 3, 2017	Article revised to show the HETS QMB release will be in November 2017. All other information remains the same.
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 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.

Question	Answer
How do I request a Telephone Reopening?	To request a reopening via telephone, call 1-866-419-9458.
What are the hours for Telephone Reopenings?	Monday through Friday 8 a.m. – 5 p.m. ET Further closing information can be found at https://med.noridianmedicare.com/web/jadme/contact/holiday-schedule.
What information do I need before I can initiate a Telephone Reopening?	Before a reopening can be completed, the caller must have all of the following information readily available as it will be verified by the Telephone Reopenings representative. If at any time the information provided does not match the information in the claims processing system, the Telephone Reopening cannot be completed. • National Provider Identifier (NPI) • Provider Transaction Access Number (PTAN) • Last five digit of Tax ID Number (TIN) • Supplier name • Beneficiary's Health Insurance Claim Number (HICN) • Beneficiary's first and last name • Date of service (DOS) • Last five of the Claim Control Number (CCN) • Healthcare Common Procedure Coding System (HCPCS) code(s) in question • Corrective action to be taken Note: Claims with remark code MA130 can never be submitted as a reopening (telephone or written). Claims with remark code MA130 are considered unprocessable and do not have reopening or appeal rights. The claim is missing information that is needed for processing or was invalid and must be resubmitted.

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

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

What do I do when I have a large amount of corrections?	If a supplier has at least 10 of the same correction, that are able to be completed as a reopening, the supplier should notify a Telephone Reopenings representative. The representative will gather the required information for the supplier to submit a Special Project.

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

Liability Modifier Appeal Rights Webpage Now Available

What appeal rights are available when adding or removing a liability modifier (GA, GX, GY, and GZ)?

View the newly added Liability Modifier Appeal Rights webpage to determine what remedial claims action is available when requesting a liability modifier be added or removed.

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.

CERT Contractor's New Provider Mailing Address Process - Effective August 14, 2018

Effective August 14, 2018, the Comprehensive Error Rate Testing (CERT) Review Contractor is sending initial additional documentation requests (ADRs) to the Correspondence Address in Provider Enrollment Chain and Ownership System (PECOS).

Learn more on the Provider Mailing Addresses and Point of Contact for CERT Requests webpage.

CERT Late/Additional Documentation Deadline - August 30, 2018

The Comprehensive Error Rate Testing (CERT) Review Contractor must receive late/additional documentation for claims in the 2018 report by Thursday, August 30, 2018.

For additional questions or support, access the Noridian CERT team phone and email address from the CERT Contact Information webpage.

Medical Review Pre-Claim Review Webpage Updates

On September 1, 2018, Power Mobility Device (PMD) Demonstration HCPCS (K0813-K0829 and K0835-K0855) will become part of the nationwide Required Prior Authorization (PA) program.

Effective August 18, 2018, DME MACS can no longer accept PA review requests for PA review in the demonstration program.

To best provide our supplier community with the most relevant, up-to-date, and consolidated information on this, access the below from the, formally titled "Prior Authorization" and revised, Medical Review Pre-Claim Review webpage.

- Program related information
- Educational events and resources
- Lookup Tool
- Condition of Payment PA Program vs. PMD PA Demonstration vs. ADMC Comparison Tool

Prior Authorization: Notification of Advance Beneficiary Notice of Noncoverage (ABN) Review – Revised

This article is being revised and republished to include 31 additional HCPCS code(s) that will be suspended for review when a Prior Authorization (PA) applicable claim is billed with a GA modifier.

Noridian Jurisdiction A, DME MAC, Medical Review will be adding 31 HCPCS codes to the review of PA applicable claims billed with a GA modifier.

HCPCS codes to be added to the K0856 and K0861 PA ABN review.

- K0813-K0816, K0820-K0829: Standard Power Wheelchairs
- K0835-K0843: Group 2 Complex Rehabilitative Power Wheelchairs
- K0848-K0855: Group 3 Complex Rehabilitative Power Wheelchairs without Power Options

To evaluate compliance with Medicare coverage and coding rules, claims billed with an appended GA modifier, for a Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) item subject to PA, will result in a mailed Additional Documentation Request (ADR) letter to the supplier requesting the ABN. The ABN will confirm that it complies with current CMS-R-131 form requirements. Submission instructions are included in the ADR.

Fax or mail the ABN and a copy of the ADR letter to Noridian. Failure to supply the ABN within 45 days of the ADR letter date will result in claim denial.

View ABN requirements information in the CMS Internet Only Manual (IOM), Publication 100-04, Medicare Claims Processing Manual, Chapter 30.

Additional information, educational opportunities, and training tools related to this product category are available within Education & Outreach.

Automating First Claim Review in Serial Claims for DMEPOS – Revised

MLN Matters Number: MM10426 Revised
Related Change Request (CR) Number: 10426
Related CR Release Date: July 12, 2018
Effective Date: July 2, 2018
Related CR Transmittal Number: R2098OTN
Implementation Date: January 7, 2019

This article was revised on July 13, 2018, to reflect a revised Change Request (CR) that revise business requirement 10426.30 and 10426.30.2 (see bold text page 2 below). The CR release date, transmittal number and link to the CR also changed. All other information remains the same.

PROVIDER TYPE AFFECTED

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

WHAT YOU NEED TO KNOW

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

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

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

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

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

- If a paper claim is submitted, any additional documentation must be attached to the claim form.

If an electronic claim is submitted, the existing PWK process must be followed and the claim must also include the word "serial" in the NTE02 segment. (Refer to MLN article MM7041 for the existing PWK process.)

Make sure your billing staff is aware of these changes.

ADDITIONAL INFORMATION

The official instruction, CR10426, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R2098OTN.pdf.

There is an Excel® spreadsheet attached to CR10426 containing the HCPCS codes and related serial certification period covered by CR10426.

DOCUMENT HISTORY

Date of Change	Description
July 13, 2018	This article was revised on to reflect a revised CR that revise business requirement 10426.30 and 10426.30.2 (see bold text page 2 above). The CR release date, transmittal number and link to the CR also changed. All other information remains the same.
February 2, 2018	Initial article released.

Clinician Checklists Added to Clinician's Corner

To ensure clinician's complete the appropriate documentation needed when prescribing durable medical equipment prosthetics, orthotics and supplies (DMEPOS) to Medicare beneficiaries, the Clinician's Corner webpage contains specifically created checklists.

Check out the newly added Clinician Checklists from the Clinician's Corner webpage.

Clinician's Corner Now Available

Are you a clinician who needs guidance on coverage and documentation guidelines when providing or ordering Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) to Medicare beneficiaries?

Our new Clinician's Corner is designed especially for you and contains clinician-based information such as Clinician Resource Letters and Prescribing Checklists along with articles and additional information pertinent to ordering clinicians.

Consolidated Billing Tool Now Available

To help suppliers/providers determine if a specific Healthcare Common Procedure Coding System (HCPCS) code, specific to durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), is considered under consolidated billing for Skilled Nursing Facility (SNF), Home Health (HH), and Hospice, we now have a Consolidated Billing/SNF/Home Health/Hospice Lookup. Check it out.

For additional information on SNF, Home Health, Hospice, and helpful resources, suppliers can also see the Consolidated Billing webpage.

Medically Unlikely Edit (MUE) Lookup Tool - Revised

Updated article introduction paragraph to include corrected verbiage.

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

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

Access the MUE Lookup Tool from the Medically Unlikely Edit (MUE) webpage.

Medicare Claims Processing Manual, Chapter 24, Section 90 – Update

MLN Matters Number: MM10559
Related Change Request (CR) Number: 10559
Related CR Release Date: August 3, 2018
Effective Date: November 5, 2018
Related CR Transmittal Number: R4096CP
Implementation Date: November 5, 2018

PROVIDER TYPE AFFECTED

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

WHAT YOU NEED TO KNOW

This article is based on Change Request (CR) 10559 which reduces confusion and clarifies the Administrative Simplification Compliance Act (ASCA) waiver process guideline in the Medicare Claims Processing Manual, Chapter 24, Section 90. CR10559 combines two sections (90.3.2 and 90.3.3) into one new Section 90.3.2 with a new title and description.

BACKGROUND

Section 3 of the ASCA, Pub. L. 107-105, and the implementing regulation at 42 CFR 424.32 (see https://www.ecfr.gov/cgi-bin/text-idx?SID=c41b2cb8b72f75bd58ae2a26094f4cfe&mc=true&node=pt42.3.424&rgn=div5#se42.3.424_132), require providers to submit all initial claims for reimbursement under Medicare, (except for small providers), electronically as of October 16, 2003, with limited exceptions.

Medicare is prohibited from paying claims submitted in a non-electronic manner that do not meet the limited exception criteria. The issuance of waivers under this limited exception criteria to is discussed in Chapter 24, Section 90 of the Medicare Claims Processing Manual.

A provider may submit a waiver request to their MAC claiming other types of "unusual circumstances" outside of their control prevent submission of electronic claims. It is the responsibility of the provider to submit appropriate documentation including request application with Provider name, address, email, and phone number to establish the validity of a waiver request in this situation. Requests received without documentation and above stated information to fully explain and justify why enforcement of the requirement would be against equity and good conscience in these cases will be denied. If the MAC agrees that the waiver request has merit, the MAC sends the request to the Centers for Medicare & Medicaid Services (CMS) for review and issuance of the CMS decision.

If the MAC does not consider an "unusual circumstance" to be met, and does not recommend CMS approval, the MAC must issue a form letter to the provider. As required by the Privacy Act of 1974, letters issued to a provider to announce a waiver decision must be addressed to the organizational name of

a provider and not to an individual (whether a sole practitioner, employee, or an owner of the provider organization). The organizational name is generally a corporate name under which the provider is registered as a Medicare provider or that is used to obtain an Employer Identification Number (EIN).

ADDITIONAL INFORMATION

The official instruction, CR10559, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4096CP.pdf. The revised manual chapter is attached to the CR.

DOCUMENT HISTORY

Date of Change	Description
August 3, 2018	Initial article released.

DMEPOS CBP - October 2018 Update

MLN Matters Number: MM10802
Related Change Request (CR) Number: 10802
Related CR Release Date: June 8, 2018
Effective Date: October 1, 2018
Related CR Transmittal Number: R4070CP
Implementation Date: October 1, 2018

PROVIDER TYPE AFFECTED

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

Medical Equipment Medicare Administrative Contractors (DME MACs) for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) items or services paid under the DMEPOS fee schedule.

WHAT YOU NEED TO KNOW

Change Request (CR) 10802 provides the October 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 DME CBP files are updated on a quarterly basis in order to implement necessary changes to the Healthcare Common Procedure Coding System (HCPCS) codes, ZIP code, single payment amount, and supplier files. These requirements provide specific instruction for implementing the DMEPOS CBP files.

BACKGROUND

Congress mandated the DMEPOS CBP through the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). The statute required 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 (CBA). Suppliers are required to submit a bid for selected products. 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 supplier's eligibility, its financial stability and the bid price. Medicare awards contracts to the Medicare suppliers who offer the best price and meet applicable quality and financial standards. Contract suppliers must agree to accept assignment on all claims for bid items and will be paid the bid price amount. The amount is derived from the median of all winning bids for an item.

ADDITIONAL INFORMATION

The official instruction, CR10802, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4070CP.pdf.

DOCUMENT HISTORY

Date of Change	Description
June 8, 2018	Initial article released.

Medicare Coverage of Diabetes Supplies

MLN Matters Number: SE18011

Article Release Date: August 16, 2018

PROVIDER TYPE AFFECTED

This MLN Matters® Special Edition (SE) article is intended for physicians, providers, suppliers, and other health care professionals who furnish or provide referrals for and/or file claims to Medicare Administrative Contractors (MACs) for Medicare-covered diabetes supplies.

WHAT YOU NEED TO KNOW

This article is informational only and represents no Medicare policy changes.

BACKGROUND

This special edition article presents a current overview of the diabetes supplies covered by Medicare (Part B and Part D) to assist physicians, providers, suppliers, and other health care professionals who provide diabetic supplies to Medicare beneficiaries.

Medicare Part B Covered Diabetic Supplies

Medicare covers certain supplies if a beneficiary has Medicare Part B and has diabetes. These supplies include:

- Blood glucose self-testing equipment and supplies
- Therapeutic shoes and inserts
- Insulin pumps and the insulin used in the pumps

Blood Glucose Self-testing Equipment and Supplies

Blood glucose self-testing equipment and supplies are covered for all people with Medicare Part B who have diabetes. This includes those who use insulin and those who do not use insulin. Equipment and supplies include:

- Blood glucose monitors
- Continuous Blood Glucose monitors
- Blood glucose test strips
- Lancet devices and lancets
- Glucose control solutions for checking the accuracy of testing equipment and test strips.
- Supply allowance for therapeutic continuous glucose monitor (CGM), includes all supplies and accessories.

Medicare Part B covers the same type of blood glucose testing supplies for people with diabetes whether or not they use insulin. However, the amount of supplies that are covered varies.

If the beneficiary:

Uses insulin, they may be able to get up to 100 test strips and lancets every month, and 1 lancet device every 6 months.

Does not use insulin, they may be able to get 100 test strips and lancets every 3 months, and 1 lancet device every 6 months.

If a beneficiary's doctor documents why it is medically necessary, Medicare will cover additional test strips and lancets for the beneficiary.

Medicare will only cover a beneficiary's blood glucose self-testing equipment and supplies if they get a prescription from their doctor. Their prescription should include the following information:

- That they have diabetes
- What kind of blood glucose monitor they need and why they need it (that is, if they need a special monitor because of vision problems, their doctor must explain that.)
- Whether they use insulin
- How often they should test their blood glucose

A beneficiary who needs blood glucose testing equipment and/or supplies:

- Can order and pick up their supplies at their pharmacy
- Can order their supplies from a medical equipment supplier, but they will need a prescription from their doctor to place their order
- Must ask for refills for their supplies

Note: Medicare will not pay for any supplies not asked for, or for any supplies that were sent to a beneficiary automatically from suppliers. This includes blood glucose monitors, test strips, and lancets. Also, if a beneficiary goes to a pharmacy or supplier that is not enrolled in Medicare, Medicare will not pay. The beneficiary will have to pay the entire bill for any supplies from non-enrolled pharmacies or non-enrolled suppliers.

All Medicare-enrolled pharmacies and suppliers must submit claims for blood glucose monitor

test strips. Beneficiaries cannot submit a claim for blood glucose monitor test strips themselves. The beneficiary should make sure that the pharmacy or supplier accepts assignment for Medicare-covered supplies. If the pharmacy or supplier accepts assignment, Medicare will pay the pharmacy or supplier directly. Beneficiaries should only pay their coinsurance amount when they get their supply from their pharmacy or supplier for assigned claims. If a beneficiary's pharmacy or supplier **does not** accept assignment, charges may be higher, and the beneficiary may pay more. They may also have to pay the entire charge at the time of service and wait for Medicare to send them its share of the cost.

Before a beneficiary gets a supply, it is important for them to ask the supplier or pharmacy the following questions:

- Are you enrolled in Medicare?
- Do you accept assignment?

If the answer to either of these two (2) questions is "no," they should call another supplier or pharmacy in their area who answers "yes" to be sure their purchase is covered by Medicare, and to save them money.

If a beneficiary cannot find a supplier or pharmacy in their area that is enrolled in Medicare and accepts assignment, they may want to order their supplies through the mail, which may also save them money.

Therapeutic Shoes and Inserts

If a beneficiary has Medicare Part B, has diabetes, and meets certain conditions (see below), Medicare will cover therapeutic shoes if they need them. The types of shoes that are covered each year include one of the following:

One pair of depth-inlay shoes **and** three pairs of inserts, or

One pair of custom-molded shoes (including inserts) if the beneficiary cannot wear depth-inlay shoes because of a foot deformity **and** two additional pairs of inserts.

Note: In certain cases, Medicare may also cover shoe modifications instead of inserts.

In order for Medicare to pay for the beneficiary's therapeutic shoes, the doctor treating their diabetes must certify that they meet **all** of the following three conditions:

- They have diabetes.
- They have at least 1 of the following conditions in one or both feet:
  - Partial or complete foot amputation
  - Past foot ulcers

  - Calluses that could lead to foot ulcers
  - Nerve damage because of diabetes with signs of problems with calluses
  - Poor circulation
  - Deformed foot
- They are being treated under a comprehensive diabetes care plan and need therapeutic shoes and/or inserts because of diabetes.

Medicare also requires the following:

- A podiatrist or other qualified doctor must prescribe the shoes, and
- A doctor or other qualified individual like a pedorthist, orthotist, or prosthetist must fit and provide the shoes to the beneficiary.

Medicare helps pay for one pair of therapeutic shoes and inserts per calendar year, and the fitting of the shoes or inserts is covered in the Medicare payment for the shoes.

Insulin Pumps and the Insulin Used in the Pumps

Insulin pumps worn outside the body (external), including the insulin used with the pump, may be covered for some people with Medicare Part B who have diabetes and who meet certain conditions. If a beneficiary needs to use an insulin pump, their doctor will need to prescribe it. In the Original Medicare Plan, the beneficiary pays 20 percent of the Medicare-approved amount after the yearly Part B deductible. Medicare will pay 80 percent of the cost of the insulin pump. Medicare will also pay for the insulin that is used with the insulin pump.

Medicare Part B covers the cost of insulin pumps and the insulin used in the pumps. Recently, the DME MACs learned of an issue with pharmacies billing Medicare Part D for insulin used in a Durable Medical Equipment (DME) external insulin infusion pump. To assist the pharmacist in billing the correct payer for the insulin, the DME MACs recommend that providers specifically state "Insulin for Insulin Pump" (or similar language indicating the method of administration) on your orders. This will help ensure that the pharmacy bills the correct payer and avoid unnecessary claim denials for your patients.

However, if the beneficiary injects their insulin with a needle (syringe), Medicare Part B does not cover the cost of the insulin, but the Medicare prescription drug benefit (Part D) covers the insulin and the supplies necessary to inject it. This includes syringes, needles, alcohol swabs and gauze. The Medicare Part D plan will cover the insulin and any other medications to treat diabetes at home as long as the beneficiary is on the Medicare Part D plan's formulary.

Coverage for diabetes-related durable medical equipment (DME) is provided as a Medicare Part B benefit. The Medicare Part B deductible and coinsurance or copayment applies after the yearly Medicare part B deductible is met. In the Original Medicare Plan, Medicare covers 80 percent of the Medicare-approved amount (after the beneficiary meets their annual Medicare Part B deductible of $183 in 2018), and the beneficiary pays 20 percent of the total payment amount (after the annual Part B deductible of $183 in 2018). This amount can be higher if the beneficiary's doctor does not accept assignment, and the beneficiary may have to pay the entire amount at the time of service. Medicare will then send the beneficiary its share of the charge.

Medicare Part D Covered Diabetic Supplies and Medications

This section provides information about Medicare prescription drug coverage (Part D) for beneficiaries with Medicare who have or are at risk for diabetes. If a beneficiary wants Medicare prescription drug coverage, they must join a Medicare drug plan. The following diabetic medications and supplies are covered under Medicare drug plans:

- Diabetes supplies
- Insulin
- Anti-diabetic drugs

Diabetes Supplies

Diabetes supplies associated with the administration of insulin may be covered for all people with Medicare Part D who have diabetes. These medical supplies include the following:

- Syringes
- Needles
- Alcohol swabs
- Gauze
- Inhaled insulin devices

Insulin

Injectable insulin not associated with the use of an insulin infusion pump is covered under Medicare Part D drug plans.

Anti-diabetic Drugs

Medicare drug plans can cover anti-diabetic drugs such as:

- Sulfonylureas (such as Glipizide, Glyburide)
- Biguanides (such as metformin)
- Thiazolidinediones (such as Starlix® and Prandin®)
- Alpha glucosidase inhibitors (such as Precose®).

Supplies and Services Not Covered by Medicare

The Original Medicare Plan and Medicare drug plans (Part D) don't cover everything. Diabetes supplies and services not covered by Medicare include:

- Eye exams for glasses (eye refraction)
- Orthopedic shoes
- Weight loss programs.

ADDITIONAL INFORMATION

The Centers for Medicare & Medicaid Services (CMS) has developed a variety of educational resources for use by health care professionals and their staff as part of a broad outreach campaign to promote awareness and increase utilization of preventive services covered by Medicare. For more information about coverage, coding, billing, and reimbursement of Medicare-covered preventive services and screenings, visit http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/index.html.

Medicare Learning Network - The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information visit the Medicare Learning Network's web page at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html.

Patient Resources - For literature to share with Medicare patients, please visit http://www.medicare.gov.

The National Diabetes Education Program - NDEP (http://ndep.nih.gov/) provides a wealth of resources for health care professionals, educators, business professionals, and patients about diabetes, its complications, and self-management.

See MLN Matters article MM10013 at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm10013.pdf for more information on continuous glucose monitors.

DOCUMENT HISTORY

Date of Change	Description
August 16, 2018	Initial article released.

Public Health Emergency Extension Due to Hurricane Maria

On June 12, 2018, pursuant to the Section 319 of the Public Health Service Act, the secretary of the Department of Health & Human Services (DHHS) signed a 90-day renewal of the determination that a Public Health Emergency (PHE) continues to exist in the United States Virgin Islands (USVI). Effective June 13, 2018, for the affected area, this renewal authorizes waivers and modifications under Section 1135 and Section 1812(f) of the Social Security Act.

Refer to the CMS Medicare Learning Network (MLN) Matters Special Edition (SE)17028 for detailed information on this claim submission waiver process.

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

MLN Matters Number: SE17028 Revised
Article Release Date: July 25, 2018

This article was revised on July 25, 2018, to advise providers that the public health emergency (PHE) declaration and Section 1135 waiver authority for the U.S. Virgin Islands were renewed again on June 13, 2018. The PHE and Section 1135 waiver authority for Puerto Rico expired on June 13, 2018. All other information is unchanged.

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.

The PHE declaration and Section 1135 waiver authority for the U.S. Virgin Islands were renewed on December 15, 2017, renewed again on March 15, 2018, and renewed again on June 13, 2018. The PHE and Section 1135 waiver authority for Puerto Rico were extended to March 15, 2018, and were extended again on March 16, 2018, to June 13, 2018. The PHE and Section 1135 waiver authority for Puerto Rico expired on June 13, 2018.

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

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

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

BACKGROUND

Section 1135 and Section 1812(f) Waivers

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

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

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

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

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

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

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

Blanket Waivers Issued by CMS

Under the authority of Section 1135 (or, as noted below, Section 1812(f)), CMS has issued blanket waivers in the affected area of the United States Virgin Islands 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
July 25, 2018	This article was revised to advise providers that the PHE declaration and Section 1135 waiver authority for the U.S. Virgin Islands were renewed again on June 13, 2018. The PHE and Section 1135 waiver authority for Puerto Rico expired on June 13, 2018.
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.

Undersea and Hyperbaric Medicine Physician Specialty Code

MLN Matters Number: MM10666
Related Change Request (CR) Number: 10666
Related CR Release Date: July 13, 2018
Effective Date: January 1, 2019
Related CR Transmittal Number: R4087CP, R306FM
Implementation Date: January 7, 2019

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) 10666 informs you that the Centers for Medicare & Medicaid Services (CMS) has established a new Physician Specialty code for Undersea and Hyperbaric Medicine. This new code is D4. Make sure your billing staffs are aware of these changes.

BACKGROUND

Physicians self-designate their Medicare physician specialty on the Medicare enrollment application (CMS-855I or CMS-855O) or via the Internet-based Provider Enrollment, Chain and Ownership System (PECOS) when they enroll in the Medicare program. Medicare physician specialty codes describe the specific/unique types of medicine that physicians (and certain other suppliers) practice. Specialty codes are used by CMS for programmatic and claims processing purposes.

The CMS-855I and CMS-855O paper applications will be updated to reflect the new physician specialty in the future. In the interim, providers shall select the 'Undefined physician type' option on the enrollment application and specify Undersea and Hyperbaric Medicine in the space provided.

Existing enrolled providers who want to update their specialty to reflect the new specialty must submit a change of information application to their Medicare Administrative Contractor (MAC). Providers may submit an enrollment application to initially enroll or update their specialty within 60 days of the implementation date of the new specialty.

MACs will recognize Undersea and Hyperbaric Medicine (D4) as a valid specialty type for the following edits:

- Ordering/Referring
- Critical Access Hospital (CAH) Method II Attending and Rendering
- Attending, operating, or other physician or non-physician practitioner listed on a CAH claim

ADDITIONAL INFORMATION

The official instructions, CR10666, issued to your MAC are available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R306FM.pdf and https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4087CP.pdf.

DOCUMENT HISTORY

Date of Change	Description
July 13, 2018	Initial article released.

Continuous Glucose Monitors – Use of Smart Devices

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Continuous Glucose Monitors – Use of Smart Devices" is now available on our (Noridian) website.

View the complete Continuous Glucose Monitors – Use of Smart Devices webpage.

Correct Coding - A9286 – Hygienic Item or Device, Disposable or Non-Disposable, Any Type, Each

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Correct Coding - A9286 - HYGIENIC ITEM OR DEVICE, DISPOSABLE OR NON-DISPOSABLE, ANY TYPE, EACH" is now available on our (Noridian) website.

View the complete Correct Coding - A9286 - HYGIENIC ITEM OR DEVICE, DISPOSABLE OR NON-DISPOSABLE, ANY TYPE, EACH webpage.

Correct Coding - Incorrect Use of HCPCS Code K0108 to Bill for Battery Replacement

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

View the complete Correct Coding - Incorrect Use of HCPCS Code K0108 to Bill for Battery Replacement webpage.

Correct Coding - Incorrect Use of HCPCS Code K0108 to Bill for Battery Charger

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

View the complete Correct Coding - Incorrect Use of HCPCS Code K0108 to Bill for Battery Charger webpage.

Correct Coding - Incorrect Use of HCPCS Code K0108 to Bill for a Drive Wheel Gear Box

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Correct Coding - Incorrect Use of HCPCS Code K0108 to Bill for a Drive Wheel Gear Box" is now available on our (Noridian) website.

View the complete Correct Coding - Incorrect Use of HCPCS Code K0108 to Bill for a Drive Wheel Gear Box webpage.

Correct Coding - Incorrect Use of HCPCS Code K0108 to Bill for a Wheelchair Headrest

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

View the complete Correct Coding - Incorrect Use of HCPCS Code K0108 to Bill for a Wheelchair Headrest webpage.

Correct Coding - Incorrect Use of HCPCS Code K0108 to Bill for Wheelchair Tray

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

View the complete Correct Coding - Incorrect Use of HCPCS Code K0108 to Bill for Wheelchair Tray webpage.

Correct Coding - Incorrect Use of HCPCS Code K0108 to Bill for Wheelchair Ventilator Tray

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Correct Coding - Incorrect Use of HCPCS Code K0108 to Bill for Wheelchair Ventilator Tray - Correct Coding" is now available on our (Noridian) website.

View the complete Correct Coding - Incorrect Use of HCPCS Code K0108 to Bill for Wheelchair Ventilator Tray webpage.

Correct Coding – Porta-Lung® Negative Pressure Ventilator – Revised

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Correct Coding – Porta-Lung® Negative Pressure Ventilator – Revised" is now available on our (Noridian) website.

View the complete Correct Coding – Porta-Lung® Negative Pressure Ventilator – Revised webpage.

Correct Coding - Replacement Cecostomy Tube

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

View the complete Correct Coding - Replacement Cecostomy Tube webpage.

Dear Physician Letter – Continuous Glucose Monitor – June 2018

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Dear Physician Letter – Continuous Glucose Monitor – June 2018" is now available on our (Noridian) website.

View the complete Dear Physician Letter – Continuous Glucose Monitor – June 2018 webpage.

Dear Physician Letter – Respiratory Assist Devices (RAD) for Central Sleep Apnea or Complex Sleep Apnea – June 2018

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Dear Physician Letter – Respiratory Assist Devices (RAD) for Central Sleep Apnea or Complex Sleep Apnea – June 2018" is now available on our (Noridian) website.

View the complete Dear Physician Letter – Respiratory Assist Devices (RAD) for Central Sleep Apnea or Complex Sleep Apnea – June 2018 webpage.

Dear Physician Letter – Respiratory Assist Devices (RAD) for Chronic Obstructive Pulmonary Disease (COPD) – June 2018

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Dear Physician Letter – Respiratory Assist Devices (RAD) for Chronic Obstructive Pulmonary Disease (COPD) – June 2018" is now available on our (Noridian) website.

View the complete Dear Physician Letter – Respiratory Assist Devices (RAD) for Chronic Obstructive Pulmonary Disease (COPD) – June 2018 webpage.

Dear Physician Letter – Respiratory Assist Devices (RAD) for Hypoventilation Syndrome – June 2018

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Dear Physician Letter – Respiratory Assist Devices (RAD) for Hypoventilation Syndrome – June 2018" is now available on our (Noridian) website.

View the complete Dear Physician Letter – Respiratory Assist Devices (RAD) for Hypoventilation Syndrome – June 2018 webpage.

Dear Physician Letter – Respiratory Assist Devices (RAD) for Restrictive Thoracic Disorders – June 2018

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Dear Physician Letter – Respiratory Assist Devices (RAD) for Restrictive Thoracic Disorders – June 2018" is now available on our (Noridian) website.

View the complete Dear Physician Letter – Respiratory Assist Devices (RAD) for Restrictive Thoracic Disorders – June 2018 webpage.

LCD and Policy Article Revisions Summary for June 7, 2018

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "LCD and Policy Article Revisions Summary for June 7, 2018" is now available on our (Noridian) website.

View the complete LCD and Policy Article Revisions Summary for June 7, 2018 webpage.

Lower Limb Prostheses – Draft Local Coverage Determination (DL33787) and related Policy Article (A54517) - Retired

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Lower Limb Prostheses – Draft Local Coverage Determination (DL33787) and related Policy Article (A54517) - Retired" is now available on our (Noridian) website.

View the complete Lower Limb Prostheses – Draft Local Coverage Determination (DL33787) and related Policy Article (A54517) - Retired webpage.

Policy Article Revisions Summary for June 14, 2018

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Policy Article Revisions Summary for June 14, 2018" is now available on our (Noridian) website.

View the complete Policy Article Revisions Summary for June 14, 2018 webpage.

Policy Article Revision Summary for June 21, 2018

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Policy Article Revision Summary for June 21, 2018" is now available on our (Noridian) website.

View the complete Policy Article Revision Summary for June 21, 2018 webpage.

Policy Article Revisions Summary for July 19, 2018

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

View the complete Policy Article Revisions Summary for July 19, 2018 webpage.

Policy Article Revisions Summary for August 23, 2018

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Policy Article Revisions Summary for August 23, 2018" is now available on our (Noridian) website.

View the complete Policy Article Revisions Summary for August 23, 2018 webpage.

MBI – Get It, Use It – Second Revision

MLN Matters Number: SE18006 Revised

Article Release Date: July 11, 2018

This article was revised on July 11, 2018, to provide additional information regarding the format of the MBI not using letters S, L, O, I, B, and Z (page 2). All other information remains the same.

PROVIDER TYPE AFFECTED

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

PROVIDER ACTION NEEDED

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

1. Ask your Medicare patients

Ask your Medicare patients for their new Medicare card when they come for care. If they haven't received a new card at the completion of their geographic mailing wave, give them the "Still Waiting for Your New Card?" handout (in English or Spanish) or refer them to 1-800-Medicare (1-800-633-4227).

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

Once we mail the new Medicare card with the MBI to your patient, you can look up MBIs for your Medicare patients when they don't or can't give them. If the tool indicates the card hasn't been mailed for your Medicare patient who lives in a geographic location where the card mailing is finished, tell your patient to call 1-800-Medicare (1-800-633-4227). Sign up for the Portal to use the tool. You can use this tool even after the end of the transition period – it doesn't end on December 31, 2019.

3. Check the remittance advice

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

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

BACKGROUND

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS to remove Social Security Numbers from all Medicare cards by April 2019. A new, randomly generated Medicare Beneficiary Identifier, or MBI, is replacing the SSN-based HICN. The new MBI is noticeably different than the HICN. **Just like with the HICN, the MBI hyphens on the card are for illustration purposes: don't include the hyphens or spaces on transactions.** The MBI uses numbers 0-9 and all uppercase letters except for S, L, O, I, B, and Z. We exclude these letters to avoid confusion when differentiating some letters and numbers (e.g., between "0" and "O").

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

Use the MBI the same way you use the HICN today. Put the MBI in the same field where you've always put the HICN. This also applies to reporting informational only and no-pay claims. Don't use hyphens or spaces with the MBI to avoid rejection of your claim. The MBI will replace the HICN on Medicare transactions including Billing, Eligibility Status, and Claim Status. The effective date of the MBI, like the old HICN, is the date each beneficiary was or is eligible for Medicare. Until December 31, 2019, you can use either the HICN or the MBI in the same field where you've always put the HICN. After that the remittance advice will tell you if we rejected claims because the MBI wasn't used. It will include Claim Adjustment

Reason Code (CARC) 16, "Claim/service lacks information or has submission/billing error(s)." along with Remittance Advice Remark Code (RARC) N382 "Missing/incomplete/invalid patient identifier".

The beneficiary or their authorized representative can request an MBI change. CMS can also initiate a change to an MBI. An example is if the MBI is compromised. There are different scenarios for using the old or new MBIs:

FFS claims submissions with:

- Dates of service before the MBI change date – use the old or new MBI.
- Span-date claims with a "From Date" before the MBI change date – use the old or new MBI.
- Dates of service that are entirely on or after the effective date of the MBI change – use the new MBI.

FFS eligibility transactions when the:

- Inquiry uses new MBI – we'll return all eligibility data.
- Inquiry uses the old MBI and request date or date range overlap the active period for the old MBI –we'll return all eligibility data. We'll also return the old MBI termination date.
- Inquiry uses the old MBI and request date or date range are entirely on or after the effective date of the new MBI – we'll return an error code (AAA 72) of "invalid member ID."

When the MBI changes, we ask the beneficiary to share the new MBI with you. You can also get the MBI from your MACs secure MBI lookup tool.

Protect the MBI as Personally Identifiable Information (PII); it is confidential like the HICN.

Submit all HICN-based claims by the end of the transition period, December 31, 2019. On January 1, 2020, even for dates of services before this date, you must use MBIs for all transactions; there are a few exceptions when you can use either the HICN or MBI:

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

The MBI does not change Medicare benefits. Medicare beneficiaries may start using their new Medicare cards and MBIs as soon as they get them. Use MBIs as soon as your patients share them. The new cards are effective the date beneficiaries are eligible for Medicare.

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

ADDITIONAL INFORMATION

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

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

DOCUMENT HISTORY

Date of Change	Description
July 11, 2018	This article was revised to provide additional information regarding the format of the MBI not using letters S, L, O, I, B, and Z (page 2).
June 25, 2018	This article was revised to provide additional information regarding the ways your staff can get MBIs (page 1).
June 21, 2018	The article was revised to emphasize the need to submit the MBI without hyphens or spaces to avoid rejection of your claim.
May 25, 2018	Initial article released.

MLN Connects – June 7, 2018

MLN Connects® for Thursday, June 7, 2018

View this edition as a PDF

News & Announcements

- New Medicare Card: MBI Look-up Tool Available through your MAC
- Declines in Hospital-Acquired Conditions Save 8,000 Lives and $2.9 Billion
- 2017 Quality Payment Program Year 1 Submission Results
- DMEPOS Prior Authorization List Additions
- Draft QRDA III Implementation Guide: Submit Comments by June 20
- IRF and LTCH Provider Preview Reports: Review Your Data by June 30
- SNF Provider Preview Report: Review Your Data by June 30
- Hospice Provider Preview Reports: Review Your Data by June 30
- Eligible Hospitals: Submit a Hardship Exception Application by July 1
- PEPPER for Short-term Acute Care Hospitals
- View Your MIPS Preliminary Performance Feedback Data
- Physician Compare Downloadable Database: 2016 Performance Scores

Provider Compliance

- Bill Correctly for Device Replacement Procedures — Reminder

Claims, Pricers & Codes

- July 2018 Average Sales Price Files

Upcoming Events

- MIPS Promoting Interoperability Performance Category Webinar — June 12
- CMS Quality Measures: Development, Implementation, and You Webinar — June 13 or 14
- Medicare Diabetes Prevention Program: Supplier Enrollment Call — June 20
- IMPACT Act: Frequently Asked Questions Call — June 21
- Home Health Agencies: Quality of Patient Care Star Ratings Algorithm Call — June 27
- Ground Ambulance Providers and Suppliers: Data Collection System Listening Session — June 28
- Comparative Billing Report on Knee Orthoses Referring Providers Webinar — July 11

Medicare Learning Network® Publications & Multimedia

- New Q Code for In-Line Cartridge Containing Digestive Enzyme(s) MLN Matters Article — New
- July 2018 Update of the Ambulatory Surgical Center Payment System MLN Matters Article — New
- Claim Status Category and Claim Status Codes Update MLN Matters Article — New
- Settlement Conference Facilitation Call: Audio Recording and Transcript — New
- E/M Service Documentation Provided by Students MLN Matters Article — Revised

MLN Connects – June 14, 2018

MLN Connects® for Thursday, June 14, 2018

View this edition as a PDF

News & Announcements

- CMS Opioids Roadmap
- LTCH and IRF Compare Refresh
- Antipsychotic Drug Use in Nursing Homes: Trend Update
- Men's Health Week Ends on Father's Day

Provider Compliance

- Billing for Stem Cell Transplants — Reminder

Claims, Pricers & Codes

- FY 2019 ICD-10-CM Diagnosis Codes

Upcoming Events

- Medicare Diabetes Prevention Program: Supplier Enrollment Call — June 20
- IMPACT Act: Frequently Asked Questions Call — June 21
- Home Health Agencies: Quality of Patient Care Star Ratings Algorithm Call — June 27
- Ground Ambulance Providers and Suppliers: Data Collection System Listening Session — June 28

Medicare Learning Network® Publications & Multimedia

- Improvements in Hospice Billing and Claims Processing MLN Matters Article — New
- Provider Enrollment: Unlicensed Residents MLN Matters Article — New
- Update of the Hospital OPPS: July 2018 MLN Matters Article — New
- I/OCE Specification Version 19.2: July 2018 MLN Matters Article — New
- Quarterly Update for the DMEPOS CBP: October 2018 MLN Matters Article — New
- Medicare Claims Processing Manual Update, Chapters 18 and 35: IDTF MLN Matters Article — New
- Provider/Supplier Reporting of Adverse Legal Actions MLN Matters Article — New
- Transition to New Medicare Numbers and Cards Fact Sheet — Revised
- CMS Web Wheel Educational Tool — Revised
- Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians Web-based Training — Reminder
- Remittance Advice Resources and FAQs Booklet — Reminder

MLN Connects – June 21, 2018

MLN Connects® for Thursday, June 21, 2018

View this edition as a PDF

News & Announcements

- New Medicare Cards May Have QR Codes
- Continuous Glucose Monitors: Changes Impacting Medicare Coverage
- Quality Payment Program Look-Up Tool Updated
- Quality Payment Program Website Includes 2018 MIPS Measures and Activities
- Hospice Provider Preview Reports: Review Your Data by June 30
- IRF and LTCH Provider Preview Reports: Review Your Data by July 1
- SNF Provider Preview Report: Review Your Data by July 1
- CMS Leverages Medicaid Program to Combat the Opioid Crisis

Provider Compliance

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

Upcoming Events

- Home Health Agencies: Quality of Patient Care Star Ratings Algorithm Call — June 27
- Ground Ambulance Providers and Suppliers: Data Collection System Listening Session — June 28

Medicare Learning Network® Publications & Multimedia

- July Quarterly Update for 2018 DMEPOS Fee Schedule MLN Matters Article — New
- Qualified Medicare Beneficiary Call: Audio Recording and Transcript — New

MLN Connects Special Edition - June 25, 2018

New Medicare Card Mailing Update – Wave 3 Begins, Wave 1 Ends

We started mailing new Medicare cards to people with Medicare who live in Wave 3 states: Arkansas, Illinois, Indiana, Iowa, Kansas, Minnesota, Nebraska, North Dakota, Oklahoma, South Dakota and Wisconsin. We continue to mail new cards to people who live in Wave 2 states and territories (Alaska, American Samoa, California, Guam, Hawaii, Northern Mariana Islands, Oregon), as well as nationwide to people who are new to Medicare.

We finished mailing most cards to people with Medicare who live in Wave 1 states: Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, and West Virginia. If someone with Medicare says they did not get a card:

- Print and give them the "Still Waiting for Your New Card?" handout (in English or Spanish).
- Or tell them to call 1-800-Medicare (1-800-633-4227). There might be something that needs to be corrected, such as updating their mailing address.

All Medicare Administrative Contractor (MAC) secure portal Medicare Beneficiary Identifier (MBI) look-up tools are ready for use. If you do not already have access, sign up for your MAC›s portal to use the tool. Once we mail the new Medicare card with the MBI to your patient, you can look up MBIs for your Medicare patients when they do not or cannot give them. If the tool indicates the card has not been mailed for your Medicare patient who lives in a geographic location where the card mailing is finished, tell your patient to call 1-800-Medicare (1-800-633-4227).

To ensure people with Medicare continue to get health care services, continue to use the Health Insurance Claim Number (HICN) through December 31, 2019 or until your patient brings in their new card with the new number.

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

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

Information on the transition to the new Medicare Beneficiary identifier:

- New MBI Get It, Use It MLN Matters® Article (Updated 6/25/18)
- Transition to New Medicare Numbers and Cards MLN Fact Sheet
- New Medicare Card information website

MLN Connects – June 28, 2018

MLN Connects® for Thursday, June 28, 2018

View this edition as a PDF

News & Announcements

- New Medicare Card: Use MBI Like HICN
- CMS Data Element Library Supports Interoperability
- Physician Self-referral Law RFI: Submit Comments by August 24
- Qualified Medicare Beneficiary Information on RAs and MSNs
- Laboratory Date of Service Exception — Reminder
- Administrative Simplification Compliance Resources
- 2016 CMS Program Statistics
- Pride in Putting Patients First
- Health Care System Response to Mass Shootings

Provider Compliance

- Comprehensive Error Rate Testing: Arthroscopic Rotator Cuff Repair

Claims, Pricers & Codes

- New Part B Edit for Duplication of Diagnosis Codes on Hard Copy Claims

Upcoming Events

- Provider Compliance Focus Group — July 13

Medicare Learning Network® Publications & Multimedia

- Medicare Billing for Cardiac Device Credits Fact Sheet — New
- MBI: Get It, Use It MLN Matters Article — Revised
- Medicare Coverage for Chiropractic Services MLN Matters Article — Revised
- ESRD PPS: Quarterly Update MLN Matters Article — Revised
- I/OCE Specification Version 19.2: July 2018 MLN Matters Article — Revised
- Hospital OPPS: July 2018 Update MLN Matters Article — Revised
- Telehealth Billing Requirements for Distant Site Services MLN Matters Article — Revised
- MLN Learning Management System FAQs Booklet — Revised

MLN Connects Special Edition – July 2, 2018

CMS Takes Action to Modernize Medicare Home Health

On July 2, CMS proposed significant changes to the Home Health Prospective Payment System (PPS) to strengthen and modernize Medicare, drive value, and focus on individual patient needs rather than volume of care. Specifically, CMS is proposing changes to improve access to solutions via remote patient monitoring technology, and to update the payment model for home health care.

"Today's proposals would give doctors more time to spend with their patients, allow home health agencies to leverage innovation and drive better results for patients," said CMS Administrator Seema Verma. "The redesign of the home health payment system encourages value over volume and removes incentives to provide unnecessary care."

CMS's proposed changes promote innovation to modernize home health by allowing the cost of remote patient monitoring to be reported by home health agencies as allowable costs on the Medicare cost report form. This is expected to help foster the adoption of emerging technologies by home health agencies and result in more effective care planning, as data is shared among patients, their caregivers, and their providers. Supporting patients in sharing this data will advance the Administration's MyHealthEData initiative.

As required by the Bipartisan Budget Act of 2018, this proposed rule would also implement a new Patient-Driven Groupings Model (PDGM) for home health payments. The proposed rule also includes information on the implementation of home infusion therapy temporary transitional payments as required by the Bipartisan Budget Act of 2018. In addition, the proposed rule solicits comments on elements of the new home infusion therapy benefit category and proposes standards for home infusion therapy suppliers and accrediting organizations of these suppliers as required by the 21st Century Cures Act.

Physicians who order home health services for their patients would also see administrative burden reduced under this rule. CMS is proposing to eliminate the requirement that the certifying physician estimate how much longer skilled services would be needed when recertifying the need for continuing home health care, as this information is already gathered on a patient's plan of care.

The proposed rule helps advance the Trump Administration's Meaningful Measures Initiative. CMS is proposing changes to the Home Health Quality Reporting Program (HH QRP). The cost impact related to updated data collection processes as a result of the proposed implementation of the PDGM and proposed changes to the HH QRP are estimated to result in a net $60 million in annualized cost savings to Home Health Agencies (HHAs), or $5,150 in annualized cost savings per HHA, beginning in CY 2020.

In the proposed rule CMS is releasing a Request for Information to welcome continued feedback on the Medicare program and interoperability. CMS is gathering stakeholder feedback on revising the CMS patient health and safety standards that are required for providers and suppliers participating in the Medicare and Medicaid programs to further advance electronic exchange of information that supports safe, effective transitions of care between hospitals and community providers.

For More Information:

- Proposed Rule
- Fact Sheet
- Home Health PPS website
- HHA Center website
- Home Health Value-Based Purchasing Model webpage
- Home Health Quality Reporting Requirements webpage

See the full text of this excerpted CMS Press Release (issued July 2).

MLN Connects – July 5, 2018

MLN Connects® for Thursday, July 5, 2018

View this edition as a PDF

News & Announcements

- New Medicare Card: MBI Changes
- MIPS Payment Adjustment Targeted Review: Request by September 30
- Open Payments Program 2017 Financial Data
- Laboratory Date of Service Exception
- Qualified Medicare Beneficiary Information on RAs and MSNs

Provider Compliance

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

Claims, Pricers & Codes

- Rejected Claims for Medicare Diabetes Prevention Program Services
- ESRD Claims Error: Transitional Drug Adjustment Add-On Payment Adjustment

Upcoming Events

- CMS Data Element Library Webinar — July 11
- Public Reporting on Physician Compare Webinar — July 24 or 26

Medicare Learning Network® Publications & Multimedia

- NCCI PTP Edits, Version 24.3: Quarterly Update MLN Matters Article — New
- Medicare Diabetes Prevention Program Call: Audio Recording and Transcript — New
- IMPACT Act Call: Audio Recording and Transcript — New
- Prohibition Billing Dually Eligible Individuals Enrolled in the QMB Program MLN Matters Article — Revised
- Global Surgical Days for CAH Method II MLN Matters Article — Revised
- HCPCS Drug/Biological Code Changes: July 2018 Quarterly Update MLN Matters Article — Revised
- Comprehensive ESRD Care Model Telehealth: Implementation MLN Matters Article — Revised
- ASC Payment System: July 2018 Update MLN Matters Article — Revised

MLN Connects Special Edition – July 11, 2018

New CMS Proposals to Modernize and Drive Innovation in DME and ESRD Programs

Combined actions would increase access to durable medical equipment, reduce administrative burden, and encourage development of innovative therapies for beneficiaries on dialysis

On July 11, CMS proposed innovative changes to the payment rules for Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) and the End-Stage Renal Disease (ESRD) program. The DME proposals in the proposed rule aim to increase access to items for patients and simplify Medicare's DMEPOS Competitive Bidding Program (CBP) to drive competition and increase affordability. The rule also includes ESRD proposals, including a proposal to address new renal dialysis drug and biological costs and foster innovations in treatment by incentivizing new therapies for patients on dialysis and a proposal to reduce facility-related documentation burden.

"At CMS, we celebrate innovation in the health care system and encourage new therapies that will help save lives and lower costs for patients," said CMS Administrator Seema Verma. "Today's proposals will help secure sustainable access to durable medical equipment and reward dialysis facilities that adopt innovative new therapies."

The proposed rule takes key steps towards changing Medicare's DME fee schedule payments and the DMEPOS CBP. CMS sought ways to improve competitive bidding going forward and worked with market experts to leverage opportunities to increase the program's effectiveness. This rule proposes market-oriented reforms to the DMEPOS CBP. The process for recompeting contracts with suppliers currently in effect under the DMEPOS CBP has not yet been initiated. As a result, we note that the current contracts for the DMEPOS CBP will expire on December 31, 2018. Beginning January 1, 2019, and until new contracts are awarded under the DMEPOS CBP, beneficiaries may receive DMEPOS items from any Medicare enrolled DMEPOS supplier.

As required by the 21st Century Cures Act, this rule also includes proposals that address Medicare fee schedule payments for DME furnished on or after January 1, 2019, in areas of the country where competitive bidding is not in effect. The proposed rule also solicits stakeholder feedback on CMS' approach to establishing the fee schedule amounts for new DME technologies. These improvements will modernize the Medicare DME program.

CMS is also taking steps to promote innovation in Medicare's ESRD prospective payment system by expanding the ESRD Transitional Drug Add-on Payment Adjustment to encourage the use of new drug therapies and the development and use of new treatments and therapies. We are proposing to make changes to Medicare's payment structure that will support access to new renal dialysis drugs and foster innovation in this critical area of heath care.

This proposed rule also takes significant steps forward by strengthening quality incentives and reducing administrative burden. Based on stakeholder feedback, CMS intends to reduce ESRD facility-related documentation burdens for certain payment adjustments so that requirements are more consistent with other payment systems. These changes will allow doctors to spend less time on paperwork and more time with their patients, which is in line with the CMS Patients Over Paperwork initiative. Also, CMS is proposing to update the measure set for the ESRD Quality Incentive Program so that it is more closely aligned with the quality priorities the agency has adopted as part of the Meaningful Measures Initiative.

For More Information:

- Proposed Rule
- Fact Sheet

See the full text of this excerpted CMS Press Release (issued July 11).

MLN Connects – July 12, 2018

MLN Connects® for Thursday, July 12, 2018

View this edition as a PDF

News & Announcements

- New Medicare Card Reminder: Wave 1 Mailing Complete
- Qualified Medicare Beneficiary: Learn about State Medicaid Agency Requirements
- MIPS 2019 Payment Adjustment Fact Sheet
- Quality Payment Program: Obtaining Your EIDM Credentials
- IRF QRP Non-Compliance Letters: Request for Reconsideration by August 7
- LTCH QRP Non-Compliance Letters: Request for Reconsideration by August 7
- SNF QRP Non-Compliance Letters: Request for Reconsideration by August 7
- HQRP Non-Compliance Letters: Request for Reconsideration by August 7

Provider Compliance

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

Medicare Learning Network® Publications & Multimedia

- HHA Star Ratings Call: Audio Recording and Transcript — New
- Ambulance Services Listening Session: Audio Recording and Transcript — New
- HCPCS Drug/Biological Code Changes: July 2018 Quarterly Update MLN Matters Article — Revised
- Dual Eligible Beneficiaries under Medicare and Medicaid Booklet — Revised
- Medicare Vision Services Fact Sheet — Revised
- SNF Consolidated Billing Web-Based Training Course — Revised
- Looking for Educational Materials?

MLN Connects Special Edition – July 12, 2018

CMS Proposes Historic Changes to Modernize Medicare and Restore the Doctor-Patient Relationship

Proposed changes to the Medicare Physician Fee Schedule and Quality Payment Program would streamline clinician billing and expand access to high-quality care

On July 12, CMS proposed historic changes that would increase the amount of time that doctors and other clinicians can spend with their patients by reducing the burden of paperwork that clinicians face when billing Medicare. The proposed rules would fundamentally improve the nation's health care system and help restore the doctor-patient relationship by empowering clinicians to use their Electronic Health Records (EHRs) to document clinically meaningful information, instead of information that is only for billing purposes.

"Today's reforms proposed by CMS bring us one step closer to a modern health care system that delivers better care for Americans at a lower cost," said HHS Secretary Alex Azar. "Such a system requires empowering American patients by giving them price and quality transparency and control over their own interoperable health records, goals supported by CMS's proposals. These proposals will also advance the successful Medicare Advantage program and accomplish a historic regulatory rollback to help physicians put patients over paperwork. Further, today's proposed reforms to how CMS pays for medicine demonstrate the commitment of HHS to implementing President Trump's blueprint for lowering drug prices. The ambitious reforms proposed by CMS under Administrator Verma will help deliver on two HHS priorities: creating a value-based health care system for the 21st century and making prescription drugs more affordable."

"Today's proposals deliver on the pledge to put patients over paperwork by enabling doctors to spend more time with their patients," said CMS Administrator Seema Verma. "Physicians tell us they continue to struggle with excessive regulatory requirements and unnecessary paperwork that steal time from patient care. This Administration has listened and is taking action. The proposed changes to the Physician Fee Schedule and Quality Payment Program address those problems head-on, by streamlining documentation requirements to focus on patient care and by modernizing payment policies so seniors and others covered by Medicare can take advantage of the latest technologies to get the quality care they need."

The proposals, part of the Physician Fee Schedule (PFS) and the Quality Payment Program (QPP), would also modernize Medicare payment policies to promote access to virtual care, saving Medicare beneficiaries time and money while improving their access to high-quality services no matter where they live. Such changes would establish Medicare payment for when beneficiaries connect with their doctor virtually using telecommunications technology (e.g., audio or video applications) to determine whether they need an in-person visit. Additionally, the QPP proposal would make changes to quality reporting requirements to focus on measures that most significantly impact health outcomes. The proposed changes would also encourage information sharing among health care providers electronically, so patients can see various medical professionals according to their needs while knowing that their updated medical records will follow them through the health care system. The QPP proposal would make important changes to the Merit-based Incentive Payment System (MIPS) "Promoting Interoperability" performance category to support greater EHR interoperability and patient access to their health information, as well as to align this clinician program with the proposed new "Promoting Interoperability" program for hospitals.

If these proposals were finalized, clinicians would see a significant increase in productivity – leading to substantially more and better care provided to their patients. Removing unnecessary paperwork requirements through the PFS proposal would save individual clinicians an estimated 51 hours per year if 40 percent of their patients are in Medicare. Changes in the QPP proposal would collectively save clinicians an estimated 29,305 hours and approximately $2.6 million in reduced administrative costs in CY 2019.

Proposed CY 2019 PFS Key Changes:

The PFS establishes payment for physicians and medical professionals treating Medicare patients. It is updated annually to make changes to payment policies, payment rates and quality-related provisions. Extensive public feedback the agency has received has highlighted a need to streamline documentation requirements for physician services known as Evaluation and Management (E&M) visits, as well as a need to support greater access to care using telecommunications technology. The proposed changes to the PFS would reinforce CMS' Patients Over Paperwork initiative focused on reducing administrative burden while improving care coordination, health outcomes, and patients' ability to make decisions about their own care.

Streamlining E&M Payment and Reducing Clinician Burden:

CMS and the Office of the National Coordinator for Health Information Technology have heard from stakeholders that CMS's extensive documentation requirements for E&M codes have resulted in unintended consequences. To meet these documentation requirements, providers have to create medical records that are a collection of predefined templates and boilerplate text for billing purposes, in many cases reflecting very little about the patients' actual medical care or story.

Responding to stakeholder concerns, several provisions in the proposed CY 2019 PFS would help to free EHRs to be powerful tools that would actually support efficient care while giving physicians more time to spend with their patients, especially those with complex needs, rather than on paperwork. Specifically, this proposal would:

- Simplify, streamline and offer flexibility in documentation requirements for E&M office visits — which make up about 20 percent of allowed charges under the PFS and consume much of clinicians' time
- Reduce unnecessary physician supervision of radiologist assistants for diagnostic tests
- Remove burdensome and overly complex functional status reporting requirements for outpatient therapy

Advancing Virtual Care:

"CMS is committed to modernizing the Medicare program by leveraging technologies, such as audio/video applications or patient-facing health portals, that will help beneficiaries access high-quality services in a convenient manner," said Administrator Verma.

Getting to the doctor can be a challenge for some beneficiaries, whether they live in rural or urban areas. Innovative technology that enables remote services can expand access to care and create more opportunities for patients to access personalized care management as well as connect with their physicians quickly. Provisions in the proposed CY 2019 PFS would support access to care using telecommunications technology by:

- Paying clinicians for virtual check-ins – brief, non-face-to-face appointments via communications technology
- Paying clinicians for evaluation of patient-submitted photos
- Expanding Medicare-covered telehealth services to include prolonged preventive services

Lowering Drug Costs:

President Trump is putting American patients first and lowering prescription drug costs, and CMS is committed to advancing this effort. CMS is proposing changes as part of the continued rollout of the Administration's blueprint to lower drug prices and reduce out-of-pocket costs. The changes would affect payment under Medicare Part B. Part B covers medicines that patients receive in a doctor's office, such as infusions. CMS is proposing a change in the payment amount for new drugs under Part B, so that the payment amount would more closely match the actual cost of the drug. This change would be effective January 1, 2019, and would reduce the amount that seniors would have to pay out-of-pocket, especially for drugs with high launch prices. This is one of many steps that CMS is taking to ensure that seniors have access to the drugs they need.

Proposed CY 2019 Quality Payment program Key Changes:

To implement the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), CMS established the QPP, which consists of two participation pathways for doctors and other clinicians – MIPS, which measures performance in four categories to determine an adjustment to Medicare payment, and Advanced Alternative Payment Models (Advanced APMs), in which clinicians may earn an incentive payment through sufficient participation in risk-based payment models. The proposed changes to QPP aim to reduce clinician burden, focus on outcomes, and promote interoperability of EHRs, including by:

- Removing MIPS process-based quality measures that clinicians have said are low-value or low-priority, in order to focus on meaningful measures that have a greater impact on health outcomes
- Overhauling the MIPS "Promoting Interoperability" performance category to support greater EHR interoperability and patient access to their health information, as well as to align this performance category for clinicians with the proposed new Promoting Interoperability Program for hospitals

Under the requirements of the Bipartisan Budget Act of 2018, CMS is continuing the gradual implementation of certain MIPS requirements to ease administrative burden on clinicians. The proposed changes to the QPP reflect feedback and input from clinicians and stakeholders, and we will continue to offer free and customized support from CMS's technical assistance networks.

Medicare Advantage Qualifying Payment Arrangement Incentive Demonstration:

Aligning with the agency's goals of improving quality of care and responding to the feedback we have received from clinicians, CMS also proposes waivers of MIPS requirements as part of testing a demonstration called the Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) demonstration. The MAQI demonstration would test waiving MIPS reporting requirements and payment adjustments for clinicians who participate sufficiently in Medicare Advantage (MA) arrangements that are similar to Advanced APMs.

Some MA plans are developing innovative arrangements that resemble Advanced APMs. However, without this demonstration, physicians are still subject to MIPS even if they participate extensively in Advanced APM-like arrangements under Medicare Advantage. The demonstration will look at whether waiving MIPS requirements would increase levels of participation in such MA payment arrangements and whether it would change how clinicians deliver care.

Price transparency: Request for information:

Finally, as part of its commitment to price transparency, CMS is seeking comment through a Request for Information asking whether providers and suppliers can and should be required to inform patients about charge and payment information for health care services and out-of-pocket costs, what data elements

would be most useful to promote price shopping, and what other changes are needed to empower health care consumers.

Public comments on the proposed rules are due by September 10.

For More Information:

- Proposed Rule
- Proposed Policy, Payment, and Quality Provisions Changes to the Medicare PFS for CY 2019 Fact Sheet
- Proposed Rule for the QPP Year 3 Fact Sheet
- MA Qualifying Payment Arrangement Incentive Demonstration Fact Sheet

MLN Connects – July 19, 2018

MLN Connects® for Thursday, July 19, 2018

View this edition as a PDF

News & Announcements

- MIPS 2017 Performance Feedback User Guide
- MIPS Payment Adjustment Targeted Review: Request by October 1
- PEPPERs for Home Health Agencies, Partial Hospitalization Programs
- July Quarterly Provider Update

Provider Compliance

- Cardiac Device Credits: Medicare Billing

Upcoming Events

- CY 2018 eCQM Self-Directed Tools and Resources Webinar — July 24
- IMPACT Act and SPADE Special Open Door Forum — July 25
- Meeting the Behavioral Health Needs of the Dually Eligible Webinar — August 2
- ESRD Quality Incentive Program: CY 2019 ESRD PPS Proposed Rule Call — August 14
- CBR on Independent Diagnostic Testing Facilities Referring Providers Webinar — August 22

Medicare Learning Network® Publications & Multimedia

- New MBI: Get It, Use It MLN Matters® Article — Revised
- Medical Review of E/M Documentation MLN Matters Article — New
- New Physician Specialty Code for Undersea and Hyperbaric Medicine MLN Matters Article — New
- Medicare Part A SNF PPS Pricer Update MLN Matters Article — New
- Automating First Claim Review in Serial Claims for DMEPOS MLN Matters Article — Revised
- Medicare Preventive Services Educational Tool — Revised
- Behavioral Health Integration Services Fact Sheet — Reminder
- Chronic Care Management Services: Changes for 2017 Fact Sheet — Reminder
- Chronic Care Management Services Fact Sheet — Reminder
- Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians Web-based Training — Reminder

MLN Connects Special Edition – July 23, 2018

New Medicare Card Mailing Update – Wave 4 Begins, Wave 2 Ends

CMS started mailing new Medicare cards to people with Medicare who live in Wave 4 states: Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Rhode Island, and Vermont. We continue to mail new cards to people who live in Wave 3 states, as well as nationwide to people who are new to Medicare.

We finished mailing cards to people with Medicare who live in Wave 1 and Wave 2 states and territories (Alaska, American Samoa, California, Delaware, District of Columbia, Guam, Hawaii, Maryland, Northern Mariana Islands, Pennsylvania, Oregon, Virginia, and West Virginia). If someone with Medicare says they did not get a card, print and give them the "Still Waiting for Your New Card?" handout (in English or Spanish) or instruct them to:

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

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

Check the mailing strategy as the mailings progress. Continue to direct people with Medicare to Medicare.gov/NewCard for information about the mailings and to sign up to get email about the status of card mailings in their state.

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

Information on the transition to the new MBI:

- New MBI Get It, Use It MLN Matters® Article (Updated7/11/18)
- Transition to New Medicare Numbers and Cards MLN Fact Sheet
- New Medicare Card information website

MLN Connects Special Edition – July 25, 2018

CMS Empowers Patients and Ensures Site-Neutral Payment in Proposed Rule

Outpatient Prospective Payment System (OPPS) & Ambulatory Surgical Center (ASC) proposed rule advances CMS commitment to increasing transparency and lowering drug prices

On July 25, CMS took steps to strengthen the Medicare program with proposed changes to ensure that seniors can access the care they need at the site of care that they choose. In addition, as part of the agency's ongoing efforts to lower drug prices as outlined in the President's Blueprint, CMS included a Request for Information on how best to develop a model leveraging authority provided to the agency under the Competitive Acquisition Program (CAP) to strengthen negotiations for prescription drugs.

"Our healthcare system should always put patients first, and CMS today is taking important steps to empower patients and provide more affordable choices and options," said CMS Administrator Seema Verma. "In line with President Trump and Secretary Azar's priority to lower drug prices, today's proposed rule is also an important step towards expanding competition for drug payment in Medicare, in order to get the best deal for patients."

The proposed policies in the CY 2019 Medicare Hospital OPPS and ASC Payment System proposed rule would help lay the foundation for a patient-driven healthcare system. To increase the sustainability of the Medicare program and improve quality of care for seniors, CMS is moving toward site neutral payments for clinic visits (which are essentially check-ups with a clinician). Clinic visits are the most common service billed under the OPPS. Currently, CMS often pays more for the same type of clinic visit in the hospital outpatient setting than in the physician office setting.

If finalized, this proposal is projected to save patients about $150 million in lower copayments for clinic visits provided at an off-campus hospital outpatient department. CMS is also proposing to close a potential loophole through which providers are billing patients more for visits in hospital outpatient departments when they create new service lines.

Additionally, CMS is giving patients more options on where to obtain care, in order to improve access and convenience and ensure that CMS policies are not favoring any particular provider type from the start. The proposed rule aims to address other payment differences between sites of service, so that patients can choose the setting that best meets their needs among safe and clinically appropriate options. For 2019, CMS is proposing to:

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

As part of active efforts to reduce the cost of prescription drugs, CMS is issuing a Request for Information to solicit public comment on how best to leverage the authority provided under the CAP to get a better deal for beneficiaries as part of a CMS Innovation Center model. We believe a CAP-based model would allow CMS to introduce competition to Medicare Part B, the part of Medicare that pays for medicines that patients receive in a doctor's office. Currently, CMS pays the average sales price for these therapies plus an extra add-on payment. A CAP-based model would allow CMS to bring on vendors to negotiate payment amounts for Part B drugs, so that Medicare is no longer merely a price taker for these medicines. We are seeking public comment on how the vendors that CMS brings on could help the agency structure value-based payment arrangements with manufacturers, especially for high-cost products, so that seniors and taxpayers will know that medicines are working before they have to pay.

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

In response to recommendations from the President's Commission on Combatting Drug Addiction and the Opioid Crisis, CMS also is proposing to pay separately for certain non-opioid pain management drugs in ASCs; is seeking feedback on evidence to support that other non-opioid alternative treatments for acute or chronic pain warrant separate payment under the OPPS or ASC payment systems; and is proposing to eliminate questions regarding pain communication from the hospital patient experience survey.

As part of its commitment to price transparency, CMS is seeking comment through a Request for Information asking whether providers and suppliers can and should be required to inform patients about charge and payment information for healthcare services and out-of-pocket costs, what data elements would be most useful to promote price shopping, and what other changes are needed to empower healthcare consumers.

In the proposed rule, CMS is releasing a Request for Information to welcome continued feedback on the Medicare program and interoperability. CMS is gathering public feedback on revising the CMS patient health and safety standards that are required for providers and suppliers participating in the Medicare and Medicaid programs to further advance electronic exchange of information that supports safe, effective transitions of care between hospitals and community providers.

Across all the Fiscal Year and CY proposed Medicare payment rules, we have proposed the elimination of reporting requirements for over 100 measures across the health care delivery system, saving providers more than $175 million over the next two years.

See the full text of this excerpted CMS Press Release (issued July 25).

For More Information:

- Proposed Rule
- Fact Sheet

MLN Connects – July 26, 2018

MLN Connects® for Thursday, July 26, 2018

View this edition as a PDF

News & Announcements

- New Medicare Card: Using Your MAC's MBI Look-Up Tool
- E/M Coding Reform: Recording of Panel Discussion
- Patients Over Paperwork July Newsletter
- Hospice Quality Reporting Program Quick Reference Guide
- HQRP Non-Compliance Letters: Request for Reconsideration by August 7
- IRF QRP Non-Compliance Letters: Request for Reconsideration by August 7
- LTCH QRP Non-Compliance Letters: Request for Reconsideration by August 7
- SNF QRP Non-Compliance Letters: Request for Reconsideration by August 7
- Emergency Preparedness: Information on Radiological Incidents, DME, and Blood
- World Hepatitis Day: Medicare Coverage for Viral Hepatitis

Provider Compliance

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

Upcoming Events

- MIPS Improvement Activities Performance Category Year 2 Overview Webinar — August 1
- MIPS Quality Performance Category Year 2 Overview Webinar — August 6
- ESRD Quality Incentive Program: CY 2019 ESRD PPS Proposed Rule Call — August 14

Medicare Learning Network® Publications & Multimedia

- IOM Update to Publication 100-02, Chapter 11 – ESRD MLN Matters Article — New
- New Waived Tests MLN Matters Article — New
- HCPCS Codes Used for SNF CB Enforcement: Annual Update MLN Matters Article — New
- Changes to the Laboratory NCD Edit Software: October 2018 MLN Matters Article — New
- CLFS and Laboratory Services Payment: Quarterly Update MLN Matters Article — New

MLN Connects – August 2, 2018

MLN Connects® for Thursday, August 2, 2018

View this edition as a PDF

News & Announcements

- SNF FY 2019 Payment and Policy Changes
- IRF FY 2019 Prospective Payment System Final Rule
- IPF FY 2019 Final Medicare Payment and Quality Reporting Updates
- Qualified Medicare Beneficiary Program Billing Requirements FAQs
- Data Element Library Webinar: Video Recording
- CMS Administrator Address on Strengthening Medicare
- 2018 QRDA III Implementation Guide for Eligible Professionals — Updated
- LTCH Provider Preview Reports Reissued

Provider Compliance

- Ophthalmology Services: Questionable Billing and Improper Payments — Reminder

Upcoming Events

- MIPS Quality Performance Category for Year 2 (2018) Overview Webinar — August 6
- ESRD Quality Incentive Program: CY 2019 ESRD PPS Proposed Rule Call — August 14
- Sharing Federal Strategies to Address the Opioid Epidemic Open Door Forum — August 15
- Physician Fee Schedule Proposed Rule: Understanding 3 Key Topics Listening Session – August 22

Medicare Learning Network® Publications & Multimedia

- Provider Minute Video: Physician Orders/Intent to Order Laboratory Services and Other Diagnostic Services - New
- PECOS Technical Assistance Contact Information Fact Sheet — Reminder
- Medicare Enrollment Resources Educational Tool — Reminder
- PECOS for DMEPOS Suppliers Booklet — Reminder

MLN Connects Special Edition – August 2, 2018

Changes to Empower Patients and Reduce Administrative Burden

Changes in the IPPS and LTCH PPS final rule will advance price transparency and electronic health records

On August 2, CMS finalized a rule to empower patients and advance the White House MyHealthEData initiative and the CMS Patients Over Paperwork initiative. This final rule and others issued earlier this week will help improve access to hospital price information, give patients greater access to their health information and allow clinicians to spend more time with their patients.

Individually and collectively, these final rules put patients first, ease provider burden, and make significant strides in modernizing Medicare. The August 2 final rule makes updates to Medicare payment policies and rates under the Inpatient Prospective Payment System (IPPS) and the Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) that will incentivize value-based, quality care at these facilities. CMS also issued final rules this week on fiscal year (FY) 2019 Medicare payments and policies for the Skilled Nursing Facility (SNF) PPS, Inpatient Psychiatric Facility (IPF) PPS, Inpatient Rehabilitation Facility (IRF) PPS, and the Hospice Wage Index and Payment Rate Update.

"We're excited to make these changes to ensure care will focus on the patient, not on needless paperwork," said CMS Administrator Seema Verma. "We've listened to patients and their doctors who urged us to remove the obstacles getting in the way of quality care and positive health outcomes. Today's

final rule reflects public feedback on CMS proposals issued in April, and the agency's patient-driven priorities of improving the quality and safety of care, advancing health information exchange and usability, and removing outdated or redundant regulations on healthcare providers to make way for innovation and greater value."

Along with policy changes, the FY 2019 IPPS/LTCH PPS final rule provides acute care hospitals an average payment increase of approximately 3 percent, which reflects rate updates required by law and payments for new technologies and uncompensated care.

The IPPS/LTCH PPS final rule also updates geographic payment adjustments for IPPS hospitals. CMS looks forward to continuing to work on geographic payment disparities, particularly for rural hospitals, to the extent permitted under current law and appreciates responses to our request for public input on this issue. By allowing the imputed wage index floor to expire for all-urban states, CMS has begun the process of making geographic payments more equitable for rural hospitals.

In addition, CMS is updating the LTCH PPS standard federal payment rate by 1.35 percent. Overall, under the changes included in the final rule, CMS projects that LTCH PPS payments will increase by approximately 0.9 percent, or $39 million in FY 2019. In addition, CMS is finalizing the proposal to eliminate the 25 percent threshold policy in a budget neutral manner.

MyHealthEData and Interoperability

The policies in the FY 2019 IPPS/LTCH PPS final rule will bring us closer to the agency's goal of creating a patient-centered healthcare system by increasing price transparency and fluid information exchange—essential components of value-based care —while also significantly lifting the administrative burden on hospitals so they can operate with greater flexibility and patients have the information they need to make decisions about their own care. CMS received stakeholder feedback on solutions for achieving interoperability, or the sharing of healthcare data between providers, through responses to a Request for Information (RFI) issued in April in the IPPS/LTCH PPS proposed rule.

While CMS previously required hospitals to make publicly available a list of their standard charges or their policies for allowing the public to view this list upon request, CMS has updated its guidelines to specifically require hospitals to post this information on the Internet in a machine-readable format. The agency is considering future actions based on the public feedback it received on ways hospitals can display price information that would be most useful to stakeholders and how to create patient-friendly interfaces that allow consumers to more easily access relevant healthcare data and compare providers.

The policies released on August 2 begin implementing core pieces of the White House-led MyHealthEData initiative through several steps to strengthen interoperability. In the IPPS/LTCH PPS final rule, CMS overhauls the Medicare and Medicaid Promoting Interoperability Programs (formerly known as the "Meaningful Use" program or Medicare and Medicaid Electronic Health Record Incentive Programs) to:

- Make the program more flexible and less burdensome
- Emphasize measures that require the exchange of health information between providers and patients
- Incentivize providers to make it easier for patients to obtain their medical records electronically

Meaningful Measures and Transparency

CMS's Meaningful Measures initiative is centered on patient safety, quality of care, transparency and ensuring that the measure sets providers are asked to report make the most sense. In the IPPS/LTCH PPS final rule, CMS is removing unnecessary, redundant and process-driven measures from several pay-for-reporting and pay-for-performance quality programs. The final rule eliminates a number of measures acute care hospitals are currently required to report across the four hospital pay-for-reporting and value-based purchasing quality programs. It also "de-duplicates" certain measures that are in multiple programs, keeping them in the program where they can best incentivize improvement and maintaining transparency through public reporting. In all, these changes will remove a total of 18 measures from the programs and de-duplicate another 25 measures while still ensuring meaningful measures of hospital quality and patient safety. In addition to the changes that apply to acute care hospitals, the final rule eliminates three measures in the LTCH Quality Reporting Program. Lastly, CMS is making a variety of other changes to reduce the hours providers spend on paperwork. This new flexibility will allow hospitals to spend more time providing care to their patients, thereby improving the quality of care their patients receive. Overall, changes in the hospital quality and value measures across the four programs will eliminate more than 2 million burden

hours for hospitals impacted by the IPPS/LTCH PPS rule, saving them about $75 million annually after these changes are implemented.

Similarly, the SNF PPS, IPF PPS and IRF PPS final rules establish policies that ensure the measures those providers must report are patient-centered and outcome-driven rather than process-oriented. Where applicable, these changes will allow providers to work with a smaller set of more meaningful healthcare measures and spend more time on patient care.

CMS is also advancing Meaningful Measures through the Hospice Wage Index and Payment Rate Update. This final rule will make Hospice Compare public data easier and more efficient to use.

Patients Over Paperwork

The SNF PPS final rule incorporates the agency's Patients Over Paperwork initiative through avenues that reduce unnecessary burden on providers by easing documentation requirements and offering more flexibility. As part of the agency's actions to modernize Medicare, the SNF PPS rule establishes an innovative new classification system, the Patient Driven Payment Model (PDPM), which ties skilled nursing facility payments to patients' conditions and care needs rather than volume of services provided. The new model will better incentivize treating the needs of the whole patient, rather than focusing on the amount of services for that patient, which requires substantial paperwork to track over time. The PDPM approach advances CMS's efforts to build a patient-driven healthcare system starting with innovation throughout Medicare's payment systems. Under this new SNF payment model, patients will have more opportunity to choose a skilled nursing facility that offers services tailored to their condition and preferences, as the payment to these facilities will be based more on the patient's condition rather than the specific services each skilled nursing facility provides.

Modernizing Medicare in additional ways to benefit patients, the final IRF PPS rule adopts advances in telecommunications technology and removes obstacles that may prevent rehabilitation physicians from conducting certain meetings without being physically in the room. The rule also removes overly prescriptive documentation requirements for admission orders for these rehabilitation facilities.

Read the full text of this excerpted Press Release (issued August 2).

Final Rules:

- IPPS/LTCH
- SNF
- IPF
- Hospice
- IRF

Fact Sheets:

- IPPS/LTCH
- SNF
- IPF
- Hospice
- IRF

MLN Connects – August 9, 2018

MLN Connects® for Thursday, August 9, 2018

View this edition as a PDF

News & Announcements

- Help Your Medicare Patients Avoid and Report Scams
- SNF VBP FY 2019 Annual Performance Score Report: Submit Correction Requests by August 31
- Quality Payment Program Exception Applications Due by December 31
- Quality Payment Program: 2017 MIPS Performance Feedback and Payment Adjustment
- Quality Payment Program Performance Feedback and Targeted Review Videos
- Medicare Diabetes Prevention Program Suppliers: Separate Medicare Enrollment
- Vaccines are Not Just for Kids

Provider Compliance

- Reporting Changes in Ownership — Reminder

Upcoming Events

- ESRD Quality Incentive Program: CY 2019 ESRD PPS Proposed Rule Call — August 14
- Physician Fee Schedule Proposed Rule: Understanding 3 Key Topics Listening Session — August 22
- Comparative Billing Report on Licensed Clinical Social Workers Webinar — September 12

Medicare Learning Network® Publications & Multimedia

- Quarterly Influenza Virus Vaccine Code Update: January 2019 MLN Matters Article — New
- Update to Medicare Claims Processing Manual, Chapter 24 MLN Matters Article — New
- IRF Annual Update: PPS Pricer Changes for FY 2019 MLN Matters Article — New
- Implementing Epoetin Alfa Biosimilar, Retacrit for ESRD/AKI Claims MLN Matters Article — New
- Medicare Claims Processing Manual, Chapter 24 Update: Form Letters — New
- IPF PPS Updates for FY 2019 MLN Matters Article — New
- ASP Medicare Part B Drug Pricing Files and Revisions: October 2018 MLN Matters Article — New
- August 2018 Catalog — Revised
- Medicare Preventive Services Educational Tool — Revised
- Medicare Enrollment for Providers Who Solely Order, Certify, or Prescribe Booklet — Revised
- Quality Payment Program Year 2 Overview Web-Based Training Course — Revised
- Quality Payment Program: MIPS Promoting Interoperability Performance Category Year 2 Web-Based Training Course — Revised
- Quality Payment Program MIPS Quality Performance Category Year 2 Web-Based Training Course — Revised
- Safeguard Your Identity and Privacy Using PECOS Booklet — Reminder
- PECOS FAQs Booklet — Reminder
- PECOS for Provider and Supplier Organizations Booklet — Reminder

MLN Connects – August 16, 2018

MLN Connects® for Thursday, August 16, 2018

View this edition as a PDF

News & Announcements

- New Medicare Card: Order Handouts for Patients That Did Not Get Their New Cards
- Proposed Pathways to Success for the Medicare Shared Savings Program
- Quality Payment Program: Design Examples for CY 2019 Proposed Rule
- Quality Payment Program: Participation Status Tool Includes 2018 Data Snapshot

Provider Compliance

- Cochlear Devices Replaced Without Cost: Bill Correctly — Reminder

Upcoming Events

- Physician Fee Schedule Proposed Rule: Understanding 3 Key Topics Listening Session — August 22

Medicare Learning Network® Publications & Multimedia

- Inclusion of PMD Codes in DMEPOS Prior Authorization Program MLN Matters® Article — New
- Medicare Physician Fee Schedule Database: October 2018 Update MLN Matters Article — New
- Hospice Payment Rates, Cap, Wage Index, and Pricer: FY 2019 Update MLN Matters Article — New
- HCPCS Drug/Biological Code Changes: October 2018 Update MLN Matters Article — New
- 2018 DMEPOS Fee Schedule: October Update MLN Matters Article — New
- Advance Care Planning Fact Sheet — Revised
- PECOS for Physicians and NPPs Booklet — Reminder
- Medicare Enrollment for Institutional Providers Booklet — Reminder
- Medicare Part D Vaccines and Vaccine Administration Fact Sheet — Reminder

MLN Connects Special Edition – August 20, 2018

New Medicare Card Mailing Update – Wave 5 Begins, Wave 3 Ends

We started mailing new Medicare cards to people with Medicare who live in Wave 5 states: Alabama, Florida, Georgia, North Carolina, and South Carolina. We continue to mail new cards to people who live in Wave 4 states, as well as nationwide to people who are new to Medicare.

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

Sign into MyMedicare.gov to see if we mailed their card. If so, they can print an official card. They must create an account if they do not already have one.

Call 1-800-MEDICARE (1-800-633-4227). There might be something that needs to be corrected, such as updating their mailing address.

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

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

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

Information on the transition to the new MBI:

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

MLN Connects – August 23, 2018

MLN Connects® for Thursday, August 23, 2018

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News & Announcements

- New Medicare Card: 0 not O
- Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier
- 2016 PQRS and 2018 Value Modifier Experience Reports
- Patients Over Paperwork: Medicare Physician Fee Schedule Proposed Rule Presentation
- 2019 MIPS Performance Year Virtual Groups Toolkit
- Hospice Compare Quarterly Refresh
- 2016 Inpatient Hospital Utilization and Payment Data
- Hospices: Second Quarter HQRP Update

Provider Compliance

- Medicare Hospital Claims: Avoid Coding Errors — Reminder

Claims, Pricers & Codes

- 2019 MS-DRG Definitions Manual and Software
- Hospice: NOE information in the HETS Transaction

Upcoming Events

- Quality Payment Program Virtual Groups Webinar — August 27
- Person-Centered Approaches to Support Dual Eligibles for Medicare & Medicaid- September 6
- Dementia Care: Opioid Use & Impact for Persons Living with Dementia Call — September 18

Medicare Learning Network® Publications & Multimedia

- Additional Search Features on FISS Provider DDE Screen MLN Matters Article — New
- ICD-10 and Other Coding Revisions to NCDs MLN Matters Article — New
- Clarifying Language for Chapters 3 and 5 of the MSP Manual MLN Matters Article — New
- Medicare Coverage of Diabetes Supplies MLN Matters Article — New
- Improvements in Hospice Billing and Claims Processing MLN Matters Article — Revised

MLN Connects – August 30, 2018

MLN Connects® for Thursday, August 30, 2018

View this edition as a PDF

News & Announcements

- ACOs Taking Risk in Innovative Payment Model Generate Savings for Patients and Taxpayers
- Physician Fee Schedule Year 3 Proposed Rule: Comments due September 10
- Call for Panel on 2018 MIPS IA Performance Category — Nominations due September 21
- MIPS Targeted Review Request: Deadline October 1
- Hospice Public Reporting: Key Dates
- 2019 eCQM Flows for EPs
- Home Health Agencies: 2016 Utilization and Payment Data

Provider Compliance

- Provider Minute: Laboratory and Diagnostic Services Billing Video

Claims, Pricers & Codes

- Integrated OCE Files for October 2018
- Claims for Biosimilar Drug Code Q5108

Upcoming Events

- New Medicare Card Open Door Forum — September 13
- Dementia Care: Opioid Use & Impact for Persons Living with Dementia Call — September 18
- Medicare Diabetes Prevention Program: New Covered Service Call—September 26

Medicare Learning Network® Publications & Multimedia

- Next Generation ACO Model 2019 Benefit Enhancement MLN Matters Article — New
- Update to Chapter 15: Certification Statement Policies MLN Matters Article — New
- HPTCs Code Set Update: October 2018 MLN Matters Article — New
- I/OCE Specifications Version 19.3: October 2018 MLN Matters Article — New
- Implement Operating Rules - Phase III ERA EFT MLN Matters Article — New
- Claim Status Category and Codes Update MLN Matters Article — New
- Medicare Billing for Outpatient Physical Therapy Fact Sheet — New
- Diabetes Self-Management Training Accrediting Organizations Fact Sheet — New
- ESRD Quality Incentive Program Call: Audio Recording and Transcript — New
- Medical Privacy of Protected Health Information Fact Sheet — Revised
- Diagnosis Coding: Using the ICD-10-CM Web-Based Training Course — Revised
- Medicare Enrollment for Physicians, NPPs, and Other Part B Suppliers Booklet — Reminder
- Screening Pap Tests and Pelvic Examinations Booklet — Reminder

MBI Look-Up Tool Available on the Noridian Medicare Portal

The Medicare Beneficiary Identifier (MBI) Look-Up Tool is now available on the Noridian Medicare Portal (NMP). This tool is an option for providers/suppliers to use if they are not able to obtain the MBI number from the patient. The new portal feature **will only return the MBI if the patient's new Medicare card has been mailed.** The new cards are being mailed in phases following a geographic location strategy.

The MBI Lookup requires users to enter first and last name, Date of Birth (DOB) and Social Security Number (SSN). Users will also need to complete the "I am not a robot" verification for every five transactions.

Note: The SSN may be different than the Health Insurance Claim Number (HICN) if the patient receives benefits under a spouse or family member.

To begin using the MBI Look-Up Tool, log onto the Noridian Medicare Portal. For step-by-step instructions, view the NMP User Manual and self-paced tutorial.

More information regarding MBI efforts and educational resources are available on the CMS New Medicare Cards website.

Noridian Medicare Portal (NMP) Offers Expanded Denial Details

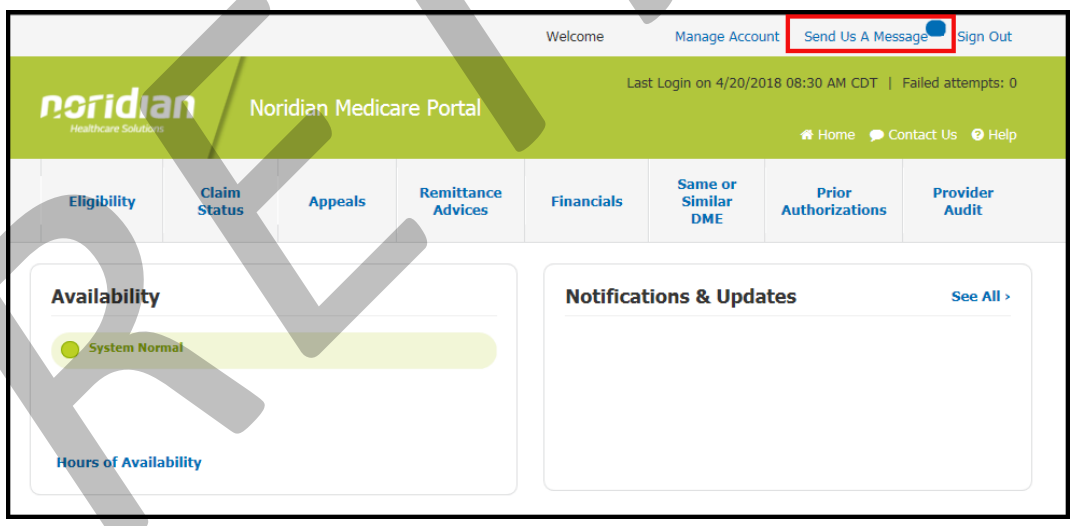
Noridian Medicare Portal (NMP) now offers the ability to view claim denial details for Medicare Secondary Payer (MSP) and Medicare Advantage/Health Maintenance Organization (HMO) denials. For claims with MSP and HMO denials, this new feature will allow access to the related MSP and HMO insurance information without the need to perform a separate eligibility search.

Go to the MSP and HMO Denial Details section of the NMP User Manual and view the MSP and HMO Denial Details self-paced tutorial to get started today.

Send Us A Message on the Noridian Medicare Portal

Effective July 27, 2018, all Noridian Medicare Portal (NMP) users have the ability to send Noridian Medical Review teams a direct, secure message regarding their medical review concerns.

Click the "Send Us A Message" link in the upper right-hand corner of any screen on NMP to begin.



Exchanges with Noridian are intended to help providers understand Medical Review decisions, and learn how to avoid future denials.

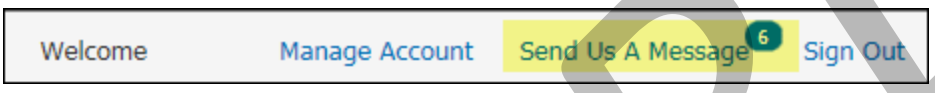
Messages sent regarding non-Medical Review/CERT will be redirected to contact the Provider/Supplier Contact Centers.

Below are the Topics and Subtopics available.

Topic	Subtopic
Noridian CERT	CID Status Noridian CERT Letter/Communication Questions Other
Medical Review Case	Question on Claim Determination Education Information Prior Authorization Other

A New Message notification displays when Noridian has responded. Please allow 2-3 business days for a response. This is not intended to be a way of instant messaging with Noridian.

Note: Supporting documentation for an Additional Documentation Requests can not be submitted through this function.



To learn how to get started and other important information, view the Send Us A Message section of the Noridian Medicare Portal User Manual and view the Send Us A Message self-paced tutorial.

Oxygen and Oxygen Equipment Services: KX, GA, GY, or GZ Modifier Required for DOS On/After August 1, 2018

For oxygen and oxygen equipment claims with Dates of Service (DOS) on/after August 1, 2018, the use of a KX, GA, GY, or GZ modifier is mandatory. Claim lines missing one of these modifiers will reject as missing information. For details, see the joint DMD Correct Coding - Submitting Oxygen Claims with Modifiers KX, GA, GY, and GZ article.

Transition of Eligible PMD HCPCS Codes in the PMD Demonstration to the Required Prior Authorization

CMS issued a final rule that established a prior authorization (PA) process as a condition of payment for certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) that are frequently subject to unnecessary utilization. This process was implemented in March 2017 for two HCPCS codes: K0856 Group 3 Single Power Option and K0861 Group 3 Multiple Power Option Power Wheelchairs.

To expand on the success of the PA program, CMS will transition eligible HCPCS codes from the Power Mobility Device (PMD) PA Demonstration, which is set to end August 31, 2018, to the required PA program nationwide beginning on September 1, 2018. The eligible HCPCS codes will include K0813-K0829 and K0835-K0855. The K0856 and K0861 HCPCS code will continue to be subject to the required PA nationally.

DME MACs will begin accepting PA review requests under the Required PA program August 18, 2018 for planned dates of service on/after September 1, 2018.

DME Macs will honor PMD Demonstration and Advanced Determination of Medicare Coverage (ADMC) decisions rendered prior to September 1, 2018.

Information related to the PA request process, links to educational resources and common reasons for non-affirmation of requests can be found on the Noridian Prior Authorization webpage.

Inclusion of Power Mobility Device Codes in the Prior Authorization Program for DMEPOS Items

MLN Matters Number: SE18010
Article Release Date: August 7, 2018
Effective Date: August 17, 2018
Implementation Date: August 17, 2018

PROVIDER TYPES AFFECTED

This MLN Matters Article is intended for providers and suppliers prescribing, ordering, or billing Medicare Administrative Contractors (MACs) for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) items provided to Medicare beneficiaries.

WHAT YOU NEED TO KNOW

This Special Edition alerts suppliers to the inclusion of power mobility device codes in the DMEPOS prior authorization program. Please be sure your billing staffs are aware of these updates.

BACKGROUND

The goal of prior authorization for select DMEPOS items is to reduce unnecessary usage and aberrant billing for these devices. Medicare pays for DMEPOS items only if the beneficiary's medical record contains sufficient documentation of the beneficiary's medical condition to support the need for the type and quantity of items ordered. In addition, all required documentation elements outlined in Medicare policies must be present for the claim to be paid. Improper payments are made for claims that do not comply with one or more Medicare coding, billing or coverage requirements. This prior authorization process will ensure that Medicare coverage and documentation requirements are likely met before the item or service is rendered and a claim is submitted.

Prior authorization has the added benefit of providing a supplier some assurance of payment for items receiving a provisional affirmation decision. Beneficiaries benefit by knowing that they will not incur financial liability for non-covered items and/or will have information regarding coverage prior to receiving the item. Prior authorization enhances the coordination and collaboration of care between the provider and the supplier to deliver the most appropriate DMEPOS item to meet the needs of the beneficiary.

CMS implemented the Prior Authorization of Power Mobility Devices (PMDs) Demonstration on September 1, 2012, in California, Illinois, Michigan, New York, North Carolina, Florida and Texas. On October 1, 2014, the demonstration was expanded to include Maryland, New Jersey, Pennsylvania, Indiana, Kentucky, Ohio, Georgia, Tennessee, Louisiana, Missouri, Washington and Arizona. The demonstration was extended for 3

years and will end on August 31, 2018.

Under the Centers for Medicare & Medicaid Services (CMS) final rule 6050-F, Medicare Program; Prior Authorization Process for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies; Final Rule, CMS can select items that are frequently subject to unnecessary utilization from a Master List to be subject to prior authorization.

CMS selected two group 3 power wheelchair codes (K0856 and K0861) to be subject to required prior authorization as a condition of payment beginning March 20, 2017, in Illinois, Missouri, New York and West Virginia. Required prior authorization was expanded to the remaining states beginning July 17, 2017.

At the conclusion of the Power Mobility Device Demonstration, CMS will require prior authorization for applicable demonstration codes under the prior authorization process for certain DMEPOS items as listed in the below table. Prior authorization of these items is a condition of payment when furnished to beneficiaries in all states and US territories on or after September 1, 2018.

HCPCs Codes for Prior Authorization

HCPCS CODES	Long Description
K0813	Power wheelchair, group 1 standard, portable, sling/solid seat and back, patient weight capacity up to and including 300 pounds
K0814	Power wheelchair, group 1 standard, portable, captain's chair, patient weight capacity up to and including 300 pounds
K0815	Power wheelchair, group 1 standard, sling/solid seat and back, patient weight capacity up to and including 300 pounds
K0816	Power wheelchair, group 1 standard, captain's chair, patient weight capacity up to and including 300 pounds
K0820	Power wheelchair, group 2 standard, portable, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0821	Power wheelchair, group 2 standard, portable, captain's chair, patient weight capacity up to and including 300 pounds
K0822	Power wheelchair, group 2 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0823	Power wheelchair, group 2 standard, captain's chair, patient weight capacity up to and including 300 pounds
K0824	Power wheelchair, group 2 heavy duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds
K0825	Power wheelchair, group 2 heavy duty, captain's chair, patient weight capacity 301 to 450 pounds
K0826	Power wheelchair, group 2 very heavy duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds
K0827	Power wheelchair, group 2 very heavy duty, captain's chair, patient weight capacity 451 to 600 pounds
K0828	Power wheelchair, group 2 extra heavy duty, sling/solid seat/back, patient weight capacity 601 pounds or more
K0829	Power wheelchair, group 2 extra heavy duty, captain's chair, patient weight 601 pounds or more
K0835	Power wheelchair, group 2 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0836	Power wheelchair, group 2 standard, single power option, captain's chair, patient weight capacity up to and including 300 pounds
K0837	Power wheelchair, group 2 heavy duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds

K0838	Power wheelchair, group 2 heavy duty, single power option, captain's chair, patient weight capacity 301 to 450 pounds
K0839	Power wheelchair, group 2 very heavy duty, single power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds
K0840	Power wheelchair, group 2 extra heavy duty, single power option, sling/solid seat/back, patient weight capacity 601 pounds or more
K0841	Power wheelchair, group 2 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0842	Power wheelchair, group 2 standard, multiple power option, captain's chair, patient weight capacity up to and including 300 pounds
K0843	Power wheelchair, group 2 heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds
K0848	Power wheelchair, group 3 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0849	Power wheelchair, group 3 standard, captain's chair, patient weight capacity up to and including 300 pounds
K0850	Power wheelchair, group 3 heavy duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds
K0851	Power wheelchair, group 3 heavy duty, captain's chair, patient weight capacity 301 to 450 pounds
K0852	Power wheelchair, group 3 very heavy duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds
K0853	Power wheelchair, group 3 very heavy duty, captain's chair, patient weight capacity 451 to 600 pounds
K0854	Power wheelchair, group 3 extra heavy duty, sling/solid seat/back, patient weight capacity 601 pounds or more
K0855	Power wheelchair, group 3 extra heavy duty, captain's chair, patient weight capacity 601 pounds or more

Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) Codes

1. When no prior authorization request was submitted and the GA modifier (indicating a signed Advance Beneficiary Notice (ABN)) is appended and the ABN is valid, you will receive the following codes on your Electronic Remittance Advice (835) and the Standard Paper Remit:

- CARC 197: Precertification/authorization/notification absent.
- RARC N210: Alert: You may appeal this decision
- Group Code PR

Note: MACs will suspend claims to request documentation and conduct a review of the ABN when there is no prior authorization request and the claim is submitted with the GA modifier.

2. If the claim is denied when no prior authorization request was submitted and no valid GA modifier is appended you will receive the following codes on your Electronic Remittance Advice (835) and the Standard Paper Remit:

- CARC 197: Precertification/authorization/notification absent
- RARC N210: Alert: You may appeal this decision
- Group Code CO

3. If the claim is denied as a result of a non-affirmed decision, you will receive the following codes on your Electronic Remittance Advice (835) and the Standard Paper Remit:

- CARC 39: Services denied at the time authorization/pre-certification was requested
- RARC N210: Alert: You may appeal this decision

- Group Code CO

Note: If a GY modifier (beneficiary liable) or EY modifier (no physician or other licensed health care provider order for this item or service) is present, the claim will be process according to the modifier, taking precedence over the non-affirmative prior authorization request processing.

Important Notes and Dates

- In states that are not currently participating in the PMD Demonstration, DME MACs will begin accepting prior authorization requests for these PMDs on August 18, 2018.
- In states currently participating in the PMD Demonstration, DME MACs will continue accepting prior authorization requests for these PMDs without interruption. DME MACs will cease accepting prior authorization requests for items under the PMD Demonstration that are not being added to the Required Prior Authorization List on August 18, 2018.
- MACs will honor all valid requests for prior authorization under the Power Mobility Device Demonstration up to and including August 17, 2018.
- MACs will honor prior authorization affirmation decisions on HCPCS codes in the Power Mobility Device Demonstration, which may be applied to the rental series for claims with a delivery date on or after September 1, 2018.
- Your MAC will educate stakeholders on the requisite information and timeframes for prior authorization submissions, and the vehicle(s) for submitting such information to your MAC for assessment. Your MAC will make sure requesters/submitters are aware of the timeframes for contractors to render prior authorization decisions, dependent upon the type of submission.
- MACs will accept the prior authorization requests by fax, mail, electronic submission of medical documentation (esMD) or CMS approved electronic portal from the supplier or beneficiary.
- MACs will send written decisions to prescribing physicians, upon request, when the physician includes their return address and the MAC has verified through the medical documentation that the physician has the authority to receive the letter.
- MACs will allow an unlimited number of resubmissions for each prior authorization request. Resubmissions are subsequent prior authorization requests submitted after the initial prior authorization request was submitted, reviewed, and a non-affirmed decision was made. Resubmissions may include additional documentation.
- MACs will consider an expedited prior authorization request if the standard timeframe for making a decision could seriously jeopardize the life or health of the beneficiary.

ADDITIONAL INFORMATION

You can review more information on the prior authorization process for certain DMEPOS at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/DMEPOS/Prior-Authorization-Process-for-Certain-Durable-Medical-Equipment-Prosthetic-Orthotics-Supplies-Items.html. For more information on prior authorization, you may want to review MM9940 (The Process of Prior Authorization).

DOCUMENT HISTORY

Date of Change	Description
August 7, 2018	Initial article released.

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

MLN Matters Number: MM10904
Related Change Request (CR) Number: 10904
Related CR Release Date: August 24, 2018
Effective Date: January 1, 2019
Related CR Transmittal Number: R4117CP
Implementation Date: January 7, 2019

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 and Home Health & Hospice MACs, for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

CR 10904 instructs the MACs and Medicare's Shared System Maintainers to update their systems based on the Committee on Operating Rules for Information Exchange (CORE) 360 Uniform Use of Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC), and Claim Adjustment Group Code (CAGC) Rule publication. These system updates are based on the CORE Code Combination List to be published on or about October 1, 2018. Make sure that your billing staff is aware of these changes.

BACKGROUND

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

The Health Insurance Portability and Accountability Act amended the Social Security Act by adding Part C—Administrative Simplification—to Title XI, requiring the Secretary of HHS 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.

CR10904 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 October 1, 2018. This update is based on the CARC and RARC updates as posted at the Washington Publishing Company (WPC) website on or about July 1, 2018. This will also include updates based on market-based review that CAQH CORE conducts once a year to accommodate code combinations that are currently being used by Health Plans including Medicare as the industry needs them. See: http://www.wpc-edi.com/, for reference for CARC and RARC updates and http://www.caqh.org/sites/default/files/core/phase-iii/code-combinations/CORE-required_CodeCombos.xlsx?token=_29xvBua for CAQH CORE defined code combination updates.

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, CR10904, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4117CP.pdf.

DOCUMENT HISTORY

Date of Change	Description
August 24, 2018	Initial article released.

Qualified Medicare Beneficiary Information on RAs and MSNs

Medicare providers may not bill beneficiaries enrolled in the Qualified Medicare Beneficiary (QMB) program for Medicare Parts A and B deductibles, coinsurance, or copays, but state Medicaid programs may pay for those costs. To make it easier to identify the QMB status of your patients, CMS will reintroduce QMB information in provider Remittance Advices (RAs) and Medicare Summary Notices (MSNs) for claims processed on or after July 2, 2018. You can also verify QMB enrollment by using Medicare eligibility information returned by the CMS Health Insurance Portability and Accountability Act (HIPAA) Eligibility Transaction System (HETS) 270/271 application.

For more information:

- Reinstating the QMB Indicator MLN Matters Article
- Prohibition on Billing Dually Eligible Individuals Enrolled in the QMB Program MLN Matters Article
- QMB Program webpage
- Materials from June 6 Medicare Learning Network call, including presentation and FAQs

This is a national CMS article published within the CMS MLN Connects dated June 28, 2018.

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