Communiqué

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ITEMS OF IMPORTANCE
Subscribe to WPS GHA Medicare eNews to Stay Up to Date - Sign Up Today! 2

PART B PROVIDERS ONLY
Centralized Billing for Flu and Pneumococcal (PPV) Vaccination Claims 3

COVERAGE – GENERAL
Correction to L37228 Wound Care 6

COVERAGE – LOCAL COVERAGE DETERMINATIONS AND COVERAGE ARTICLES
Information on Website 7
New Policies 7
Retired Policies 8
Revised Policies 9

PROVIDER EDUCATION
Educational Opportunities 27
Medicare Learning Network (MLN) 27
Quarterly Provider Update 28

REIMBURSEMENT
Unsolicited/Voluntary Refunds 29

MLN CONNECTS
MLN Connects® Newsletters 30

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Items of Importance

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- *Communiqué* (quarterly newsletter)
- Specialty- and service-specific educational articles
- Much, much more

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Part B Providers Only

CENTRALIZED BILLING FOR FLU AND PNEUMOCOCCAL (PPV) VACCINATION CLAIMS

Centralized billing is a process in which a provider, who provides mass immunization services for influenza virus and Pneumococcal (PPV) immunizations, can send all claims to a single contractor for payment regardless of the geographic locality in which they administered the vaccination. (This does not include claims for the Railroad Retirement Board, United Mine Workers, or Indian Health Services. These claims must continue to go to the appropriate processing entity.) This process is only available for claims for the influenza virus and pneumococcal vaccines and their administration. Medicare reimburses the administration of the vaccinations at the assigned rate based on the Medicare physician fee schedule (MPFS) for the appropriate locality. Medicare reimburses the vaccines at the assigned rate using the Medicare standard method for reimbursement of drugs and biologicals.

Individuals and entities interested in centralized billing must contact CMS central office, in writing, at the following address by June 1 of the year they wish to begin centrally billing.

Centers for Medicare & Medicaid Services
Division of Practitioner Claims Processing
Provider Billing and Education Group
7500 Security Boulevard
Mail Stop C4-10-07
Baltimore, Maryland 21244

By agreeing to participate in the centralized billing program, providers agree to abide by the following criteria.

Criteria for Centralized Billing

- To qualify for centralized billing, an individual or entity providing mass immunization services for influenza virus and pneumococcal vaccinations must provide these services in at least three payment localities for which there are at least three different contractors processing claims.
- Individuals and entities providing the vaccine and administration must be properly licensed in the state in which they give the immunizations.
- Centralized billers must agree to accept assignment (i.e., they must agree to accept the amount that Medicare pays for the vaccine and the administration). Since there is no coinsurance or deductible for the influenza virus and pneumococcal benefit, accepting assignment means the provider cannot charge Medicare beneficiaries for the vaccination, (i.e., beneficiaries may not incur any out-of-pocket expense). For example, a drugstore may not charge a Medicare beneficiary $10 for an influenza virus vaccination and give the beneficiary a coupon for $10 for use in the drugstore. **Note:** It is not appropriate to require a beneficiary to pay for the vaccination upfront and to file his or her own claim for reimbursement. Medicare requires all providers to file claims on behalf of the beneficiary per §1848(g)(4)(A) of the Social Security Act, and centralized billers may not collect any payment.

- At their discretion, CMS chooses the contractor assigned to process the claims for centralized billing based on such considerations as workload, user-friendly software developed by the contractor for billing claims, and overall performance. The assigned contractor for this year is Novitas.
- Medicare bases the payment rates for the administration of the vaccinations on the MPFS for the appropriate year. Geographic locality determines payments made through the MPFS. Therefore, centralized billers may receive different payments based on the geographic localities where they perform services. Medicare makes payment at the assigned rate.
- Medicare determines payment rates for the vaccines by the standard method used for reimbursement of drugs and biologicals. Medicare makes payment at the assigned rate.
- Centralized billers must submit their claims on roster bills in an approved Electronic Media Claims standard format. Centralized billers may not submit paper claims.
- Centralized billers must obtain certain information for each beneficiary including name, Medicare Beneficiary Identifier (MBI), date of birth, gender, and signature. The provider must contact Novitas prior to the season for exact requirements. The responsibility lies with the centralized biller to submit correct beneficiary Medicare information (including the beneficiary's MBI) as the contractor will not be able to process incomplete or incorrect claims.
- Centralized billers must obtain an address for each beneficiary so that Medicare can send a Medicare Summary Notice (MSN). Beneficiaries are sometimes confused when they receive an MSN from a contractor other than the contractor that normally processes their claims which results in unnecessary calls to Medicare. Therefore, centralized billers must provide every beneficiary receiving an influenza virus or pneumococcal vaccination with the name of the processing contractor. The centralized biller must provide this notification in writing, in the form of a brochure or handout, at the time the beneficiary receives the vaccination.
- Centralized billers must retain roster bills with beneficiary signatures at their permanent location for a time period consistent with Medicare regulations. Novitas can provide this information.
- Though centralized billers may already have a Medicare provider number, for purposes of centralized billing, they must also obtain a provider number from Novitas. Providers can do this by completing the appropriate Form CMS-855 (Provider Enrollment Application), which they can obtain from Novitas.
- If CMS approves an individual or entity's request for centralized billing, the approval is limited to the 12-month period from September 1 through August 31 of the following year. It is the responsibility of the centralized biller to reapply to CMS CO for approval each year by June 1. Medicare will not process any claims for any centralized biller without permission from CMS.
- Each year the centralized biller must contact Novitas to verify understanding of the coverage policy for the administration of the pneumococcal vaccine, and for a copy of the warning language that is required on the roster bill.
- The centralized biller is responsible for providing the beneficiary with a record of the pneumococcal vaccination.

The individual or entity requesting to be a centralized biller must include the information in items 1 through 8 below with their annual request to participate in centralized billing:

1. Estimates for the number of beneficiaries who will receive influenza virus vaccinations;
2. Estimates for the number of beneficiaries who will receive pneumococcal vaccinations;

3. The approximate dates for when they will give the vaccinations;
4. A list of the states in which they will hold influenza virus and pneumococcal clinics;
5. The type of services the corporation generally provides (e.g., ambulance, home health, or visiting nurse);
6. Whether the nurses who will administer the influenza virus and pneumococcal vaccinations are employees of the corporation or will be hired by the corporation specifically for the purpose of administering influenza virus and pneumococcal vaccinations;
7. Names and addresses of all entities operating under the corporation's application;
8. Contact information for the designated contact person for centralized billing program.

Coverage – General

CORRECTION TO L37228 WOUND CARE

A correction to final Local Coverage Determination (LCD) L37228 is necessary for consistency between the final LCD, effective February 9, 2020, and the draft LCD (DL37228). In the Documentation section, we replaced the term “Physical Therapist” with “Therapist.” The section now indicates, “When wound care is provided by the Therapist, for either in or out patient wound care, the medical record is required to have the following documentation.” L37228 will reflect this change on February 13, 2020.

Coverage – Local Coverage Determinations and Coverage Articles

INFORMATION ON WEBSITE

WPS GHA publishes Local Coverage Determinations (LCDs) and Coverage Articles on its website: https://www.wpsgha.com/wps/portal/mac/site/policies/guides-and-resources

You can also find our LCDs and Coverage Articles within the CMS Medicare Coverage Database (MCD): http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx

Having trouble getting access to the Internet? Many establishments offer free internet access for the price of a cup of coffee. You can request a hard copy of a retired LCD by writing to our Freedom of Information (FOI) Unit: https://www.wpsgha.com/wps/portal/mac/site/training/guides-and-resources/freedom-of-information

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NEW POLICIES/ARTICLES

Below we list new policies/articles. Please note the effective date of the new policy/article. The policy/article will not appear as active until the effective date.

Visit our website at the link below for more information: https://www.wpsgha.com/wps/portal/mac/site/policies/news-and-updates

January 2020

Contract	Title	CMS MCD Policy #	WPS Policy #	Effective Date
J5/J8	**Billing and Coding: MolDX: HLA for Transplant Histocompatibility**	A57851	NA	12/26/2019
J5/J8	**Billing and Coding: MolDX: MolDX: Testing of Multiple Genes**	A57880	NA	12/26/2019
J5/J8	**Billing and Coding: MolDX: Next-Generation Sequencing for Solid Tumors**	A57858	NA	02/09/2020
J5/J8	**Billing and Coding: MolDX: Next-Generation Sequencing Lab-Developed Tests for Myeloid Malignancies and Suspected Myeloid Malignancies**	A57878	NA	02/09/2020
J5/J8	**MolDX: Clarification on Primary Cancer Designation in Metastatic, Progressive, or Recurrent Disease for Molecular Diagnostic Testing**	A57852	NA	12/26/2019

Contract	Title	CMS MCD Policy #	WPS Policy #	Effective Date
J5/J8	**MolDX: Next-Generation Sequencing for Solid Tumors**	L38158	MolDX-061	02/09/2020
J5/J8	**MolDX: Next-Generation Sequencing Lab Developed Tests for Myeloid Malignancies and Suspected Myeloid Malignancies**	L38176	MolDX-060	02/09/2020

February 2020

Contract	Title	CMS MCD Policy #	Effective Date
J5/J8	**Billing and Coding: MolDX: Plasma-Based Genomic Profiling in Solid Tumors**	A57936	03/15/2020
J5/J8	**MolDX: Plasma-Based Genomic Profiling in Solid Tumors**	L38168	03/15/2020

March 2020

Contract	Title	CMS MCD Policy #	Effective Date
J5/J8	**Billing and Coding MolDX: Pigmented Lesion Assay**	A57983	04/12/2020
J5/J8	**Billing and Coding: MolDX: Prospera™**	A57981	04/12/2020
J5/J8	**MolDX: Pigmented Lesion Assay**	L38178	04/12/2020
J5/J8	**MolDX: Prospera™**	L38174	04/12/2020

RETIRED POLICIES/ARTICLES

We retired the following policies/articles. Please be sure to note the effective date of the retired policy/article. It will not appear as retired until the effective date.

Visit our website at the link below for more information:
https://www.wpsgha.com/wps/portal/mac/site/policies/news-and-updates

January 2020 – We retired no Policies/Articles for January 2020

February 2020

Contract	Title	CMS MCD Policy #	Effective Date
J5/J8	**Billing and Coding: MolDX: Guardant360® Plasma-Based Comprehensive Genomic Profiling in Non-Small Cell Lung Cancer (NSCLC)**	A57573	03/14/2020
	We are retiring this article and replacing it with A57936.		
J5/J8	**MolDX: Guardant360® Plasma-Based Comprehensive Genomic Profiling in Non-Small Cell Lung Cancer (NSCLC)**	L37671	03/14/2020

Contract	Title	CMS MCD Policy #	Effective Date
	We are retiring this policy and replacing it with L38168.		

March 2020

Contract	Title	CMS MCD Policy #	Effective Date
J5/J8	**Billing and Coding: Clinical Social Worker Services**	A54829	12/31/2019
	Retired; Clinical Social Worker information may be found in CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 15 - Covered Medical and Other Health Services, 170-Clinical Social Worker (CSW) Services and CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 12 – Physicians/Nonphysician Practitioners, 150-Clinical Social Worker (CSW) Services.		

REVISED POLICIES/ARTICLES

We revised the following policies/articles. Please be sure to note the effective date of the revised policy/article. The policy/article will not appear as active until the effective date.

Visit our website at the link below for more information:
https://www.wpsgha.com/wps/portal/mac/site/policies/news-and-updates

January 2020

Contract	Title	CMS MCD Policy #	WPS Policy #	Effective Date
J5/J8	**2020 CPT/HCPCS Code Updates**	NA	NA	01/01/2020
	View the list: https://www.wpsgha.com/wps/wcm/connect/mac/9ebb0986-f416-428f-953f-857d03231103/2020-cpt-hcpcs-code-updates.pdf?MOD=AJPERES&CVID=mYO.XOS			
J5/J8	**Billing and Coding: Botulinum Toxin Type A & Type B**	A57474	NA	12/26/2019
	The following sentence was removed from Coding Guidelines: “It is acceptable for the provider to bill for the discarded drug on the last patient of the day when more than one patient is treated with one single use vial of Botulinum toxin.”			
J5/J8	**Billing and Coding: Erythropoiesis Stimulating Agents (ESAs)**	A56795	NA	01/01/2020
	CR 11244: Discontinuing the Erythropoietin Stimulating Agent (ESA) Monitoring Policy System Edits under the End Stage Renal Dialysis Prospective Payment System (ESRD PPS). Effective 01/01/2020. CPT/HCPCS Modifiers removed: ED HEMATOCRIT LEVEL HAS EXCEEDED 39% (OR HEMOGLOBIN LEVEL HAS EXCEEDED 13.0 G/DL) FOR 3 OR MORE CONSECUTIVE BILLING CYCLES IMMEDIATELY PRIOR TO AND INCLUDING THE CURRENT CYCLE			

Contract	Title	CMS MCD Policy #	WPS Policy #	Effective Date
	EE HEMATOCRIT LEVEL HAS NOT EXCEEDED 39% (OR HEMOGLOBIN LEVEL HAS NOT EXCEEDED 13.0 G/DL) FOR 3 OR MORE CONSECUTIVE BILLING CYCLES IMMEDIATELY PRIOR TO AND INCLUDING THE CURRENT CYCLE GS DOSAGE OF ERYTHROPOIETIN STIMULATING AGENT HAS BEEN REDUCED AND MAINTAINED IN RESPONSE TO HEMATOCRIT OR HEMOGLOBIN LEVEL CPT/HCPCS annual update: Description change noted: Q5105 Injection, epoetin alfa-epbx, biosimilar (retacrit) (for ESRD on dialysis) 100 units Q5106 Injection, epoetin alfa-epbx, biosimilar (retacrit) (for non-ESRD use) 1000 units Group 8 Paragraph: Anemia of chronic disease Dual Diagnosis Necessary for J0881 or J0885 Added Q5106. Removed the following information from the Article: CMS Pub 100-04 Medicare Claim Processing Manual, Chapter 8- Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims, Section 60.4.1 – ESA Claims Monitoring Policy (Rev. 2582, Issued: 11-02-12, Effective: 04-01-13, Implementation: 04-01-13) from CMS National Coverage Policy and referenced content from Article Text. Added Utilization Guidelines to the Article text: Utilization Guidelines CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 8 - Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims, Sections 60.4.1 – ESA Claims Monitoring Policy and 60.4.2 – Facility Billing Requirements for ESAs. Medically Unlikely Edits (MUE) For dates of service on and after January 1, 2008, the MUE for claims billing for Epogen® is reduced to 400,000 units from 500,000. Maximum Allowable Administrations The maximum number of administrations of EPO for a billing cycle is 13 times in 30 days and 14 times in 31 days. CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 8 - Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims, Sections 60.4.1- ESA Claims Monitoring Policy and 60.4.2 – Facility Billing Requirements for ESAs. Medically Unlikely Edits (MUE) For dates of service on and after January 1, 2008, the MUE for claims billing for Aranesp® is reduced to 1200 mcg from 1500 mcg. Darbepoetin alfa is given not more than once per week according to its Food and Drug Administration approved labeling. Maximum Allowable Administrations The maximum number of administrations of Aranesp for a billing cycle is 5 times in 30 / 31 days.			

<table>
<tr><th>Contract</th><th>Title</th><th>CMS MCD Policy #</th><th>WPS Policy #</th><th>Effective Date</th></tr>
<tr><td>J5/J8</td><td>Billing and Coding: Erythropoiesis Stimulating Agents (ESAs)</td><td>A56795</td><td>NA</td><td>02/09/2020</td></tr>
<tr><td></td><td colspan="4">Content updated related to reconsideration request.

ICD-10 Codes that Support Medical Necessity:
Added Group 11 Paragraph: Myelofibrosis for J0881, J0885 and Q5106, and Group 11 Codes
C94.40 Acute panmyelosis with myelofibrosis not having achieved remission
C94.41 Acute panmyelosis with myelofibrosis, in remission
C94.42 Acute panmyelosis with myelofibrosis, in relapse
D47.1 Chronic myeloproliferative disease
D47.4 Osteomyelofibrosis and D75.81 Myelofibrosis .

ICD-10 Codes that DO NOT Support Medical Necessity:
Added Group 1 Paragraph: Myelofibrosis for J0881 or J0885 and Q5106 and Group 1 Codes:
D61.82 Myelophthisis.

Please see content of LCD updated related to reconsideration request/effective 02/09/2020: Coverage Indications, Limitations, and/or Medical Necessity: Added to Group C: Indications other than Renal Disease, 8. Myelofibrosis. Summary of Evidence, Analysis of Evidence and Bibliography related to reconsideration request included.</td></tr>
<tr><td>J5/J8</td><td>Billing and Coding: Lab: Bladder/Urothelial Tumor Markers</td><td>A56332</td><td>NA</td><td>12/26/2019</td></tr>
<tr><td></td><td colspan="4">The title of this article has changed from “MolDX: Bladder Tumor Marker FISH Billing and Coding Guidelines Update” to “Billing and Coding: Lab: Bladder/Urothelial Tumor Markers”. Under Article Text added billing information.

Added TC modifier to the modifier table.

The following codes were added to CPT/HCPCS Group 1 codes:

<table>
<tr><td>86294</td><td>IMMUNOASSAY FOR TUMOR ANTIGEN, QUALITATIVE OR SEMIQUANTITATIVE (EG, BLADDER TUMOR ANTIGEN)</td></tr>
<tr><td>86316</td><td>IMMUNOASSAY FOR TUMOR ANTIGEN, OTHER ANTIGEN, QUANTITATIVE (EG, CA 50, 72-4, 549), EACH</td></tr>
<tr><td>86386</td><td>NUCLEAR MATRIX PROTEIN 22 (NMP22), QUALITATIVE</td></tr>
</table>

The following codes were added to ICD-10 Codes that Support Medical Necessity Group 1:

<table>
<tr><td>C67.0-C67.9</td><td>Malignant neoplasm of trigone of bladder- Malignant neoplasm of bladder, unspecified</td></tr>
<tr><td>C7A.00</td><td>Malignant carcinoid tumor of unspecified site</td></tr>
</table>
</td></tr>
</table>

Contract	Title	CMS MCD Policy #	WPS Policy #	Effective Date

C7A.010-C7A.012	Malignant carcinoid tumor of the duodenum- Malignant carcinoid tumor of the ileum
C7A.019-C7A.026	Malignant carcinoid tumor of the small intestine- Malignant carcinoid tumor of the appendix, large intestine, and rectum
C7A.029	Malignant carcinoid tumor of the large intestine, unspecified portion
C7A.090-C7A.096	Malignant carcinoid tumor of the bronchus and lung- Malignant carcinoid tumor of the hindgut, unspecified
C7A.098	Malignant carcinoid tumors of other sites
C7A.8	Other malignant neuroendocrine tumors
C7B.00-C7B.04	Secondary carcinoid tumors, unspecified site- Secondary carcinoid tumors of peritoneum
C7B.09	Secondary carcinoid tumors of other sites
C7B.8	Other secondary neuroendocrine tumors
C78.00	Secondary malignant neoplasm of unspecified lung
D09.0	Carcinoma in situ of bladder
D41.4	Neoplasm of uncertain behavior of bladder
D49.4	Neoplasm of unspecified behavior of bladder
E34.0	Carcinoid syndrome
R31.0	Gross hematuria
R31.1	Benign essential microscopic hematuria
R31.21*	Asymptomatic microscopic hematuria
R31.29*	Other microscopic hematuria
R31.9	Hematuria, unspecified
Z78.9*	Other specified health status
Z85.51	Personal history of malignant neoplasm of bladder

Under Group 1 table the following verbiage was added:
Group 1 Medical Necessity ICD-10 Codes Asterisk Explanation: R31.2 (before October 1, 2016) and R31.21 or R31.29 (effective October 1, 2016) are to be used only when repeat testing is believed to be medically reasonable and necessary, and must be listed as secondary with the primary neoplastic diagnosis. Z78.9 To

<table>
<tr><th>Contract</th><th>Title</th><th>CMS MCD Policy #</th><th>WPS Policy #</th><th>Effective Date</th></tr>
<tr><td></td><td colspan="4">be used only when repeat testing is believed to be medically reasonable and necessary, and must be listed as secondary with the primary neoplastic diagnosis.</td></tr>
<tr><td>J5/J8</td><td>Billing and Coding: MolDX: clonoSEQ® Assay for Assessment of Minimal Residual Disease (MRD) in Patients with Specific Lymphoid Malignancies</td><td>A56277</td><td>NA</td><td>12/26/2019</td></tr>
<tr><td></td><td colspan="4">Coverage for chronic lymphocytic leukemia has been added to this article.

The following updates were made to this article:
Clinical practice guidelines in a number of hematological malignancies recommend MRD testing and recognize MRD status as a reliable indicator of clinical outcome and response to therapy, which is currently recommended in the course of treatment of patients with acute lymphoblastic leukemia (ALL), multiple myeloma (MM), and chronic lymphocytic leukemia (CLL).1,2,3

The clonoSEQ® Assay has received State of New York Clinical Laboratory Evaluation Program (CLEP) approval for B-cell malignancies.

ICD-10 Codes that that Support Medical Necessity
Group 1 Paragraph:
Group 1 Codes
C91.10 Chronic lymphoblastic leukemia not having achieved remission
C91.11 Chronic lymphoblastic leukemia, in remission
C91.12 Chronic lymphoblastic leukemia, in relapse

References
4. National Comprehensive Cancer Network (NCCN). NCCN Clinical Practice Guidelines in Oncology
(NCCN Guidelines®). Chronic Lymphocytic Leukemia / Small Lymphocytic Lymphoma (Version 2.2020).
https://www.nccn.org/professionals/physician_gls/pdf/myeloma.pdf. Accessed 11/13/2019</td></tr>
<tr><td>J5/J8</td><td>Billing and Coding: MolDX: Genetic Testing for Lynch Syndrome</td><td>A55135</td><td>NA</td><td>12/26/2019</td></tr>
<tr><td></td><td colspan="4">Due to Fourth Quarter CPT/HCPCS code updates; added 0130U & 0134U to Group 2 effective 10/01/2019:

CPT/HCPCS Codes
Group 2 Paragraph: NA
Group 2 Codes

<table><tr><td>0130U</td><td>HEREDITARY COLON CANCER DISORDERS (EG, LYNCH SYNDROME, PTEN HAMARTOMA SYNDROME, COWDEN SYNDROME, FAMILIAL ADENOMATOSIS POLYPOSIS), TARGETED MRNA SEQUENCE ANALYSIS PANEL (APC, CDH1, CHEK2, MLH1, MSH2, MSH6, MUTYH, PMS2, PTEN, AND TP53)</td></tr></table></td></tr>
</table>

<table>
<tr><th>Contract</th><th>Title</th><th>CMS MCD Policy #</th><th>WPS Policy #</th><th>Effective Date</th></tr>
<tr><td></td><td colspan="4">
<table>
<tr><td></td><td>(LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)</td></tr>
<tr><td>0134U</td><td>HEREDITARY PAN CANCER (EG, HEREDITARY BREAST AND OVARIAN CANCER, HEREDITARY ENDOMETRIAL CANCER, HEREDITARY COLORECTAL CANCER), TARGETED MRNA SEQUENCE ANALYSIS PANEL (18 GENES) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)</td></tr>
</table>

Added CPT 81436 and moved CPT 81301, 81403 & 81435 from CPT/HCPCS Group 1 to CPT/HCPCS Group 3:

CPT/HCPCS Codes
Group 3 Paragraph: CPT Codes that are also referenced in other articles
Group 3 Codes:
<table>
<tr><td>81301</td><td>MICROSATELLITE INSTABILITY ANALYSIS (EG, HEREDITARY NON-POLYPOSIS COLORECTAL CANCER, LYNCH SYNDROME) OF MARKERS FOR MISMATCH REPAIR DEFICIENCY (EG, BAT25, BAT26), INCLUDES COMPARISON OF NEOPLASTIC AND NORMAL TISSUE, IF PERFORMED</td></tr>
<tr><td>81403</td><td>MOLECULAR PATHOLOGY PROCEDURE, LEVEL 4 (EG, ANALYSIS OF SINGLE EXON BY DNA SEQUENCE ANALYSIS, ANALYSIS OF >10 AMPLICONS USING MULTIPLEX PCR IN 2 OR MORE INDEPENDENT REACTIONS, MUTATION SCANNING OR DUPLICATION/DELETION VARIANTS OF 2-5 EXONS)</td></tr>
<tr><td>81435</td><td>HEREDITARY COLON CANCER DISORDERS (EG, LYNCH SYNDROME, PTEN HAMARTOMA SYNDROME, COWDEN SYNDROME, FAMILIAL ADENOMATOSIS POLYPOSIS); GENOMIC SEQUENCE ANALYSIS PANEL, MUST INCLUDE SEQUENCING OF AT LEAST 10 GENES, INCLUDING APC, BMPR1A, CDH1, MLH1, MSH2, MSH6, MUTYH, PTEN, SMAD4, AND STK11</td></tr>
<tr><td>81436</td><td>HEREDITARY COLON CANCER DISORDERS (EG, LYNCH SYNDROME, PTEN HAMARTOMA SYNDROME, COWDEN SYNDROME, FAMILIAL ADENOMATOSIS POLYPOSIS); DUPLICATION/DELETION ANALYSIS PANEL, MUST INCLUDE ANALYSIS OF AT LEAST 5 GENES, INCLUDING MLH1, MSH2, EPCAM, SMAD4, AND STK11</td></tr>
</table>
</td></tr>
<tr><td>J5/J8</td><td>Billing and Coding: MolDX: Molecular Diagnostic Tests (MDT)</td><td>A57772</td><td>NA</td><td>01/01/2020</td></tr>
<tr><td></td><td colspan="4">Multiple code changes were made to this article to be consistent with the MolDX Program Contractor’s Billing and Coding Article.

Added CPT codes 0084U-0103U due to 2nd quarter 2019 CPT/HCPCs code updates. They are effective 07/01/2019:</td></tr>
</table>

Contract	Title	CMS MCD Policy #	WPS Policy #	Effective Date

CPT/HCPCS Codes
Group 1 Paragraph: NAx
Group 1 Codes

0084U	Rbc dna gnotyp 10 bld groups
0087U-0092U	Crd hrt trnspl mrna 1283 gen - Onc lng 3 prtn bmrk plsm alg
0094U	Genome rapid sequence alys
0101U - 0103U	Hered colon ca do 15 genes - Hered ova ca pnl 24 genes

These CPT codes were moved from Group 1 paragraph to Group 2:

Group 2 Paragraph: CPT codes that are also referenced in other articles
Group 2 Codes:

81401	Mopath procedure level 2
81403	Mopath procedure level 4
81406	Mopath procedure level 7
81407	Mopath procedure level 8
81412	Ashkenazi jewish assoc dis

The following code additions and deletions were made so the only CPT/HCPCs codes that apply to the MolDX Program are listed.

The following codes were added under *CPT/HCPCS Codes Group 1: Codes* added CPT® codes

87999	Microbiology procedure
0045U-0050U	Onc brst dux carc is 12 gene - Trgt gen seq dna 194 genes
0053U-0060U	Onc prst8 ca fish alys 4 gen - Twn zyg gen seq alys chrms2
0062U	Ai sle igg&igm alys 80 bmrk
0067U	Onc brst imhchem prfl 4 bmrk
0068U	Candida species pnl amp prb
0070U-0076U	Cyp2d6 gen com&slct rar vrnt - Cyp2d6 3' gene dup/mlt
0078U-0080U	Pain mgt opi use gnotyp pnl - Onc lng 5 clin rsk factr alg
0083U	Onc rspse chemo cntrst tomog

<table>
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<tr><td></td><td>
<table>
<tr><td>0105U</td><td>Neph ckd mult eclia tum nec</td></tr>
<tr><td>0107U</td><td>C diff tox ag detcj ia stool</td></tr>
<tr><td>0108U</td><td>Gi barrett esoph 9 prtn bmrk</td></tr>
<tr><td>0111U</td><td>Onc colon ca kras&nras alys</td></tr>
<tr><td>0113U</td><td>Onc prst8 pca3&tmprss2-erg</td></tr>
<tr><td>0114U</td><td>Gi barretts esoph vim&ccna1</td></tr>
<tr><td>0118U</td><td>Trnsplj don-drv cll-fr dna</td></tr>
<tr><td>0120U</td><td>Onc b cll lymphm mrna 58 gen</td></tr>
<tr><td>0129U-0132U</td><td>Hered brst ca rltd do panel - Hered ova ca rltd do pnl 17</td></tr>
<tr><td>0134U-0138U</td><td>Hered pan ca mrna pnl 18 gen - Brca1 brca2 mrna seq alys</td></tr>
</table>

The following codes were removed:
CPT® codes 81370-81383, 81596, 88120, 88121, 0002M, 0003M, 0002U, 0006U-0008U, 0010U, 0011U, 0025U, 0035U, 0038U, 0041U-0044U, 0086U, 0093U, 0095U-0100U

See CPT/HCPCs 2020 Code updates table.</td><td></td><td></td><td></td></tr>
<tr><td>J5/J8</td><td>Billing and Coding: MolDX: Multiplex Nucleic Acid Amplified Tests for Respiratory Viral Panels</td><td>A57579</td><td>NA</td><td>12/26/2019</td></tr>
<tr><td></td><td>Under Article Text added the third bullet point verbiage “For dates of service on or after 10/01/2019, laboratories billing for services using GenMark® ePlex Respiratory Pathogen (RP) Panel should report 0115U. While this panel is able to report results for a specific number of pathogens, this contractor will interpret the use of 0115U to represent the use of a specific testing platform regardless of the number of pathogens reported by the laboratory”.

Under CPT/HCPCS Codes Group 1 Codes: added 0115U.
<table>
<tr><td>0115U</td><td>RESPIRATORY INFECTIOUS AGENT DETECTION BY NUCLEIC ACID (DNA AND RNA), 18 VIRAL TYPES AND SUBTYPES AND 2 BACTERIAL TARGETS, AMPLIFIED PROBE TECHNIQUE, INCLUDING MULTIPLEX REVERSE TRANSCRIPTION FOR RNA TARGETS, EACH ANALYTE REPORTED AS DETECTED OR NOT DETECTED</td></tr>
</table>

Under ICD-10 Codes that Support Medical Necessity Group 1 Paragraph: added the verbiage “and 0115U”. “These are the diagnosis codes corresponding to coverage of 87631, 0098U, 0099U, 0100U, and 0115U.”</td><td></td><td></td><td></td></tr>
</table>

Contract	Title	CMS MCD Policy #	WPS Policy #	Effective Date
	This revision is retroactive effective for dates of service on or after 10/01/2019 (CR 11406).			
J5/J8	**Billing and Coding: Wound Care**	A55909	NA	02/09/2020
	This article's revision is related to the reconsideration process and medical literature submitted during the comment period 09/26/2019-11/10/2019. The following ICD-10 Codes have been added to Group One: L89.012 Pressure ulcer of right elbow, stage 2 L89.022 Pressure ulcer of left elbow, stage 2 L89.112 Pressure ulcer of right upper back, stage 2 L89.122 Pressure ulcer of left upper back, stage 2 L89.132 Pressure ulcer of right lower back, stage 2 L89.142 Pressure ulcer of left lower back, stage 2 L89.152 Pressure ulcer of sacral region, stage 2 L89.212 Pressure ulcer of right hip, stage 2 L89.222 Pressure ulcer of left hip, stage 2 L89.312 Pressure ulcer of right buttock, stage 2 L89.322 Pressure ulcer of left buttock, stage 2 L89.42 Pressure ulcer of contiguous site of back, buttock and hip, stage 2 L89.512 Pressure ulcer of right ankle, stage 2 L89.522 Pressure ulcer of left ankle, stage 2 L89.612 Pressure ulcer of right heel, stage 2 L89.622 Pressure ulcer of left heel, stage 2 L89.812 Pressure ulcer of head, stage 2 L89.892 Pressure ulcer of other site, stage 2 L97.111 Non-pressure chronic ulcer of right thigh limited to breakdown of skin L97.121 Non-pressure chronic ulcer of left thigh limited to breakdown of skin L97.211 Non-pressure chronic ulcer of right calf limited to breakdown of skin L97.221 Non-pressure chronic ulcer of left calf limited to breakdown of skin L97.311 Non-pressure chronic ulcer of right calf limited to breakdown of skin L97.321 Non-pressure chronic ulcer of left ankle limited to breakdown of skin L97.411 Non-pressure chonic ulcer of right heel and midfoot limited to breakdown of skin L97.421 Non-pressure chronic ulcer of unspecified part of left lower leg limited to breakdown of skin L97.511 Non-pressure chronic ulcer of other part of right foot limited to breakdown of skin L97.521 Non-pressure chronic ulcer of other part of left foot limited to breakdown of skin L97.811 Non-pressure chronic ulcer of other part of right lower leg limited to skin breakdown L97.821 Non-pressure chronic ulcer of other part of left lower leg limited to skin breakdown L98.411 Non-pressure chronic ulcer of buttock limited to breakdown of skin L98.421 Non-pressure chronic ulcer of back limited to breakdown of skin L98.491 Non-pressure chronic ulcer of skin of other sites limited to breakdown of skin L98.496 Non-pressure chronic ulcer of skin other sites with bone involvement			

Contract	Title	CMS MCD Policy #	WPS Policy #	Effective Date
	without evidence of necrosis L98.498 Non-pressure chronic ulcer of skin other sites with other specified severity The following ICD-10 codes have been removed from Group One due to more specific codes available: L97.912 Non-pressure chronic ulcer of unspecified part of right lower leg with fat layer exposed L97.913 Non-pressure chronic ulcer of unspecified part of right lower leg with necrosis of muscle L97.914 Non-pressure chronic ulcer of unspecified part of right lower leg with necrosis of bone L97.915 Non-pressure chronic ulcer of unspecified part of right lower leg with muscle involvement without evidence of necrosis L97.916 Non-pressure chronic ulcer of unspecified part of right lower leg with bone involvement without evidence of necrosis L97.918 Non-pressure chronic ulcer of unspecified part of right lower leg with other specified severity L97.922 Non-pressure chronic ulcer of unspecified part of left lower leg with fat layer exposed L97.923 Non-pressure chronic ulcer of unspecified part of left lower leg with necrosis of muscle L97.924 Non-pressure chronic ulcer of unspecified part of left lower leg with necrosis of bone L97.925 Non-pressure chronic ulcer of unspecified part of left lower leg with muscle involvement without evidence of necrosis L97.926 Non-pressure chronic ulcer of unspecified part of left lower leg with bone involvement without evidence of necrosis L97.928 Non-pressure chronic ulcer of unspecified part of left lower leg with other specified severity			
J5/J8	**Category III Codes**	L35490	PHYS-084	02/09/2020
	Content updated related to reconsideration request for: CPT code 0254T: Endovascular repair of iliac artery bifurcation (e.g., aneurysm, pseudoaneurysm, arteriovenous malformation, trauma, dissection) using bifurcated endograft from the common iliac artery into both the external and internal iliac artery, including all selective and/or nonselective catheterization(s) required for device placement and all associated radiological supervision and interpretation, unilateral. Analysis of Evidence CPT code 0254T: The reconsideration request asserts, “the evidence supporting the use of the Gore® Excluder® IBE (with Gore® Excluder® AAA Endoprosthesis) is sufficiently robust to support that it is ‘reasonable and necessary’ under the Statute and the LCD.” Wisconsin Physicians Service Government Health Administrators (WPS GHA) does not agree. The literature submitted for review is mostly retrospective studies with limitations well outlined by the respective authors. WPS GHA believes that the authors caution is warranted. Coverage is denied at this time.			

Contract	Title	CMS MCD Policy #	WPS Policy #	Effective Date
	CPT code 0355T: Gastrointestinal tract imaging, intraluminal (e.g., capsule endoscopy), colon, with interpretation and report. Analysis of Evidence CPT code 0355T: The reconsideration request asserts " current published evidence and FDA approval support PillCam COLON 2 as a safe, effective and clinically meaningful diagnostic option in patients after an incomplete colonoscopy or for patients with evidence of a lower GI bleed with major risks for colonoscopy or moderate sedation." Wisconsin Physicians Service Government Health Administrators (WPS GHA) does not agree. The literature submitted for review is mostly preliminary studies with an unjustified sample size with limitations well outlined by the respective authors. As well as the associated editorials. WPS GHA believes that the authors caution is warranted. Coverage is denied at this time. Summary of Evidence, Analysis of Evidence and Bibliography related to reconsideration request included. Effective 01/01/2020 CPT/HCPCS Annual Update: deleted CPT 0254T. Providers are responsible for determining the correct diagnostic and procedural coding for the services they furnish to Medicare beneficiaries.			
J5/J8	**Erythropoiesis Stimulating Agents (ESAs)**	L34633	INJ-023	02/09/2020
	Content updated related to reconsideration request. Coverage Indications, Limitations, and/or Medical Necessity: Added to Group C: Indications other than Renal Disease 8. Myelofibrosis. Summary of Evidence, Analysis of Evidence and Bibliography related to reconsideration request included. Please refer to A56975 Billing and Coding: Erythropoiesis Stimulating Agents (ESAs) Group 11 Paragraph Myelofibrosis Group 11 Codes that support Medical Necessity and ICD-10 Codes that DO NOT Support Medical Necessity. Change Request References updated: added CR 11244 Discontinuing the Erythropoietin Stimulating Agent (ESA) Monitoring Policy System Edits under the End Stage Renal Dialysis Prospective Payment System (ESRD PPS) Effective 01/01/2020.			
J5/J8 (Part B Only)	**Independent Diagnostic Testing Facilities- Physician Supervision and Technician Requirements**	A54943	NA	01/01/2020
	Please see the 2020 CPT/HCPCS code update table for description changes, deleted and added codes.			

<table>
<tr><th>Contract</th><th>Title</th><th>CMS MCD Policy #</th><th>WPS Policy #</th><th>Effective Date</th></tr>
<tr><td></td><td colspan="4">Request for Coverage by an IDTF:
Added CPT code 27369:
Long Description: Injection of contrast for imaging of knee joint
Short Description: Njx cntrst kne arthg/ct/mri

Supervising Physician Qualification Requirements: Radiologist or Orthopedic Surgeon Technician Qualification: Physician Only Service</td></tr>
<tr><td>J5/J8</td><td><u>MolDX: myPath Melanoma Assay</u></td><td>L37923</td><td>MolDX-053</td><td>12/26/2019</td></tr>
<tr><td></td><td colspan="4">Added 0090U due to 3rd Quarter CPT/HCPCS code updates; effective 07/01/2019.

CPT/HCPCS Codes
Group 1 Paragraph: NA
Group 1 Codes
<table><tr><td>0009U</td><td>ONCOLOGY (CUTANEOUS MELANOMA), MRNA GENE EXPRESSION PROFILING BY RT-PCR OF 23 GENES (14 CONTENT AND 9 HOUSEKEEPING), UTILIZING FORMALIN-FIXED PARAFFIN-EMBEDDED TISSUE, ALGORITHM REPORTED AS A CATEGORICAL RESULT (IE, BENIGN, INDETERMINATE, MALIGNANT)</td></tr></table>
All of the coding in the LCD has been moved to the associated Billing and Coding article</td></tr>
<tr><td>J5/J8</td><td>Wound Care</td><td>L37228</td><td>G-SURG-056</td><td>02/09/2020</td></tr>
<tr><td></td><td colspan="4">Added the following to CMS National Coverage Policy:
CMS IOM Publication 100-08, Medicare Program Integrity Manual, Chapter 13, Section 13.5.4 - Reasonable and Necessary Provisions in an LCD.
Change Request 10901, Local Coverage Determinations (LCDs)
42 Code of Federal Regulations (CFR) § 410.20 - Physicians' services

Added the following to Coverage Guidance:
Active wound care procedures are performed to remove necrotic tissue and/or devitalized tissue to promote healing. Providers are responsible to determine medical necessity and use the appropriate current CPT/HCPCS code for service provided. Please consult the current AMA CPT book for the complete code description of the procedures being performed to submit claims.

This LCD supplements but does not replace, modify or supersede existing Medicare applicable National Coverage Determinations (NCDs) or payment policy rules and regulations for additional wound care. Federal statute and subsequent Medicare regulations regarding provision and payment for medical services are lengthy. They are not repeated in this LCD. Neither Medicare payment policy rules nor this LCD replace, modify or supersede applicable state statutes regarding</td></tr>
</table>

Contract	Title	CMS MCD Policy #	WPS Policy #	Effective Date
	medical practice or other health practice professions acts, definitions and/or scopes of practice. All providers who report services for Medicare payment must fully understand and follow all existing laws, regulations and rules for Medicare payment for additional wound care sessions and must properly submit only valid claims for them. Please review and understand them and apply the medical necessity provisions in the policy within the context of the manual rules. Relevant CMS manual instructions and policies are provided under CMS National Coverage Policy section. **Debridement section added:** • Pressure Injury • Stage II • Diabetic Foot Ulcer(s) Should deep tissue pressure injury or Stage II injury progress to Unstageable, Stage III or Stage IV requiring debridement then documentation supporting this must be included in the medical record. **Evaluation and Management Section has been revised and the following has been removed:** The following services may be done during wound care services and can be medically necessary, but they are not considered wound debridement services and wound debridement CPT codes should not be used. • Removal of necrotic tissue by cleansing, scraping (other than by a scalpel or a curette), chemical application, or **dry-to-dry** or **wet-to dry** dressing. Generally, dressing changes are not considered a skilled service. The prior dressings are different and distinct from **wet-to-moist** dressings that are used for removal of devitalized tissue from wound(s) for non-selective debridement. • Washing bacterial or fungal debris from lesions. • Removal of secretions and coagulation serum from normal skin surrounding an ulcer. • Dressing of small or superficial lesions. • Removal of fibrinous material from the margin of an ulcer. • Paring or cutting of corns or non-plantar calluses. Skin breakdown under a dorsal corn that begins to heal when the corn is removed, and shoe pressure eliminated is not considered an ulcer that requires debridement unless there is extension into the subcutaneous tissue. • Incision and drainage of abscess including paronychia, trimming or debridement of mycotic nails, avulsion of nail plates, acne surgery, or destruction of warts. • Removal of non-tissue integrated fibrin exudates, crusts, biofilms or other materials from a wound without removal of tissue does not meet the definition of any debridement code and may not be reported as such. • While mechanical debridement is a valuable technique for healing ulcers, it does not qualify as a surgical wound debridement service, and therefore should not be coded as such.			

Contract	Title	CMS MCD Policy #	WPS Policy #	Effective Date
	• Scraping the base of the wound bed to induce bleeding, following the removal of devitalized tissue, is not considered to be a separately billable service. • Removing a collar of callus (hyperkeratotic tissue) around an ulcer is not debridement of skin or necrotic tissue and should not be billed as debridement unless additional partial full skin thickness tissue directly deep to the callus is removed as well. • Infrared, ultrasound thermal and phototherapy-ultraviolet modalities are not considered debridement services. **Negative Pressure Wound Therapy has been revised and the following has been removed** For disposable NPWT (dNPWT) devices, this contractor recommends following manufacturer's instructions but, generally be limited to a maximum of 4 applications per 30 days. NPWT services should not exceed a 120-day period. It is expected a licensed medical professional must directly assess the wound(s) being treated with NPWT and supervise or directly perform the NPWT dressing changes. It is expected there will be an evaluation with documentation of the wound's dimensions and characteristics conducted every 30 days. NWPT coverage would end, and the pump and/or supplies will be denied as not reasonable and necessary with any of the following, whichever occurs earliest. 1. In the judgment of the treating physician, adequate wound healing has occurred to the degree that NPWT may be discontinued, 2. Any measurable degree of wound healing has failed to occur over the prior month. Wound healing is defined as improvement occurring in either surface area (length times width) or depth of the wound. 3. One hundred twenty (120) days (including the time NPWT was applied in an inpatient setting prior to discharge to the home) have elapsed using NPWT in the treatment of the most recent wound. **Documentation Section revision completed** When wound care is provided by the Physical Therapist, for both in and out patient wound care, the medical record is required to have the following documentation: Physician order(s) for therapy /wound care services and signed plan of treatment (also known as a plan of care) detailing treatment modalities for therapy/wound care services must be established as soon as possible or within 30 days. Every 10 days progress notes to include current wound status, measurements (including size and depth), and the treatment provided. **Utilization Guidelines has been revised and the following two statements have been removed:** For disposable NPWT (dNPWT) devices, this contractor recommends following			

Contract	Title	CMS MCD Policy #	WPS Policy #	Effective Date
	manufacturer's instructions but, generally be limited to a maximum of 4 applications per 30 days. Negative Pressure Wound Therapy services should not exceed a 120-day period. There should be no more than 4 dressing changes per wound per month for the majority of wounds. With dNPWT, there should be a maximum of 4 new disposable NPWT per month. It is expected there will be an evaluation with documentation for a wound(s) every 30 days. Added Summary of Evidence, Analysis of Evidence, and Bibliography related to Comment Period (09/26/2019 – 11/10/2019).			

February 2020

Contract	Title	CMS MCD Policy #	Effective Date
J5/J8	**Special Stains and Immunohistochemistry (IHC) Indications for Gastric Pathology**	A55739	01/30/2020
	Under CPT/HCPCS Codes Group 1 the following code was added: 88341 Immunohistochemistry or immunocytochemistry, per specimen; each additional single antibody stain procedure		

March 2020

Contract	Title	CMS MCD Policy #	Effective Date
J5/J8	**Billing and Coding: Cosmetic and Reconstructive Surgery**	A57475	02/27/2020
	Added the following statements to support National Coverage Determination (NCD) for Dermal Injections for the Treatment of Facial Lipodystrophy Syndrome (LDS) NCD 250.5: Group 11 Paragraph: Both diagnosis are required on the claim; Group 12 Paragraph and Group 13 Paragraph: Both diagnosis are required on the claim. Must be billed with G0429. Updated and reformatted ICD-10 Codes that DO NOT Support Medical Necessity Group 1 Paragraph. Cosmetic procedures and/or surgery are statutorily excluded by Medicare. Please refer to: • CPT/HCPCS Codes Group 2 Paragraph for the procedures being performed for cosmetic reasons which will be denied as non-covered. • Please refer to CPT/HCPCS Codes Group 3 Paragraph for the procedures which are generally considered cosmetic and may be medically reviewed or denied as non-covered. • See WPS LCD L34698 for coverage of the services that are reconstructive and therefore, medically necessary.		

Contract	Title	CMS MCD Policy #	Effective Date

Non-covered procedures do not need to be billed to the Contractor. If the beneficiary requests a claim be submitted for a cosmetic procedure, then use the billing instructions below to receive a non-covered cosmetic denial.
Please use diagnosis code: Z41.1 Encounter for cosmetic surgery.

Updated and relocated information from Other Coding Information:
Group 1 Paragraph: The following procedures being performed for cosmetic reasons will be denied, Group 1 Codes: [15775 15776] 15781 [15788 15793] [15828 15829] 15830 19300 19318 [30400 30450]

Relocated to CPT/HCPCS Codes:
Group 2 Paragraph: The following procedures being performed for cosmetic reasons will be denied as listed in L34698.
Please use diagnosis code: Z41.1 Encounter for cosmetic surgery.
Group 2 Codes:

15775-15776	PUNCH GRAFT FOR HAIR TRANSPLANT; 1-15 PUNCH GRAFTS – MORE THAN 15 PUNCH GRAFTS
15781	DERMABRASION; SEGMENTAL, FACE
15788-15793	CHEMICAL PEEL, FACIAL; EPIDERMAL - CHEMICAL PEEL, NONFACIAL; DERMAL
15828-15829	RHYTIDECTOMY; CHEEK, CHIN, AND NECK - RHYTIDECTOMY; SUPERFICIAL MUSCULOAPONEUROTIC SYSTEM (SMAS) FLAP
15830	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDES LIPECTOMY); ABDOMEN, INFRAUMBILICAL PANNICULECTOMY
19300	MASTECTOMY FOR GYNECOMASTIA
19318	REDUCTION MAMMAPLASTY
30400-30450	RHINOPLASTY, PRIMARY; LATERAL AND ALAR CARTILAGES AND/OR ELEVATION OF NASAL TIP - RHINOPLASTY, SECONDARY; MAJOR REVISION (NASAL TIP WORK AND OSTEOTOMIES)

Updated and relocated information from Other Coding Information:
Group 2 Paragraph: The following CPT codes/procedures are generally considered cosmetic and may be medically reviewed or denied as non-covered, Group 2 Codes: [11950 11954] 15780 15782 15783 15819 [15824 15826] [15832 15839] [15876 15879] 17340 17360 17380 69300

Relocated to CPT/HCPCS Codes:
Group 3 Paragraph: The following CPT codes/procedures are generally considered cosmetic and may be medically reviewed or denied as non-covered as listed in L34698. Please use diagnosis code: Z41.1 Encounter for cosmetic surgery.
Group 3 Codes:

Contract	Title	CMS MCD Policy #	Effective Date
	11950-11954 SUBCUTANEOUS INJECTION OF FILLING MATERIAL (EG, COLLAGEN); 1 CC OR LESS-OVER 10.0 CC 15780 DERMABRASION; TOTAL FACE (EG, FOR ACNE SCARRING, FINE WRINKLING, RHYTIDS, GENERAL KERATOSIS) 15782 REGIONAL, OTHER THAN FACE 15783 SUPERFICIAL, ANY SITE (EG, TATTOO REMOVAL) 15819 CERVICOPLASTY 15824-15826 RHYTIDECTOMY; FOREHEAD-GLABELLAR FROWN LINES 15832-15839 EXCISSION, EXCESSIVE SKIN AND SUBCUATNEOUS TISSUE, INCLUDING LIPECTOMY THIGH - OTHER AREA 15876-15879 SUCTION ASSISTED LIPECTOMY; HEAD AND NECK-LOWER EXTREMITY 17340 CRYOTHERAPY (C02 SLUSH, LIQUID N2) FOR ACNE 17360 CHEMICAL EXFOLIATION FOR ACNE (EG, ACNE PASTE, ACID) 17380 ELECTROLYSIS EPILATION, EACH 30 MINUTES 69300 OTOPLASTY, PROTRUDING EAR, WITH OR WITHOUT SIZE REDUCTION		
J5/J8	**Independent Diagnostic Testing Facilities-physician supervision and technician requirements**	A54953	01/01/2020
	CPT codes changed from long descriptions to short description: 95700 Eeg cont rec w/vid eeg tech 95705 Eeg w/o vid 2-12 hr unmntr 95706 Eeg wo vid 2-12hr intmt mntr 95707 Eeg w/o vid 2-12hr cont mntr Added the following CPT codes: 95708 Eeg wo vid ea 12-26hr unmntr 95709 Eeg w/o vid ea 12-26hr intmt 95710 Eeg w/o vid ea 12-26hr cont 95711 Veeg 2-12 hr unmonitored 95712 Veeg 2-12 hr intmt mntr 95713 Veeg 2-12 hr cont mntr 95714 Veeg ea 12-26 hr unmntr 95715 Veeg ea 12-26hr intmt mntr 95716 Veeg ea 12-26hr cont mntr 95717 Eeg phys/qhp 2-12 hr w/o vid 95718 Eeg phys/qhp 2-12 hr w/veeg 95719 Eeg phy/qhp ea incr w/o vid 95720 Eeg phy/qhp ea incr w/veeg 95721 Eeg phy/qhp>36<60 hr w/o vid 95722 Eeg phy/qhp>36<60 hr w/veeg 95723 Eeg phy/qhp>60<84 hr w/o vid		

Contract	Title	CMS MCD Policy #	Effective Date
	95724 Eeg phy/qhp>60<84 hr w/veeg 95725 Eeg phy/qhp>84 hr w/o vid 95726 Eeg phy/qhp>84 hr w/veeg Supervising Physician Qualification Requirements: Neurologist Technician Qualification: Credentialed by ABRET as R. EEG T		
J5/J8	**Wound Care**	L37228	02/09/2020
	Correction necessary for consistency between final Local Coverage Determination (LCD) effective 02/09/2020 and DL37228 in Documentation section to read, "When wound care is provided by the Therapist, for either in or out patient wound care, the medical record is required to have the following documentation" (removed, "Physical").		

EDUCATIONAL OPPORTUNITIES

WPS GHA Learning Center

WPS GHA Provider Outreach & Education (POE) offers numerous educational opportunities in our Learning Center: http://wpsghalearningcenter.com/store-catalog. We offer on-demand learning, allowing you to access the education at your convenience. We also offer live events on many subjects via seminar, teleconference, and webinar. You can browse through and register for these events in the Learning Center. Our education offers Certificates of Achievement identifying the length of time of the education. You can use these certificates (without an index number) to receive Continuing Education Units (CEUs) from most accrediting organizations.

We provide all educational materials in an electronic format. Please access and print the materials prior to the session. To locate materials, choose the Additional References tab within the individual course in our Learning Center.

Visit the WPS GHA Learning Center and look for the upcoming live events or a complete list of the on-demands.

WPS GHA YouTube

WPS GHA YouTube channel contains training videos. Most videos are under 15 minutes. Our goal is to provide fast and current education for you. You can find our YouTube channel at the following address: https://www.youtube.com/channel/UCscLmgYJDEJ8Zh2_r_SivUw. YouTube videos do not offer certificate of achievements. The videos are informational only in nature.

MEDICARE LEARNING NETWORK (MLN)

We encourage you to visit the Medicare Learning Network the place for official CMS Medicare fee-for-service provider educational information. There you can find one of our most popular products, MLN Matters national provider education articles. These articles help you understand new or changed Medicare policy and how those changes affect you. You can access a full array of other educational products (including Web-based training courses, hard copy and downloadable publications, and CD-ROMs) at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/index. You can also find other important Web sites by visiting the Physician Center Web page at: https://www.cms.gov/Center/Provider-Type/Physician-Center, and the All Fee-For-Service Providers Web page at: https://www.cms.gov/Center/Provider-Type/All-Fee-For-Service-Providers-Center.

In addition to educational products, the MLN also offers providers and suppliers opportunities to learn more about the Medicare program through MLN National Provider Calls. These national

conference calls, held by CMS for the Medicare Fee-For-Service provider and supplier community, educate and inform participants about new policies and/or changes to the Medicare program. Offered free of charge, you can receive continuing education credits for participation in certain National Provider Calls. To learn more about MLN National Provider Calls including upcoming calls, registration information, and links to previous call materials, visit https://www.cms.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events.

QUARTERLY PROVIDER UPDATE

The Centers for Medicare & Medicaid Services (CMS) publishes the Quarterly Provider Update on the first business day of each quarter. CMS publishes this comprehensive resource to make it easier for providers, suppliers, and the general public to understand proposed and implemented changes.

CMS publishes this update to inform the public about the following:

- Regulations and major policies completed or cancelled
- New/Revised manual instructions

You can access the Quarterly Provider Update on the CMS website at: https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/index.

We encourage you to bookmark this web page and visit it often for this valuable information. To receive notification when CMS adds regulations and program instructions throughout the quarter, sign up for the Quarterly Provider Update Listserv at: https://public.govdelivery.com/accounts/USCMS/subscriber/new?topic_id=USCMS_460.

Reimbursement

UNSOLICITED/VOLUNTARY REFUNDS

The acceptance of a voluntary refund as repayment for the claims specified 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.

Please see MLN Matters Article (MM) 3274 for more information:
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM3274.pdf

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WPS GHA includes MLN Connects articles published during the previous quarter in the *Communiqué*. The information included in these articles is current at the time we publish the *Communiqué.* Changes may occur subsequent to publication.

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MLN Connects Special Edition – Tuesday, November 26, 2019
https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/new-medicare-card-claim-reject-codes-after-january-1

MLN Connects® for Wednesday, November 27, 2019
https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2019-11-27

MLN Connects Special Edition – Tuesday, December 3, 2019
https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2019-12-03

MLN Connects® for Thursday, December 5, 2019
https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2019-12-05

MLN Connects Special Edition – Tuesday, December 10, 2019
https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2019-12-10

MLN Connects® for Thursday, December 12, 2019
https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2019-12-12

MLN Connects Special Edition – Tuesday, December 17, 2019
https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2019-12-17

MLN Connects® for Thursday, December 19, 2019
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MLN Connects Special Edition – Monday, December 23, 2019
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MLN Connects Special Edition – Thursday, December 26, 2019
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MLN Connects® for Thursday, January 9, 2020
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MLN Connects® for Thursday, February 13, 2020
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WPS GHA PROVIDER SERVICES

Please contact a customer service representative at the telephone numbers/addresses listed below for:

- Additional information on the content of this newsletter
- Changes in policy or procedures
- How to obtain a hardcopy of a Local Coverage Determination (LCD)/Coverage Article
- If you experience difficulties obtaining a policy/coverage article on our website

<table>
<tr><th colspan="2">J5 MAC PART A (IA, KS, MO, NE)</th></tr>
<tr><th>Iowa</th><th>Kansas</th></tr>
<tr><td>WPS GHA
General Correspondence
P.O. Box 7665
Madison, WI 53707-7665
(866) 518-3285</td><td>WPS GHA
General Correspondence
P.O. Box 7576
Madison, WI 53707-7576
(866) 518-3285</td></tr>
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<tr><td>WPS GHA
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P.O. Box 8890
Madison, WI 53708-8890
(866) 518-3285</td><td>WPS GHA
General Correspondence
P.O. 8799
Madison, WI 53708-8799
(866) 518-3285</td></tr>
<tr><th colspan="2">J5 National</th></tr>
<tr><td colspan="2">WPS GHA
General Correspondence
P.O. Box 7861
Madison, WI 53707-7861
(866) 518-3285</td></tr>
<tr><th colspan="2">J5 MAC PART B (IA, KS, MO, NE)</th></tr>
<tr><th>Iowa</th><th>Kansas</th></tr>
<tr><td>WPS GHA
General Correspondence
P.O. Box 8550
Madison, WI 53708-8550
(866) 518-3285</td><td>WPS GHA
General Correspondence
P.O. Box 7238
Madison, WI 53707-7238
(866) 518-3285</td></tr>
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<tr><td>WPS GHA
General Correspondence
P.O. Box 14260
Madison, WI 53708-0260
(866) 518-3285</td><td>WPS GHA
General Correspondence
P.O. 8667
Madison, WI 53708-8667
(866) 518-3285</td></tr>
<tr><th colspan="2">J8 MAC PART A (IN, MI)</th></tr>
<tr><th>Indiana</th><th>Michigan</th></tr>
<tr><td>WPS GHA
General Correspondence
P.O. Box 8602
Madison, WI 53708-8602
(866) 234-7331</td><td>WPS GHA
General Correspondence
P.O. Box 8604
Madison, WI 53708-8604
(866) 234-7331</td></tr>
<tr><th colspan="2">J8 MAC PART B (IN, MI)</th></tr>
<tr><th>Indiana</th><th>Michigan</th></tr>
<tr><td>WPS GHA
General Correspondence
P.O. Box 8580
Madison, WI 53708-8580
(866) 234-7331</td><td>WPS GHA
General Correspondence
P.O. Box 8939
Madison, WI 53708-8939
(866) 234-7331</td></tr>
</table>

VISIT THE WPS GHA WEBSITE FOR ALL YOUR MEDICARE NEEDS

Remember, the *Communiqué* does not include all the information needed by Medicare providers. While this publication does include general information, articles, and updates, our website (http://www.wpsgha.com/) is the most comprehensive source of information. Visit us today!

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