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This bulletin should be shared with all health care practitioners and managerial members of the provider staff. Bulletins are available at no cost from our website: [http://www.wpsgha.com](http://www.wpsgha.com)

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Advance Care Planning (ACP) Implementation for Outpatient Prospective Payment System (OPPS) Claims

Provider Types Affected

This MLN Matters® Article is intended for physicians and providers submitting claims on Type of Bill 13x to Medicare Administrative Contractors (MACs) for Advance Care Planning (ACP) services payable under the Outpatient Prospective Payment System (OPPS).

Provider Action Needed

This article is based on Change Request (CR) 9862 which implements system changes necessary to process Advance Care Planning (ACP) services for OPPS claims. Make sure that your billing staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) made Current Procedural Terminology (CPT) code 99497 for Advance Care Planning (ACP) separately payable for OPPS claims when the service meets the criteria for separate payment under the OPPS. This policy changes will be implemented through the annual Medicare Physician Fee Schedule Database (MPFSDB) update.

Effective for dates of service on or after January 1, 2016, payment for CPT code 99497 (Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate) is conditionally packaged under the OPPS and is consequently assigned to a conditionally packaged payment status indicator of “Q1.”

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this service is furnished with another service paid under the OPPS, payment is packaged; when it is the only service furnished, payment is made separately.

CPT code 99498 (Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure)) is an add-on code and therefore payment for the service described by this code is unconditionally packaged (assigned status indicator “N”) in the OPPS in accordance with 42 CFR 419.2(b)(18).

CMS is including voluntary ACP as an optional element of the Annual Wellness Visit (AWV). ACP services furnished on the same day and by the same provider as an AWV are considered a preventive service. Therefore, the deductible and coinsurance are not applied to the codes used to report ACP services when performed as part of an AWV and billed with a covered AWV code. However, if the AWV payment is denied, MACs will apply the deductible and coinsurance. Remember that the deductible and coinsurance for ACP billed with an AWV can only be waived once a year. When ACP services are furnished on the same day and by the same provider as a covered AWV, they are reimbursed under the MPFSDB rates.

Voluntary ACP means the face-to-face service between a physician (or other qualified health care professional) and the patient discussing advance directives, with or without completing relevant legal forms. An advance directive is a document appointing an agent and/or recording the wishes of a patient pertaining to his/her medical treatment at a future time should he/she lack decisional capacity at that time.

Voluntary ACP, upon agreement with the patient, is an optional element of the AWV. When ACP services are provided as a part of an AWV, practitioners would report CPT code 99497 (plus add-on code 99498 for each additional 30 minutes, if applicable) for the ACP services in addition to either of the HCPCS AWV codes G0438 (Annual wellness visit; includes a Personalized Prevention Plan of Service (PPPS), initial visit) and G0439 (Annual wellness visit, includes a Personalized Prevention Plan of Service (PPPS), subsequent visit). When voluntary ACP services are furnished as a part of an AWV, the coinsurance and deductible do not apply for ACP. The deductible and coinsurance does apply when ACP is not furnished as part of a covered AWV.

MACs will adjust claims ACP claims processed incorrectly from January 1, 2016 forward when ACP was an optional element of the Annual Wellness Visit (AWV).

Additional Information


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DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

MLN Matters® Number: MM10002
Related Change Request (CR) #: CR 10002
Related CR Release Date: March 10, 2017
Effective Date: April 1, 2017
Related CR Transmittal #: R3735CP
Implementation Date: April 3, 2017

April 2017 Integrated Outpatient Code Editor (I/OCE) Specifications
Version 18.1

Provider Types Affected

This MLN Matters® Article is intended for providers who submit institutional claims to Medicare Administrative Contractors (MACs), including Home Health and Hospice (HH+H) MACs for services provided to Medicare beneficiaries.

What You Need to Know

Change Request (CR) 10002 provides instructions and specifications for the Integrated Outpatient Code Editor (I/OCE) used for Outpatient Prospective Payment System (OPPS) and non-OPPS claims. This is for hospital outpatient departments, community mental health centers, all non-OPPS providers and for limited services when provided in a home health agency not under the Home Health Prospective Payment System (PPS) or to a hospice patient for the treatment of a non-terminal illness. Make sure your billing staff is aware of these changes. The I/OCE specifications will be posted at http://www.cms.gov/OutpatientCodeEdit/. These specifications contain the appendices mentioned in the table below.

Key I/OCE Changes for April 2017

The following table summarizes the modifications of the I/OCE for the April 2017 v18.1 release. Note that some I/OCE modifications in the update may be retroactively added to prior releases. If so, the retroactive date appears in the “Effective Date” column.

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<tr>
<td>1/1/2017</td>
<td>101</td>
<td>Update Section 603 logic to remove observation and change Payment Method Flag assignment to 8 (see Appendix E, Appendix Q of attachment to CR10002).</td>
</tr>
<tr>
<td>1/1/2017</td>
<td></td>
<td>Update Section 603 logic to change the Payment Method Flag to 8 for New Technology Ambulatory Payment Classifications (APC) (see Appendix Q).</td>
</tr>
<tr>
<td>1/1/2015</td>
<td></td>
<td>Update comprehensive APC logic to clear Composite Adjustment Flag assignment (if present) from the output when reported on a comprehensive APC claim (see Special processing logic, Appendix X - multiple imaging composite and Appendix L).</td>
</tr>
<tr>
<td>1/1/2017</td>
<td></td>
<td>Update logic to output Status Indicator (SI) = E1 for revenue codes reported without HCPCS codes that previously had SI = E (see Appendix N).</td>
</tr>
<tr>
<td>1/1/2017</td>
<td></td>
<td>Update logic for Advance Care Planning (ACP) to revert to processing at the day level (not claim level). Additionally, update logic for add-on ACP code 99498 to retain SI = N when reported on a claim with the Annual Wellness Visit (AWV) but without primary ACP code 99497 (see Special processing logic).</td>
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<td>2/1/2017</td>
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<td>Implement mid-quarter coverage for new Proprietary Laboratory Analysis (PLA) codes 0001U, 0002U, and 0003U.</td>
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<td>4/1/2017</td>
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<td>Terminate the editing requirements for Partial Hospitalization Program (PHP)/Community Mental Health Centers (CMHC) add-on codes reported without a primary PHP procedure (see notes in Table 4 and Appendix F-a).</td>
</tr>
<tr>
<td>1/1/2017</td>
<td></td>
<td>Correct conditional APC program logic to assign standard SI/APC for critical care ancillary service codes 36600, 43752 and 94660 that have SI = Q1 when the codes are reported without critical care or other payable HCPCS.</td>
</tr>
<tr>
<td>4/1/2017</td>
<td></td>
<td>Revised documentation in the special processing logic section for Conditional APC processing and Critical Care Ancillary Services processing for clarity; this clarification does not represent any changes to the processing logic.</td>
</tr>
<tr>
<td>4/1/2017</td>
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<td>Update the following lists for the release (see quarterly data files):</td>
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<td>- Edit 99 exclusion list</td>
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<tr>
<td></td>
<td></td>
<td>- Device procedure list (edit 92)</td>
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<tr>
<td></td>
<td></td>
<td>- Skin substitute product list (edit 87 and Appendix O)</td>
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<td></td>
<td></td>
<td>- Complexity-adjusted comprehensive APC pairs (new table, CapcPairs)</td>
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<td></td>
<td></td>
<td>- Terminated Device-Procedures (terminated procedures or those submitted for device credit): note several codes with corrected device credit amounts</td>
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<td></td>
<td></td>
<td>- Code Pairs (termination of PHP pairs for edit 84; move complexity-adjusted pairs to new table CapcPair)</td>
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<td>- Offset APC (Contrast APCs subject to pass-through offset)</td>
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<td>- Radiation HCPCS (new table listing HCPCS subject to Section 603 exclusion logic)</td>
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<tr>
<td>4/1/2017</td>
<td></td>
<td>Make all HCPCS/APC/SI changes as specified by CMS (quarterly data files).</td>
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<tr>
<td>4/1/2017</td>
<td>20, 40</td>
<td>Implement version 23.1 of the NCCI (as modified for applicable outpatient institutional providers).</td>
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Additional Information


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

Document History

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<td>March 10, 2017</td>
<td>Initial article released</td>
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Billing for Advance Care Planning (ACP) Claims

Provider Types Affected

This MLN Matters® Article is intended for providers who submit claims to Medicare Administrative Contractors (MACs) for Advance Care Planning (ACP) services provided as an optional element of the Annual Wellness Visit (AWV) to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 10000 provides billing instructions for ACP when furnished as an optional element of an AWV. Make sure that your billing staffs are aware of the billing instructions.

Background

The Centers for Medicare & Medicaid Services (CMS) has made the CPT code 99497 (Advance care planning, including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by a physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate) for ACP separately payable for Medicare OPPS claims when the service meets the criteria for separate payment under OPPS. The change in policy will be implemented through the annual Medicare Physician Fee Schedule Database (MPFSDB) update.
ACP with Other Services

Effective January 1, 2016, payment for the service described by CPT code 99497 is conditionally packaged under the OPPS and is consequently assigned to a conditionally packaged payment status indicator of “Q1.” When this service is furnished with another service paid under the OPPS, payment is packaged.

ACP Service Only

When ACP is the only service furnished, payment is made separately.

ACP Service with Add-on Code

CPT code 99498 (Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure)) is an add-on code and therefore, payment for the service described by this code is unconditionally packaged (assigned status indicator “N”) in the OPPS in accordance with 42 CFR 419.2(b)(18).

ACP Service with AWV

CMS is also including voluntary ACP as an optional element of the AWV. ACP services furnished on the same day and by the same provider as an AWV are considered a preventive service. Therefore, the deductible and coinsurance are not applied to the codes used to report ACP services when performed as part of an AWV. Additionally, when ACP services are furnished on the same day and by the same provider as an AWV, they are reimbursed under the MPFSDB rates.

Voluntary ACP means the face-to-face service between a physician (or other qualified health care professional) and the patient discussing advance directives, with or without completing relevant legal forms. An advance directive is a document appointing an agent and/or recording the wishes of a patient pertaining to his/her medical treatment at a future time should he/she lack decisional capacity at that time.

Voluntary ACP, upon agreement with the patient, is an optional element of the AWV. When ACP services are provided as a part of an AWV, practitioners should report CPT code 99497 (plus add-on code 99498 for each additional 30 minutes, if applicable) for the ACP services in addition to either of the AWV codes G0438 and code G0439. When voluntary ACP services are furnished as a part of an AWV, the coinsurance and deductible do not apply for ACP. The deductible and coinsurance does apply when ACP is not furnished as part of a covered AWV.

**Note:** The deductible and coinsurance for ACP will only be waived when billed on the same day and on the same claim as an AWV (code G0438 or G0439) and must also be furnished by the same provider. Waiver of the deductible and coinsurance for ACP is limited to once per year. Payment for an AWV is limited to once per year. If the AWV billed with ACP is denied for exceeding the once per year limit, the deductible and coinsurance will be applied to the ACP.
Summary of Changes

Beginning in CY 2016, CPT code 99497 used to describe ACP is conditionally packaged under the OPPS when it is not part of the AWV, and is consequently assigned to a conditionally packaged payment status indicator of ‘‘Q1.’’ When this service is furnished with another service paid under the OPPS, payment is packaged. When it is the only service furnished, payment is made separately. CPT code 99498 is unconditionally packaged (assigned status indicator ‘‘N’’) when it is not part of the AWV. Beginning in CY 2016, CPT codes 99497 and 99498 used to describe ACP will be separately payable under the MPFS for OPPS claims when billed as part of the AWV on the same date of service by the same provider.

Additional Information

The official instruction issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3739CP.pdf. You may also want to review MLN Matters Article MM9271 (Advance Care Planning (ACP) as an Optional Element of an Annual Wellness Visit (AWV)). If you have any questions, please contact your MAC at their toll-free number. That number is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/.

Document History

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MLN Matters® Number: MM9837 Revised Related Change Request (CR) #: CR 9837
Related CR Release Date: March 23, 2017 Effective Date: January 1, 2018
Related CR Transmittal #: R3740CP Implementation Date: July 3, 2017

**FISS Implementation of the Restructured Clinical Lab Fee Schedule**

Note: This article was revised on March 23, 2017, to reflect the revised CR9837 issued that day. In the article, the CR release date, transmittal number, and the Web address for accessing CR9837 are revised. All other information remains the same.

**Provider Types Affected**

This MLN Matters® Article is intended for clinical laboratory providers submitting claims to Medicare Administrative Contractors (MACs) for services paid under the Clinical Lab Fee Schedule (CLFS) and provided to Medicare beneficiaries.

**Provider Action Needed**

Change Request (CR) 9837 informs MACs about the changes to the Fiscal Intermediary Shared System (FISS) to incorporate the revised CLFS containing the National fee schedule rates. Make sure that your billing staffs are aware of these changes.

**Background**

Section 216 of Public Law 113-93, the “Protecting Access to Medicare Act of 2014,” added Section 1834A to the Social Security Act (the Act). This provision requires extensive revisions to the payment and coverage methodologies for clinical laboratory tests paid under the CLFS. The Centers for Medicare & Medicaid Services (CMS) published the CLFS final rule “Medicare Clinical Diagnostic Laboratory Tests Payment System Final Rule” (CMS-1621-F) was displayed in the Federal Register on June 17, 2016, and was published on June 23, 2016, which implemented the provisions of the new legislation.

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The final rule set forth new policies for how CMS sets rates for tests on the CLFS and is effective for dates of service on and after January 1, 2018. Beginning on January 1, 2017, applicable laboratories will be required to submit private payor rate data to CMS. (See MLN Matters Article SE1619 for further details of the laboratory data reporting requirements.) In general, with certain designated exceptions, the payment amount for a test on the CLFS furnished on or after January 1, 2018, will be equal to the weighted median of private payer rates determined for the test, based on data collected from laboratories during a specified data collection period. In addition, a subset of tests on the CLFS, Advanced Diagnostic Laboratory Tests (ADLTs), will have different data, reporting, and payment policies associated with them. In particular, the final rule discusses CMS’ proposals regarding:

- Definition of “applicable laboratory” (who must report data under Section 1834A of the Act)
- Definition of “applicable information” (what data will be reported)
- Data collection period
- Schedule for reporting data to CMS
- Definition of ADLT
- Data Integrity
- Confidentiality and public release of limited data
- Coding for new tests on the CLFS
- Phased in payment reduction

**Additional Information**


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

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Document History

- November 10, 2016 - Initial article released
- March 23, 2017 - Article revised to reflect revised CR9837. In the article, the CR release date, transmittal number, and the Web address of the CR are revised. All other information remains the same.

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Healthcare Provider Taxonomy Codes (HPTCs) April 2017 Code Set Update

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9869 instructs MACs to obtain the most recent Healthcare Provider Taxonomy Code (HPTC) set and to update their internal HPTC tables and/or reference files.

Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that covered entities use the standards adopted under this law for electronically transmitting certain health care transactions, including health care claims. The standards include implementation guides which dictate when and how data must be sent, including specifying the code sets which must be used. The institutional and professional claim electronic standard implementation guides (X12 837-I and 837-P) each require use of valid codes contained in the HPTC set when there is a need to report provider type or physician, practitioner, or supplier specialty for a claim.

The National Uniform Claim Committee (NUCC) maintains the HPTC set for standardized classification of health care providers, and updates it twice a year with changes effective April 1 and October 1. These changes include the addition of a new code and addition of definitions to existing codes.

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You should note that:

1. Valid HPTCs are those that the NUCC has approved for current use.
2. Terminated codes are not approved for use after a specific date.
3. 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.
4. Specialty and/or provider type codes issued by any entity other than the NUCC are not valid.

CR9869 implements the NUCC HPTC code set that is effective on April 1, 2017, and instructs MACs to obtain the most recent HPTC set and use it to update their internal HPTC tables and/or reference files. MACs will implement the April 2017 HPTC update as soon as they can after April 1, 2017, but not beyond July 3, 2017. The HPTC set is available for view or for download from the Washington Publishing Company (WPC) at [http://www.wpc-edi.com/codes](http://www.wpc-edi.com/codes).

When reviewing the Health Care Provider Taxonomy code set online, you can identify revisions made since the last release by the color code:

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

**Additional Information**


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

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Implementation of New Influenza Virus Vaccine Code

Note: This article was revised on April 21, 2017, to reflect a revised CR9876 issued that day. In the article, the CR release date, transmittal number, and the Web address for accessing the CR are revised. All other information remains the same.

Provider Types Affected

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

What You Need to Know

Change Request (CR) 9876 provides instructions for payment and edits for the common working file (CWF) to include influenza virus vaccine code 90682 (Influenza virus vaccine, quadrivalent (RIV4), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use) for claims with dates of service on or after July 1, 2017. Make sure that your billing staffs are aware of these instructions.

Background

Effective for dates of service on and after July 1, 2017, influenza virus code 90682 will be payable by Medicare. Annual Part B deductible and coinsurance amounts do not apply to this code. MACs will:

- Effective for dates of service on or after August 1, 2017, MACs will pay for code 90682 using the Centers for Medicare & Medicaid Services (CMS) Seasonal
Influenza Vaccines Pricing at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html) to determine the payment rate for influenza virus vaccine code 90682.

- Pay for vaccine code 90682 on institutional claims as follows:
  - Hospitals – Types of Bill (TOB) 12X and 13X, Skilled Nursing Facilities (SNFs) – TOB 22X and 23X, Home Health Agencies (HHAs) – TOB 34X, hospital-based Renal Dialysis Facilities (RDFs) – TOB 72X, and Critical Access Hospitals (CAHs) – TOB 85X, based on reasonable cost
  - Indian Health Service (IHS) Hospitals – TOB 12X, and 13X, IHS CAHs – TOB 85X, and hospices (81X and 82X) based on the lower of the actual charge or 95 percent of the Average Wholesale Price (AWP)
  - Comprehensive Outpatient Rehabilitation Facility (CORF) – TOB 75X, and independent RDFs – TOB 72X, based on the lower of actual charge or 95 percent of the AWP

- MACs will pay at discretion claims for code 90682 with dates of service July 1, 2017, through July 31, 2017.
- MACs will return to the provider (RTP) institutional claims if submitted with code 90682 for dates of service January 1, 2017, through June 30, 2017.
- MACs will deny Part B claims submitted with code 90682 for dates of service January 1, 2017, through June 30, 2017, using the following messages:
  - Claim Adjustment Reason Code: 181 – “Procedure code was invalid on the date of service.”
  - Remittance Advice Remark Code: N56 – “Procedure code billed is not correct/valid for the services billed or the date of service billed.”
  - Group Code: CO (Contractual Obligation)

In addition, effective for claims with dates of service on or after October 1m 2016, MACs will pay vaccines (Influenza, PPV, and HepB) to hospices based on the lower of the actual charge or 95% of AWP. Coinsurance and deductibles do not apply. Further, MACs will adjust previously processed hospice claims (TOB 81x or 82x) for these vaccines with dates of service on or after October 1, 2016.

**Additional Information**


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

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Document History

- February 3, 2017 - Initial article released.
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**Instruction to Process Services Not Authorized by the Veterans Administration (VA) in a Non-VA Facility Reported with Value Code (VC) 42**

Note: This article was revised on February 17, 2017, to reflect a revised CR9818 issued on February 14. In the article, the CR release date, transmittal number, and the Web address for accessing the CR were revised. All other information remains the same.

**Provider Types Affected**

This MLN Matters® Article is intended for hospitals and skilled nursing facilities who submit inpatient claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

**Provider Action Needed**

Change Request (CR) 9818 corrects a misinterpretation of the changes made with CR8198 - Updating the Shared Systems and Common Working File (CWF) to no Longer Create Veteran Affairs (VA) “I” records in the Medicare Secondary Payer (MSP) Auxiliary File. CR9818 clarifies how Medicare contractors will process inpatient claims for services in a Non-VA facility that were not authorized by the VA. Make sure that your billing staff are aware of these changes.

**Background**

The Social Security Act (Section 1862(a) (3)) precludes Medicare from making payment for services or items that are paid for directly or indirectly by another government entity.

The Centers for Medicare & Medicaid Services (CMS) issued MLN Matters® Special Edition Article (SE) 1517 to provide clarification and coding reminders for billing.

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Medicare when the Department of Veterans Affairs (VA) is involved for a portion of the services.

CMS was recently notified of a scenario where a hospital cannot follow the instructions in SE 1517 to split the claim to bill Medicare for only the non-VA authorized services as instructed in SE 1517.

Currently hospitals submit no pay inpatient claims paid by the VA to Medicare for the purpose of crediting the Part A deductible and coinsurance amounts. This process is not changing.

Medicare is precluded from making payment for services or items that are paid for directly or indirectly by another government entity. For inpatient claims where the VA is the Payer, the covered VA services are exclusions to the Medicare program per Section 1862 of the Social Security Act. If the VA doesn’t approve all the services, any Medicare covered services not considered by the VA may be billed to the Medicare program.

When a VA-eligible beneficiary chooses to receive services in a Medicare Certified Facility for which the VA has not authorized, the facility shall use Condition Code 26 to indicate the patient is a VA eligible patient and chooses to receive services in a Medicare Certified provider instead of a VA facility and value code 42 with the amount of the VA payment for the authorized days.

MACs will accept value code ‘42’ on inpatient claims with type of bill codes 11X, 18X, 21X, 41X and 51X. MACs will calculate the Medicare payment for an inpatient claim when condition code ‘26’ and value code ‘42’ are present on a claim. However, MACs will return the claim to the provider if CC ‘26’ is present without VC ‘42’ or vice versa.

Additional Information


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

Document History

- October 31, 2016 - Initial issuance
- February 17, 2017 - Article updated to reflect a revised CR9818 issued on February 14, 2017. In the article, the CR release date, transmittal number, and the Web address for accessing the CR were revised. All other information remains the same.
New Common Working File (CWF) Medicare Secondary Payer (MSP) Type for Liability Medicare Set-Aside Arrangements (LMSAs) and No-Fault Medicare Set-Aside Arrangements (NFMSAs)

**Note:** This article was revised on May 10, 2017, due to the release of an updated Change Request (CR). The CR date, transmittal number and the link to the transmittal changed. All other information remains the same.

**Provider Types Affected**

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

**What You Need to Know**

This article is based on CR 9893. To comply with the Government Accountability Office (GAO) final report entitled Medicare Secondary Payer (MSP): Additional Steps Are Needed to Improve Program Effectiveness for Non-Group Health Plans (GAO 12-333), the Centers for Medicare & Medicaid Services (CMS) will establish two (2) new set-aside processes: a Liability Insurance Medicare Set-Aside Arrangement (LMSA), and a No-Fault Insurance Medicare Set-Aside Arrangement (NFMSA). An LMSA or an NFMSA is an allocation of funds from a liability or an auto/no-fault related settlement, judgment, award, or other payment that is used to pay for an individual’s future medical and/or future prescription drug treatment expenses that would otherwise be reimbursable by Medicare.

Please be sure your billing staffs are aware of these changes.

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Background

CMS will establish two (2) new set-aside processes: a Liability Medicare Set-aside Arrangement (LMSA), and a No-Fault Medicare Set-aside Arrangement (NFMSA).

CR 9893 addresses (1) the policies, procedures, and system updates required to create and utilize an LMSA and an NFMSA MSP record, similar to a Workers’ Compensation Medicare Set-Aside Arrangement (WCMSA) MSP record, and (2) instructs the MACs and shared systems when to deny payment for items or services that should be paid from an LMSA or an NFMSA fund.

Pursuant to 42 U.S.C. Sections 1395y(b)(2) and 1862(b)(2)(A)(ii) of the Social Security Act, Medicare is precluded from making payment when payment “has been made or can reasonably be expected to be made under a workers’ compensation plan, an automobile or liability insurance policy or plan (including a self-insured plan), or under no-fault insurance.” Medicare does not make claims payment for future medical expenses associated with a settlement, judgment, award, or other payment because payment “has been made” for such items or services through use of LMSA or NFMSA funds. However, Liability and No-Fault MSP claims that do not have a Medicare Set-Aside Arrangement (MSA) will continue to be processed under current MSP claims processing instructions.

Key Points of CR9893

Medicare will not pay for those services related to the diagnosis code (or related within the family of diagnosis codes) associated with the open LMSA or NFMSA MSP record when the claim’s date of service is on or after the MSP effective date and on or before the MSP termination date. Your MAC will deny such claims using Claim Adjustment Reason Code (CARC) 201 and Group Code “PR” will be used when denying claims based on the open LMSA or NFMSA MSP auxiliary record.

In addition to CARC 201 and Group Code PR, when denying a claim based upon the existence of an open LMSA or NFMSA MSP record, your MAC will include the following Remittance Advice Remark Codes (RARCs) as appropriate to the situation:

- N723—Patient must use Liability Set Aside (LSA) funds to pay for the medical service or item.
- N724—Patient must use No-Fault Set-Aside (NFSA) funds to pay for the medical service or item.

Where appropriate, MACs may override and make payment for claim lines or claims on which:

- Auto/no-fault insurance set-asides diagnosis codes do not apply, or
- Liability insurance set-asides diagnosis codes do not apply, or are not related, or...
When the LMSA and NFMSA benefits are exhausted/terminated per CARC or RARC and payment information found on the incoming claim as cited in CR9009.

On institutional claims, if the MAC is attempting to allow payment on the claim, the MAC will include an “N” on the ‘001’ Total revenue charge line of the claim.

**Additional Information**


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

**Document History**

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Qualified Medicare Beneficiary Indicator in the Medicare Fee-For-Service Claims Processing System

Note: The article was revised on May 1, 2017, to reflect a revised CR9911 issued on April 28, 2017. In the article, the CR release date, transmittal number, and the Web address of CR9911 are revised. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

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

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

Under federal law, Medicare providers may not bill individuals enrolled in the QMB program for Medicare deductibles, coinsurance, or copayments, under any circumstances. (See Sections 1902(n)(3)(B); 1902(n)(3)(C); 1905(p)(3); 1866(a)(1)(A); 1848(g)(3)(A) of the Social Security Act.) State Medicaid programs may pay providers for Medicare deductibles, coinsurance, and copayments. However, as permitted by Federal law, states can limit provider reimbursement for Medicare cost-sharing under certain circumstances. Nonetheless, Medicare providers must accept the Medicare payment and Medicaid payment (if any, and including any permissible Medicaid cost sharing from the beneficiary) as payment in full for services rendered to an individual enrolled in the QMB program.

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

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

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

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

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

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

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

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

**Additional Information**


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

**Document History**

- February 3, 2017 - Initial article released.
- May 1, 2017 - The article was revised to reflect a revised CR9911 issued on April 28, 2017. In the article, the CR release date, transmittal number, and the Web address of CR9911 are revised. All other information remains the same.

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Reporting of Type of Bill (TOB) 014x for Billing Screening of Hepatitis C Virus (HCV) in Adults

Note: This article was revised on May 2, 2017, to correct the TOBs for the screening of HCV other than non-patient laboratory specimen. All other information is the same.

Provider Types Affected

This MLN Matters® Article is intended for providers submitting claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries related to screening of Hepatitis C Virus (HCV) in adults.

Provider Action Needed

This article is based on Change Request (CR) 9360, which adds Type of Bill (TOB) 014x (Hospital Other Part B) as an applicable TOB for the screening of HCV when submitted for non-patient laboratory specimen (HCPCS Code G0472). Transmittal 3215, CR 8871, titled, “Screening for Hepatitis C Virus (HCV) in Adults,” omitted TOB 014x from the list of applicable TOBs for HCV screening. Payment for these services submitted on TOB 014x will be based on the laboratory fee schedule. Make sure your billing personnel are aware of this change.

Background

Appropriate TOBs for the screening of HCV other than non-patient laboratory specimen remain the same:

- 013x
- 085x
Providers report TOB 014x when submitting claims for screening for HCV when provided to non-patient laboratory specimens.

In addition, MACs will apply the same logic for G0472 on TOB 14x as described in MLN Matters articles MM8871 and MM9200.

Note that MACs will not search for claims with G0472, submitted under TOB 014x with dates of service on or after June 2, 2014, but received before April 4, 2016, but the MACs may adjust claims that are brought to their attention.

**Additional Information**


If you have any questions, please contact your MAC at their toll-free number. That number is available at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html) under - How Does It Work.

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<td>The article was revised to correct the TOBs for the screening of HCV other than non-patient laboratory specimen.</td>
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<tr>
<td>November 16, 2015</td>
<td>Initial article released</td>
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MLN Matters® Number: MM9672  Related Change Request (CR) #: CR 9672
Related CR Release Date: May 5, 2017  Effective Date: Claims received on or after January 1, 2018
Related CR Transmittal #: R1840OTN  Implementation Date: January 8, 2018

Update FISS Editing to Include All Three Patient Reason for Visit Code Fields

Provider Types Affected

This MLN Matters® Article is intended for providers submitting outpatient hospital claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries.

What You Need to Know

Change Request (CR) 9672 informs MACs about changes that update logic in the Fiscal Intermediary Standard System (FISS) (Medicare's system for processing institutional claims) to allow editing of the expanded Patient Reason for Visit (PRV) fields. CR9672 requires updating of FISS to ensure that all of the National Coverage Determination (NCD) edits within Reason Code ranges 3xxxx and 59xxx that are tied to the diagnosis code fields include all three PRV fields for outpatient hospital claims on Types of Bills (TOB) 013x and 085x. CR9672 makes no policy changes.

Additional Information


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

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Update FISS Editing to Include the Admitting Diagnosis Code Field

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9753 informs MACs about changes to system edits by the maintainer of Medicare's Fiscal Intermediary Shared System (FISS). Make sure that your billing staffs are aware of these changes.

Background

In prior system updates, Medicare required FISS to review diagnosis fields. CR9753 updates various system edits to look at the admitting diagnosis field. FISS editing is now being updated to ensure that all of the National Coverage Determination (NCD) edits within Reason Code ranges 3xxxx and 59xxx that are tied to the diagnosis code fields (other than the primary diagnosis field) include the admitting diagnosis field for Inpatient claims on Types of Bill (TOB) 011x, 012x, 018x, 021x, and 022x.

Additional Information

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

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Changes to the Laboratory National Coverage Determination (NCD) Edit Software for July 2017

MLN Matters Number: MM10036  Related Change Request (CR) Number: CR10036
Related CR Release Date: March 17, 2017  Effective Date: October 1, 2016
Related CR Transmittal Number: R3738CP  Implementation Date: July 3, 2017

PROVIDER TYPE AFFECTED

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

WHAT YOU NEED TO KNOW

This article is based on Change Request (CR) 10036 which announces the changes that will be included in the July 2017 quarterly release of the edit module for clinical diagnostic laboratory services. This is a Recurring Update Notification that applies to Chapter 16, Section 120.2, of the "Medicare Claims Processing Manual." Make sure your billing staffs are aware of these changes.

BACKGROUND

The national coverage determinations (NCDs) for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee and the final rule was published on November 23, 2001. Nationally uniform software was developed and incorporated in the Medicare shared systems so that laboratory claims subject to one of the 23 NCDs ("Medicare National Coverage Manual", Sections 190.12 - 190.34) were processed uniformly throughout the nation effective April 1, 2003.

In accordance with Chapter 16, S120.2, Publication 100-04, the laboratory edit module is updated quarterly as necessary to reflect ministerial coding updates and substantive changes to the NCDs developed through the NCD process. The changes are a result of coding analysis decisions developed under the procedures for maintenance of codes in the negotiated NCDs and biannual updates of the ICD-10-CM codes.
CR10036 communicates requirements to shared system maintainers (SSMs) and contractors notifying them of changes to the laboratory edit module to update it for changes in laboratory NCD code lists for July 2017. These changes become effective for services furnished on or after October 1, 2016, and are as follows:

- ICD-10-CM code R73.03 will be added to the list of ICD-10-CM codes that are covered by Medicare for the Glycated Hemoglobin/Glycated Protein (190.21) NCD.
- ICD-10-CM code R73.03 will be removed from the list of ICD-10-CM codes that are covered by Medicare for the Hepatitis Panel/Acute Hepatitis Panel (190.33) NCD.

**ADDITIONAL INFORMATION**


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

**DOCUMENT HISTORY**

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<td>March 20, 2017</td>
<td>Initial article released</td>
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Clarification of Admission Order and Medical Review Requirements

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9979, from which this article was developed, clarifies the rulemaking language of the Centers for Medicare & Medicaid Services (CMS) as it relates to “Admission and Medical Review Criteria for Hospital Inpatient Services Under Medicare Part A; Requirements for Physician Orders.” The updated language will be added to Chapter 1, Section 10.2 (Hospital Inpatient Admission Order and Certification) of the "Medicare Benefit Policy Manual" (Pub. 100-02).

Background

In response to concerns about the provision of observation services for increasingly long periods of time and in response to stakeholders’ concerns about the clarity and appropriateness of Medicare’s hospital inpatient admission and medical review guidelines, CMS published several clarifications and changes in policy in the Fiscal Year (FY) 2014 Inpatient Prospective Payment System (IPPS)/Long-Term Care Hospital (LTCH), PPS final rule and subsequent rulemaking. These clarifications and changes remain in the text of the final rules. However, the "Benefit Policy Manual" has not been updated to reflect the same clarifications and changes. CR 9979 resolves that issue.

In the FY 2014 IPPS/LTCH PPS final rule and subsequent rulemaking, CMS clarified and specified that an individual becomes an inpatient of a hospital, including a Critical Access
Hospital (CAH), when formally admitted as such pursuant to an order for inpatient admission by a physician or other qualified practitioner described in the final regulations. The order is required for payment of hospital inpatient services under Medicare Part A.

CMS specified that for those hospital stays in which the physician expects the beneficiary to require care that crosses two midnights and admits the beneficiary based upon that expectation, Medicare Part A payment is generally appropriate. Conversely, CMS specified that hospital stays in which the physician expects the patient to require care less than two midnights, payment under Medicare Part A is generally inappropriate.

This revised CMS guidance to hospitals and physicians relating to when hospital inpatient admissions are determined reasonable and necessary for payment under Part A.

Additional Information


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

Document History

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Gender Dysphoria and Gender Reassignment Surgery

Provider Types Affected

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

What You Need to Know

This article is based on Change Request (CR) 9981, which informs MACs that coverage determinations for gender reassignment surgery will continue to be made by the local MACs on a case-by-case basis. Make sure that your billing staffs are aware of these changes.

Background

On August 30, 2016, the Centers for Medicare & Medicaid Services (CMS) issued a final decision memorandum (DM) on gender reassignment surgery for gender dysphoria. Importantly, the DM did not create or change existing policy – CMS did not issue a national coverage determination (NCD).

The purpose of this CR is to include an explanatory paragraph about gender reassignment surgery in the Medicare NCD Manual at Chapter 1, Part 2, Section 140.9. This is in response to public inquires to have information about gender reassignment surgery among Medicare coverage information.

Policy: Effective for claims with dates of service on or after August 30, 2016, coverage determinations for gender reassignment surgery, under section 1862(a)(1)(A) of the Social Security Act and any other relevant statutory requirements, will continue to be made by the local Medicare Administrative Contractors (MACs) on a case-by-case basis.

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Additional Information


If you have any questions, please contact your MAC at their toll-free number. That number is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html on the CMS website under - How Does It Work.

Document History

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<td>March 6, 2017</td>
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ICD-10 Coding Revisions to National Coverage Determination (NCDs)

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9861 is the 10th maintenance update of ICD-10 conversions and other coding updates specific to national coverage determinations (NCDs). The majority of the NCDs included are a result of feedback received from previous ICD-10 NCD CRs, specifically CR7818, CR8109, CR8197, CR8691, CR9087, CR9252, CR9540, CR9631, and CR 9751; while others are the result of revisions required to other NCD-related CRs released separately. MLN Matters® Articles MM7818, MM8109, MM8197, MM8691, MM9087, MM9252, MM9540, MM9631, MM9751 contain information pertaining to these CR’s.

Background

The translations from ICD-9 to ICD-10 are not consistent 1-1 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. There may be
certain ICD-9 codes that were once considered appropriate prior to ICD-10 implementation that are no longer considered acceptable, as of October 1, 2015.

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. Edits to ICD-10 and other coding updates specific to NCDs will be included in subsequent, quarterly releases as needed.

CR9861 makes adjustments to the following 16 NCDs:

- NCD 40.1 - Diabetes Outpatient Self-Management Training
- NCD 40.7 - Outpatient Intravenous Insulin Treatment
- NCD 80.2 - Photodynamic Therapy (also NCD 80.2.1, 80.3, 80.3.1)
- NCD 80.11 - Vitrectomy
- NCD 100.1 - Bariatric Surgery
- NCD 110.4 – Extracorporeal Photopheresis
- NCD 110.18 - Aprepitant
- NCD 110.23 - Stem Cell Transplantation
- NCD 180.1 - Medical Nutrition Therapy
- NCD 190.1 – Histocompatibility Testing
- NCD 210.3 - Colorectal Cancer Screening
- NCD 220.4 - Mammograms
- NCD 220.6.17 - Positron Emission Tomography (PET) for Solid Tumors
- NCD 260.3.1 - Islet Cell Transplants
- NCD 260.5 - Intestinal and Multi-Visceral Transplants
- NCD 270.6 - Infrared Therapy Devices


You should remember that coding and payment areas of the Medicare Program are separate and distinct 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.

Your MACs will use default Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) messages where appropriate: Remittance Advice Remark Code (RARC) N386 with Claim Adjustment

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Reason Code (CARC) 50, 96, and/or 119, with Group Code PR (Patient Responsibility) or Group Code CO (Contractual Obligation), as appropriate.

Your MAC will not search their files to adjust previously processed claims but will adjust any claims that you bring to their attention if found appropriate to do so.

Additional Information


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

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MLN Matters® Number: MM9982
Related Change Request (CR) #: CR 9982

Related CR Release Date: February 17, 2017
Effective Date: July 1, 2017 (Unless otherwise noted in individual NCDs)

Related CR Transmittal #: R1798OTN
Implementation Date: March 20, 2017, for MAC edits and July 3, 2017, for Shared Systems

ICD-10 Coding Revisions to National Coverage Determinations (NCDs)

Provider Types Affected

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

What You Need to Know

Change Request (CR) 9982 is the 11th maintenance update of ICD-10 conversions and other coding updates specific to national coverage determinations (NCDs). The majority of the NCDs included are a result of feedback received from previous ICD-10 NCD CRs, specifically CR7818, CR8109, CR8197, CR8691, CR9087, CR9252, CR9540, CR9631, CR9751, and CR9861; while others are the result of revisions required to other NCD-related CRs released separately. MLN Matters® Articles MM7818, MM8109, MM8197, MM8691, MM9087, MM9252, MM9540, MM9631, MM9751, and MM9861 contain information pertaining to these CRs.

Background

The translations from ICD-9 to ICD-10 are not consistent 1-1 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. There may be...
certain ICD-9 codes that were once considered appropriate prior to ICD-10 implementation that are no longer considered acceptable, as of October 1, 2015.

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. Edits to ICD-10 and other coding updates specific to NCDs will be included in subsequent, quarterly releases as needed.

CR9982 makes coding and clarifying adjustments to the following NCDs:

- NCD20.31 - Intensive Cardiac Rehabilitation (ICR)
- NCD20.31.1 - ICR Pritkin Program
- NCD20.31.2 - ICR Ornish Program
- NCD20.31.3 - ICR Benson-Henry Program
- NCD20.34 - Left Atrial Appendage Closure
- NCD190.3 - Cytogenetic Studies
- NCD260.3.1 - Islet Cell Transplants in Clinical Trials
- NCD270.1 - Electrical Stimulation & Electromagnetic Therapy for Treatment of Wounds
- NCD220.4 – Mammograms


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

Your MACs will use default Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) messages where appropriate. MACs will complete all tasks that involve updates to local system edits/tables associated with the attached NCDs in this CR.

MACs will use default CAQH CORE messages where appropriate:


When denying claims associated with the attached NCDs, except where otherwise indicated, A/B MACs will use:

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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 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 MSN 8.81 per instructions in CR 7228/TR 2148 available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2148CP.pdf.

Your MAC will not search their files to adjust previously processed claims but will adjust any claims that you bring to their attention if appropriate to do so.

Additional Information


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

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9859 provides that the Centers for Medicare & Medicaid Services (CMS) has determined that, effective September 28, 2016, Medicare will cover screening for Hepatitis B Virus (HBV) infection when performed with the appropriate U.S. Food and Drug Administration (FDA) approved/cleared laboratory tests, used consistent with FDA-approved labeling and in compliance with the Clinical Laboratory Improvement Act (CLIA) regulations. Medicare coinsurance and the Part B deductible are waived for this additional preventive service. You should ensure that your billing staffs are aware of this coverage change.

Background

Pursuant to Section 1861(ddd) of the Social Security Act (the Act), CMS may add coverage of “additional preventive services” through the National Coverage Determination (NCD) process. The preventive services must meet all of the following criteria:

1. Reasonable and necessary for the prevention or early detection of illness or disability.
2. Recommended with a grade of A or B by the United States Preventive Services Task Force (USPSTF).
3. Appropriate for individuals entitled to benefits under Part A or enrolled under Part B.

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The USPSTF has updated its recommendations for HBV screening, and CMS has reviewed these recommendations and supporting evidence; and has determined that the evidence is adequate to conclude that screening for HBV infection is reasonable and necessary for individuals entitled to benefits under Part A or enrolled under Part B, as described below.

Effective for services performed on or after September 28, 2016, Medicare will cover screening for HBV infection, when ordered by the beneficiary's primary care physician or practitioner within the context of a primary care setting, and performed by an eligible Medicare provider for these services, within the context of a primary care setting with the appropriate U.S. Food and Drug Administration (FDA) approved/cleared laboratory tests, used consistent with FDA-approved labeling and in compliance with the Clinical Laboratory Improvement Act (CLIA) regulations, for beneficiaries who meet either of the following conditions:

1. Asymptomatic, non-pregnant adolescents and adults at high risk for HBV infection. “High risk” is defined as persons born in countries and regions with a high prevalence of HBV infection (that is, ≥ 2%), US-born persons not vaccinated as infants whose parents were born in regions with a very high prevalence of HBV infection (≥ 8%), HIV positive persons, men who have sex with men, injection drug users, household contacts or sexual partners of persons with HBV infection. In addition, CMS has determined that repeated screening would be appropriate annually for beneficiaries with continued high risk persons. Testing is covered annually only for persons who have continued high risk (men who have sex with men, injection drug users, household contacts or sexual partners of persons with HBV infection) who have not received hepatitis B vaccination.

2. A screening test at the first prenatal visit is covered for pregnant women and then rescreening at time of delivery for those with new or continuing risk factors. In addition, CMS has determined that screening during the first prenatal visit would be appropriate for each pregnancy, regardless of previous hepatitis B vaccination or previous negative hepatitis B surface antigen (HBsAg) test results.

For the purposes of CR9859:

- The determination of ‘high risk for HBV” is identified by the primary care physician or practitioner who assesses the patient's history, which is part of any complete medical history, typically part of an annual wellness visit and considered in the development of a comprehensive prevention plan. The medical record should be a reflection of the service provided.

- A primary care setting is defined by the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Emergency departments, inpatient hospital settings, ambulatory surgical centers, skilled nursing facilities, inpatient rehabilitation facilities, clinics providing a limited focus of health care services, and hospice are examples of settings not considered primary care settings under this definition.
Key Points of CR9859

Applicable Healthcare Common Procedure Coding System (HCPCS) Code
Effective for claims with dates of service on or after September 28, 2016, the claims processing instructions for payment of screening for hepatitis B virus will apply to the following HCPCS and CPT codes:

- HBV screening for asymptomatic, non-pregnant adolescents and adults at high risk - code G0499
- HBV screening for pregnant women - CPT codes 86704, 86706, 87340, and 87341

Types of Bills (TOB) for Institutional Claims
Effective for claims with dates of service on or after September 28, 2016, you should use the following TOBs when submitting claims with G0499, 87340, 87341, 86704, or 86706 for HBV screening:

- Outpatient hospitals - TOB 13X (payment based on Outpatient Prospective Payment System)
- Non-patient laboratory specimen - TOB 14X (payment based on laboratory fee schedule)
- Critical Access Hospitals (CAHs) - TOB 85X, (payment based on reasonable cost when the revenue code is not 096X, 097X, and 098X)
- End Stage Renal Disease (ESRD) - TOB 72X (payment based on ESRD Prospective Payment System when submitting code G0499 with diagnosis code N18.6. HBV is not separately payable for ESRD TOB 72X.)

Professional Billing Requirements
For claims with dates of service on or after September 28, 2016, CMS will allow coverage for HBV screening only when services are submitted by the following provider specialties found on the provider’s enrollment record:

- 01 - General Practice
- 08 - Family Practice
- 11 - Internal Medicine
- 16 - Obstetrics/Gynecology
- 37 - Pediatric Medicine
- 38 - Geriatric Medicine
- 42 - Certified Nurse Midwife
- 50 - Nurse Practitioner
- 89 - Certified Clinical Nurse Specialist
- 97 - Physician Assistant

Claims submitted by providers other than the specialty types noted above will be denied.

Additionally, for claims with dates of service on or after September 28, 2016, CMS will allow coverage for HBV screening only when submitted with one of the following Place of Service (POS) codes:

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11 - Physician’s Office  
19 - Off Campus Outpatient Hospital  
22 - On Campus Outpatient Hospital  
49 - Independent Clinic  
71 - State or Local Public Health Clinic  
81 - Independent Laboratory  

Claims submitted without one of the POS codes noted above will be denied.

**Diagnosis Code Reporting Requirements**

For claims with dates of service on or after September 28, 2016, CMS will allow coverage for G0499 for HBV screening only when services are reported with both of the following diagnosis codes denoting high risk:

- Z11.59 - Encounter for screening for other viral disease  
- Z72.89 - Other Problems related to life style.

For claims with dates of service on or after September 28, 2016, CMS will allow coverage for G0499 for subsequent visits, only when services are reported with the following diagnosis codes:

- Z11.59 and one of the high risk codes below  
  - F11.10-F11.99  
  - F13.10-F13.99  
  - F14.10-F14.99  
  - F15.10-F15.99  
  - Z20.2  
  - Z20.5  
  - Z72.52  
  - Z72.53

For claims with dates of service on or after September 28, 2016, CMS will allow coverage for HBV screening (CPT codes 86704, 86706, 87340 and 87341) in pregnant women only when services are reported with one of the following diagnosis codes:

- Z11.59 - Encounter for screening for other viral diseases, and one of the following  
- Z34.00 - Encounter for supervision of normal first pregnancy, unspecified trimester  
- Z34.80 - Encounter for supervision of other normal pregnancy, unspecified trimester  
- Z34.90 - Encounter for supervision of normal pregnancy, unspecified, unspecified trimester  
- O09.90 - Supervision of high risk pregnancy, unspecified, unspecified trimester

For claims with dates of service on or after September 28, 2016, CMS will allow coverage for HBV screening (CPT codes 86704, 86706, 87340, and 87341) in pregnant women at high risk only when services are reported with one of the following diagnosis codes:

- Z11.59 - Encounter for screening for other viral diseases; and  
- Z72.89 - Other problems related to lifestyle, and also one of the following:

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### MLN Matters® Number: MM9859  
**Related Change Request Number: 9859**

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<td>Encounter for supervision of other normal pregnancy, third trimester</td>
</tr>
<tr>
<td>Z34.90</td>
<td>Encounter for supervision of normal pregnancy, unspecified, unspecified trimester</td>
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<tr>
<td>Z34.91</td>
<td>Encounter for supervision of normal pregnancy, unspecified, first trimester</td>
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<td>Z34.92</td>
<td>Encounter for supervision of normal pregnancy, unspecified, second trimester</td>
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<tr>
<td>Z34.93</td>
<td>Encounter for supervision of normal pregnancy, unspecified, third trimester</td>
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<td>Supervision of high risk pregnancy, unspecified, unspecified trimester</td>
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<td>Supervision of high risk pregnancy, unspecified, second trimester</td>
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<tr>
<td>O09.93</td>
<td>Supervision of high risk pregnancy, unspecified, third trimester</td>
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</tbody>
</table>

### Claim/Service Denial

When denying payment for HBV screening use, your MAC will use the appropriate Claim Adjustment Reason Codes (CARCs), Remittance Advice Remark Codes (RARCs), or group codes.

When denying services submitted on a TOB other than 13X, 14X, or 85X, they will use:
- **CARC 170** - Payment is denied when performed/billed by this type of provider.  
  Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present
- **RARC N95** - This provider type/provider specialty may not bill this service
- **Group Code CO** (Contractual Obligation) - Assigning financial liability to the provider

When denying services when HCPCS G0499 is paid in history for claims with dates of service on and after September 28, 2016, or if the beneficiary’s claim history shows claim lines containing CPT codes 86704, 86706, 87340, and 87341 submitted in the previous 11 full months they will use the following messages:
- **CARC 119** - “Benefit maximum for this time period or occurrence has been reached.”
- **RARC N386** - “This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at [www.cms.gov/mcd/search.asp](http://www.cms.gov/mcd/search.asp). If you do not have web access, you may contact the contractor to request a copy of the NCD.”

### Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article 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. CPT only copyright 2016 American Medical Association. All rights reserved.
Group Code PR (Patient Responsibility) - Assigning financial responsibility to the beneficiary (if a claim is received with occurrence code 32 with or without GA modifier or a claim –line is received with a GA modifier indicating a signed 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).

When denying services for G0499, when ICD-10 diagnosis code Z72.89 and Z11.59 are not present on the claim, MACs will use:

- CARC 167 - “This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.”
- RARC N386 - This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.

Group Code CO

Denying services for HBV screening, HCPCS G0499, when ICD-10 diagnosis code Z34.00, Z34.01, Z34.02, Z34.03, Z34.80, Z34.81, Z34.82, Z34.83, Z34.90, Z34.91, Z34.92, Z34.93, O09.90, O09.91, O09.92, or O09.93 is present on the claim:

- CARC 167 – “This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.”
- RARC N386 - This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.

Group Code: CO (Contractual Obligation)

When denying services for G0499 for subsequent visits, when ICD-10 diagnosis code Z11.59 and one of the following high risk diagnosis codes: F11.10- F11.19, F13.10 - F13.99, F14.10 - F14.99, F15.10 - F15.99, Z20.2, Z20.5, Z72.52, or Z72.53 are not present on the claim, MACs will use:

- CARC 167 - “This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.”
- RARC N386 - This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.

Group Code CO
When denying claim lines for G0499 without the appropriate POS code, MACs will use:

- **CARC 171** - Payment is denied when performed by this type of provider on this type of facility. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- **RARC N428** - Not covered when performed in certain settings.
- Group Code CO

When denying claim lines for G0499 that are not submitted from the appropriate provider specialties, MACs will use:

- **CARC 184** - The prescribing/ordering provider is not eligible to prescribe/order the service billed. NOTE: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- **RARC N386** - “This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at [http://www.cms.gov/mcd/search.asp](http://www.cms.gov/mcd/search.asp). If you do not have web access, you may contact the contractor to request a copy of the NCD.”
- Group Code PR (Patient Responsibility) - Assigning financial responsibility to the beneficiary (if a claim is received with a GA modifier indicating a signed ABN is on file).
- Group Code CO (Contractual Obligation) - Assigning financial liability to the provider (if a claim line-item is received with a GZ modifier indicating no signed ABN is on file).

When denying services where previous HBV screening, HCPCS 86704, 86706, 87340, or 87341, is paid during the same pregnancy period or more than two screenings are paid to women that are at high risk, they will use:

- **CARC 119** - “Benefit maximum for this time period or occurrence has been reached.”
- **RARC N362** - “The number of days or units of service exceeds our acceptable maximum.”
- **RARC N386** - “This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at [www.cms.gov/mcd/search.asp](http://www.cms.gov/mcd/search.asp). If you do not have web access, you may contact the contractor to request a copy of the NCD.”
- Group Code PR (Patient Responsibility) - Assigning financial responsibility to the beneficiary (if a claim is received with a GA modifier indicating a signed 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).

When denying claim lines for HBV screening, HCPCS G0499 for a subsequent HBV screening test for non-pregnant, high risk beneficiary when a claim line for an initial HBV screening has not yet been posted in history, use the following messages:

- **CARC B15** - This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/ adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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• RARC N386 - This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.
• Group Code - CO (Contractual Obligation).

When denying services for HBV screening, HCPCS 86704, 86706, 87340, and 87341 that are billed without the appropriate diagnosis code MACs will use:
• CARC 50 - These are non-covered services because this is not deemed a “medical necessity” by the payer. Note: Refer to the 835 Healthcare Policy identification Segment (loop 2110 Service Payment information REF), if present.
• RARC N386 - “This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.”
• Group Code PR (Patient Responsibility) - Assigning financial responsibility to the beneficiary (if a claim is received with a GA modifier indicating a signed 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).

Additional Notes
• HCPCS code G0499 will appear in the January 1, 2018, Clinical Laboratory Fee Schedule (CLFS), in the January 1, 2017, Integrated Outpatient Code Editor (IOCE), and in the January 1, 2017, Medicare Physician Fee Schedule (MPFS) with indicator ‘X’. HCPCS code G0499 will be effective retroactive to September 28, 2016, in the IOCE.
• Your MAC will not search for claims containing HCPCS G0499 with dates of service on or after September 28, 2016, but may adjust claims that you bring to their attention.
• You should be aware that the revision to the “Medicare National Coverage Determinations Manual” is a National Coverage Determination (NCD). NCDs are binding on all carriers, fiscal intermediaries, contractors with the Federal government that review and/or adjudicate claims, determinations, and/or decisions, quality improvement organizations, qualified independent contractors, the Medicare appeals council, and Administrative Law Judges (ALJs) (see 42 CFR Section 405.1060(a)(4) (2005)). An NCD that expands coverage is also binding on a Medicare advantage organization. In addition, an ALJ may not review an NCD. (See Section 1869(f)(1)(A)(i) of the Social Security Act.)
• MACs will apply contractor pricing to claim lines with G0499 with dates of service September 28, 2016, through December 31, 2017.
• Deductible and coinsurance do not apply to G0499.
Additional Information

The official instruction, CR9859, was issued to your MAC via two transmittals. The first updates the “Medicare Claims Processing Manual” and it is available at 

If you have any questions, please contact your MAC at their toll-free number. That number is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html under - How Does It Work.

Document History

<table>
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<tr>
<th>Date</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>May 4, 2017</td>
<td>Initial article released.</td>
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</table>
Prior authorization is a process through which a request for provisional affirmation of coverage is submitted to a medical review contractor for review before the item or service is furnished to the beneficiary and before the claim is submitted for processing. It is a process that permits the submitter/requester (for example, provider, supplier, beneficiary) to send in...
medical documentation, in advance of the item or service being rendered, and subsequently billed, in order to verify its eligibility for Medicare claim payment.

For any item or service to be covered by Medicare it must:

- Be eligible for a defined Medicare benefit category
- Be medically reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member
- Meet all other applicable Medicare coverage, coding and payment requirements

Contractors shall, at the direction of CMS or other authorizing entity, conduct prior authorizations and alert the requester/submitter of any potential issues with the information submitted.

A prior authorization request decision can be either a provisional affirmative or a non-affirmative decision.

- A provisional affirmative decision is a preliminary finding that a future claim submitted to Medicare for the item or service likely meets Medicare’s coverage, coding, and payment requirements.
- A non-affirmative decision is a finding that the submitted information/documentation does not meet Medicare’s coverage, coding, and payment requirements, and if a claim associated with the prior authorization is submitted for payment, it would not be paid. MACs shall provide notification of the reason for the non-affirmation, if a request is non-affirmative, to the submitter/requester. If a prior authorization request receives a non-affirmative decision, the prior authorization request can be resubmitted an unlimited number of times.
- Prior authorization may also be a condition of payment. This means that claims submitted without an indication that the submitter/requester received a prior authorization decision (that is, Unique Tracking Number (UTN)) will be denied payment.

Each prior authorization program will have an associated Operational Guide that will be available on the CMS website. In addition, MACs will educate stakeholders each time a new prior authorization program is launched. That education will include the requisite information and timeframes for prior authorization submissions and the vehicle to be used to submit such information to the MAC.

Prior Authorization Program for DME MACs

A prior authorization program for certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) items that are frequently subject to unnecessary utilization is described in 42 CFR 414.234. Among other things, this section establishes a Master List of certain DMEPOS items meeting inclusion criteria and potentially subject to prior authorization. CMS will select Healthcare Common Procedure Coding System

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(HCPCS) codes from the Prior Authorization Master List to be placed on the Required Prior Authorization List, and such codes will be subject to prior authorization as a condition of payment. In selecting HCPCS codes, CMS may consider factors such as geographic location, item utilization or cost, system capabilities, administrative burden, emerging trends, vulnerabilities identified in official agency reports, or other data analysis.

- The Prior Authorization Master List is the list of DMEPOS items that have been identified using the inclusion criteria described in 42 CFR 414.234.
- The List of Required DMEPOS Prior Authorization Items contains those items selected from the Prior Authorization Master List to be implemented in the Prior Authorization Program. The List of Required DMEPOS Prior Authorization Items will be updated as additional codes are selected for prior authorization.
- CMS may suspend prior authorization requirements generally or for a particular item or items at any time and without undertaking rulemaking. CMS provides notification of the suspension of the prior authorization requirements via Federal Register notice and posting on the CMS prior authorization website.

The items on the Required Prior Authorization List, a “CMS Final Rule 6050-F” subpage containing the Master List, as well as other pertinent information and supporting documents regarding this program, are available 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.

**Additional Information**


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

**Document History**

- January 20, 2017 - Initial article released.
- May 1, 2017 - Article revised to include new Web address for the Required Prior Authorization List. All other information remains the same.
INFORMATION ON WEBSITE

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

If you cannot gain access to the Internet from your office or home, you might try one of the many public libraries that offer Internet access. You may request a hard copy of a retired LCD by writing to our Freedom of Information (FOI) Unit.

WPS GHA
Attn: Freedom of Information Act (FOIA)
P.O. Box 1604
Omaha, NE 68101

NEW POLICIES

The following are new policies. Be sure to note the effective date of the new policy, as the policy will not appear as an active policy until the effective date. Prior to the effective date, the policy can be found by selecting the link "Display Future Effective Documents" within the CMS Medicare Coverage Database (MCD):

Visit our website at the appropriate link below for more information:

June 2017

<table>
<thead>
<tr>
<th>Contract</th>
<th>Policy Title</th>
<th>CMS MCD Policy #</th>
<th>WPS Policy #</th>
<th>Effective Date</th>
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<tr>
<td>J5/J8</td>
<td>MolDX: 4Kscore Assay</td>
<td>L37013</td>
<td>MolIDX-023</td>
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<td>MolDX-CDD: ConfirmMDx Epigenetic Molecular Assay</td>
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<td>MolDX: Chromosome 1p/19q Deletion Analysis</td>
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<td>MolDX: HLA-DQB1*06:02 Testing for Narcolepsy</td>
<td>L37003</td>
<td>MolIDX-019</td>
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### Visual Electrophysiology Testing

**Contract:** J5/J8  
**Policy Title:** Visual Electrophysiology Testing  
**CMS MCD Policy #:** L37015  
**WPS Policy #:** OPHTH-057  
**Effective Date:** 07/17/2017

### May 2017

There are no new Policies/Articles for May 2017

### April 2017

There are no new Policies/Articles for April 2017

### March 2017

There are no new policies/articles for March 2017

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**RETIRED POLICIES**

The following are retired policies. Be sure to note the effective date of the retired policy, as the policy will not appear as retired until the effective date.

Visit our website at the appropriate link below for more information:

### June 2017

There are no retired Policies/Articles for June 2017

### May 2017

There are no retired Policies/Articles for May 2017

### April 2017

There are no retired Policies/Articles for April 2017

### March 2017

There are no retired policies/articles for March 2017

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**REVISED POLICIES**

The following are revised policies. Be sure to note the effective date of the revised policy, as the policy will not appear as an active policy until the effective date. Prior to the effective date, the policy can be found by selecting the link "Display Future Effective Documents" within the CMS Medicare Coverage Database (MCD):
Visit our website at the appropriate link below for more information:

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<td>J5/J8</td>
<td>Chemotherapy Drugs and their Adjuncts</td>
<td>L35053</td>
<td>HONC-010</td>
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Added to C. 27. Paclitaxel protein-bound particles/Abraxane (J9264)
Per NCCN:
Bladder Cancer-Upper GU Tract Tumors: Used as a single agent as subsequent systemic therapy for metastatic disease as an alternate regimen for select patients.
C65.1 right renal pelvis
C65.2 left renal pelvis
C66.1 right ureter
C66.2 left ureter. Effective Date 06/01/2017.

Added to C. 29. Pembrolizumab (Keytruda) (J9271)
Is indicated for the treatment of adult and pediatric patients with refractory Classical Hodgkin Lymphoma (cHL), or who have relapsed after 3 or more prior lines of therapy. (C81.11-C81.19, C81.21-C81.29, C81.31-C81.39, C81.41-81.49, C81.91-C81.99, Z85.71). FDA approval 03/14/2017. Effective date 03/14/2017.

Is indicated for palliative therapy as a single agent for relapsed or refractory disease in older adults (age 60 and greater). (C81.11-C81.19, C81.21-C81.29, C81.31-C81.39, C81.41-81.49, C81.91-C81.99, Z85.71). FDA approval 03/14/2017. Effective date 03/14/2017.


| J5/J8    | Electrocardiographic (EKG or ECG) Monitoring (Holter or Real-Time Monitoring) | L34636 | CV-016 | 06/01/2017 |

Added diagnosis code G45.9 (Transient cerebral ischemic attack, unspecified) to Group 1 Memory Loop recordings (codes 93268, 93270, 93271 and 93272), to Group 2 Other up to 48-hour recordings (codes 93224, 93225, 93226, 93227, 93228, and 93229) and to Group 3 More than 48 hours up to 21 day recordings (codes 0295T, 0296T, 0297T and 0298T).

| J5/J8    | MolDX: ENG and ACVRL1 Gene Tests Coding and Billing Guidelines | A55159 | NA     | 06/01/2017 |

The following instructions for claim submission were added:
For CPT non-NOC codes, Labs may either use the SV101-7 or SV202-7 (preferred) or the NTE field to submit this required information.

Enter the appropriate DEX Z-Code™ identifier adjacent to the CPT code in the comment/narrative field for the following Part B claim field/types:
- Loop 2400 or SV101-7 for the 5010A1 837P
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<thead>
<tr>
<th>Contract</th>
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<td>A55163</td>
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<td>MolDX: GBA Genetic Testing Coding and Billing Guidelines</td>
<td>A55164</td>
<td>NA</td>
<td>06/01/2017</td>
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</table>

Enter the appropriate DEX Z-Code™ identifier adjacent to the CPT code in the comment/narrative field for the following Part A claim field/types:
- Line SV202-7 for 837I electronic claim
- Block 80 for the UB04 claim form

Enter the appropriate DEX Z-Code™ identifier adjacent to the CPT code in the comment/narrative field for the following Part B claim field/types:
- Loop 2400 or SV101-7 for the 5010A1 837P
- Box 19 for paper claim

Enter the appropriate DEX Z-Code™ identifier adjacent to the CPT code in the comment/narrative field for the following Part A claim field/types:
- Line SV202-7 for 837I electronic claim
- Block 80 for the UB04 claim form

Enter the appropriate DEX Z-Code™ identifier adjacent to the CPT code in the comment/narrative field for the following Part B claim field/types:
- Loop 2400 or SV101-7 for the 5010A1 837P
- Box 19 for paper claim

Enter the appropriate DEX Z-Code™ identifier adjacent to the CPT code in the comment/narrative field for the following Part A claim field/types:
- Line SV202-7 for 837I electronic claim
- Block 80 for the UB04 claim form

Enter the appropriate DEX Z-Code™ identifier adjacent to the CPT code in the comment/narrative field for the following Part B claim field/types:
- Loop 2400 or SV101-7 for the 5010A1 837P
- Box 19 for paper claim

Enter the appropriate DEX Z-Code™ identifier adjacent to the CPT code in the comment/narrative field for the following Part A claim field/types:
- Line SV202-7 for 837I electronic claim
- Block 80 for the UB04 claim form
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<td>The following instructions for claim submission were added: For CPT non-NOC codes, Labs may either use the SV101-7 or SV202-7 (preferred) or the NTE field to submit this required information. Enter the appropriate DEX Z-Code™ identifier adjacent to the CPT code in the comment/narrative field for the following Part B claim field/types: o Loop 2400 or SV101-7 for the 5010A1 837P o Box 19 for paper claim Enter the appropriate DEX Z-Code™ identifier adjacent to the CPT code in the comment/narrative field for the following Part A claim field/types: o Line SV202-7 for 837I electronic claim o Block 80 for the UB04 claim form</td>
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<td>A55167</td>
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<td>MolDX: Progensa® PCA3 Assay Coverage Update</td>
<td>A55202</td>
<td>NA</td>
<td>06/01/2017</td>
</tr>
</tbody>
</table>

The following instructions for claim submission were added:
For CPT non-NOC codes, Labs may either use the SV101-7 or SV202-7 (preferred) or the NTE field to submit this required information.

Enter the appropriate DEX Z-Code™ identifier adjacent to the CPT code in the comment/narrative field for the following Part B claim field/types:
- Loop 2400 or SV101-7 for the 5010A1 837P
- Box 19 for paper claim

Enter the appropriate DEX Z-Code™ identifier adjacent to the CPT code in the comment/narrative field for the following Part A claim field/types:
- Line SV202-7 for 837I electronic claim
- Block 80 for the UB04 claim form
<table>
<thead>
<tr>
<th>Contract</th>
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<tbody>
<tr>
<td>J5/J8</td>
<td>MolDX: STAT3 Gene Testing Coding and Billing Guidelines</td>
<td>A55209</td>
<td>NA</td>
<td>06/01/2017</td>
</tr>
</tbody>
</table>

The following instructions for claim submission were added:

For CPT non-NOC codes, Labs may either use the SV101-7 or SV202-7 (preferred) or the NTE field to submit this required information.

Added Part B to the sentence below:
Enter the appropriate DEX Z-Code™ identifier adjacent to the CPT code in the comment/narrative field for the following Part B claim field/types:
- Loop 2400 or SV101-7 for the 5010A1 837P
- Box 19 for paper claim


The following instructions for claim submission were added:

For CPT non-NOC codes, Labs may either use the SV101-7 or SV202-7 (preferred) or the NTE field to submit this required information.

Enter the appropriate DEX Z-Code™ identifier adjacent to the CPT code in the comment/narrative field for the following Part B claim field/types:
- Loop 2400 or SV101-7 for the 5010A1 837P
- Box 19 for paper claim

Enter the appropriate DEX Z-Code™ identifier adjacent to the CPT code in the comment/narrative field for the following Part A claim field/types:
- Line SV202-7 for 837I electronic claim
- Block 80 for the UB04 claim form

| J5/J8    | Non-Invasive Peripheral Venous Vascular and Hemodialysis Access Studies      | L35751          | CV-047       | 06/01/2017     |

Added the following diagnosis codes to Group 1 for Peripheral Venous Examinations (93970 and 93971):
- I82.4Y1  Acute embolism and thrombosis of unspecified deep veins of right proximal lower extremity
- I82.4Y2  Acute embolism and thrombosis of unspecified deep veins of left proximal lower extremity
- I82.4Y3  Acute embolism and thrombosis of unspecified deep veins of proximal lower extremity, bilateral
- I82.4Z1  Acute embolism and thrombosis of unspecified deep veins of right distal lower extremity
- I82.4Z2  Acute embolism and thrombosis of unspecified deep veins of left distal lower extremity
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>J5/J8</td>
<td><strong>Self-Administered Drug Exclusion List (SAD List)</strong></td>
<td>A52800</td>
<td>NA</td>
<td>07/16/2017</td>
</tr>
<tr>
<td></td>
<td>Added the following sentence to the article text: Please note: some drugs may</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>be listed more than once, using a different code, on the CPT/HCPCS coding</td>
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<tr>
<td></td>
<td>table. Added J3590 Dupilumab (Dupixent); J3590 Brodalumab (Siliq); C9399 to</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>code J3490 Tesamorelin (Egrifta®); C9399, J3490, and J3590 to code Q3028 for</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Interferon Beta-1A 1 mcg (Rebif®); trade names Quadmix (+Atropine) to Trimix</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>J3490; and descriptor brand name of Papaverine HCL to J2440; all effective</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>07/16/2017. Removed J0272 Alprostadil urethral suppository (Muse®) (since it</td>
<td></td>
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<tr>
<td></td>
<td>is a suppository); J2760 Phentolamine mesylate up to 5mg (Regitine) (since not</td>
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<tr>
<td></td>
<td>self administered); J3310 Perphenazine up to 5mg (Perphenazine) (since it is</td>
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<td></td>
<td>no longer available in the US); J3590 Efalizumab (Raptiva®) (since it is off</td>
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<td></td>
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<tr>
<td></td>
<td>the US market); J1562 Immune Globulin (Vivaglobin®) (since it is not being</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>manufactured anymore); and J3490 Nitroglycerine Lingual spray (Nitrolingual,</td>
<td></td>
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<tr>
<td></td>
<td>Nitromist) (since it is not an injection); all effective 07/16/2017.</td>
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<tr>
<td>J5/J8</td>
<td><strong>Zika Virus Testing by PCR and ELISA Methods</strong></td>
<td>A55339</td>
<td>NA</td>
<td>06/01/2017</td>
</tr>
<tr>
<td></td>
<td>Article Guidance: Removed the expiration date of March 30, 2017 from modifier-</td>
<td></td>
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<tr>
<td></td>
<td>22. The statement now reads: &quot;The use of modifier -22 is a temporary measure</td>
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<td></td>
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<tr>
<td></td>
<td>to allow for added payment to help offset the costs of the specific handling</td>
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<td></td>
<td>requirements of the FDA Emergency Use Authorization (EUA) and CDCP guidance.</td>
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<tr>
<td></td>
<td>This exception will expire when a CPT® or Medicare procedure code is issued or</td>
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</tr>
<tr>
<td></td>
<td>when the FDA EUA is rescinded, whichever is sooner.</td>
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</tbody>
</table>

**May 2017**

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>J5/J8</td>
<td><strong>Allergy Testing</strong></td>
<td>L36402</td>
<td>ALRG-004</td>
<td>05/01/2017</td>
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<tr>
<td></td>
<td>Added code K20.0 (Eosinophilic esophagitis) to Groups 1 and 3. Added the phrase</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>&quot;eosinophilic esophagitis&quot; to the Indication A.1.b. for Foods under Percutaneous</td>
<td></td>
<td></td>
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<td></td>
<td>Testing.</td>
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## Contract Policy Title

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<tbody>
<tr>
<td>J5/J8</td>
<td><strong>Colonoscopy and Sigmoidoscopy-Diagnostic</strong></td>
</tr>
<tr>
<td></td>
<td><strong>L34614</strong> <strong>GI-006</strong> <strong>05/01/2017</strong></td>
</tr>
<tr>
<td></td>
<td>Added to Indications and Limitations of Coverage and/or Medical Necessity</td>
</tr>
<tr>
<td></td>
<td>A. The following are Medicare-covered indications for diagnostic colonoscopy:</td>
</tr>
<tr>
<td></td>
<td>2. d. Positive stool DNA test results.(e.g. guaiac/Fecal immunochemical test</td>
</tr>
<tr>
<td>J5/J8</td>
<td><strong>Immunizations</strong></td>
</tr>
<tr>
<td></td>
<td><strong>L34596</strong> <strong>ALRG-003</strong> <strong>05/01/2017</strong></td>
</tr>
<tr>
<td></td>
<td>Added the phrase &quot;for tetanus&quot; to the following statement.</td>
</tr>
<tr>
<td></td>
<td>Each specific immunization has specific coverage criteria.</td>
</tr>
<tr>
<td></td>
<td>The following immunizations are covered post-exposure:</td>
</tr>
<tr>
<td></td>
<td>A. Tetanus, Diphtheria and Pertussis (Td) Vaccines</td>
</tr>
<tr>
<td></td>
<td>These injections are covered when given for an acute injury to a person who is</td>
</tr>
<tr>
<td></td>
<td>incompletely immunized for tetanus.</td>
</tr>
<tr>
<td>J5/J8</td>
<td><strong>Mohs Micrographic Surgery - Billing and Coding Guideline</strong></td>
</tr>
<tr>
<td></td>
<td><strong>L35494</strong> <strong>DERM-010</strong> <strong>05/01/2017</strong></td>
</tr>
<tr>
<td></td>
<td>Added POS 31 (skilled nursing facility) to the Billing and Coding Guidelines,</td>
</tr>
<tr>
<td></td>
<td>effective 05/01/2017:</td>
</tr>
<tr>
<td></td>
<td>Claims for Mohs surgery services are payable under Medicare Part B in the</td>
</tr>
<tr>
<td></td>
<td>following places of service: office (11), off-campus outpatient hospital (19),</td>
</tr>
<tr>
<td></td>
<td>inpatient hospital (21), on-campus outpatient hospital (22), ambulatory surgery</td>
</tr>
<tr>
<td></td>
<td>center (24), skilled nursing facility (31), independent clinic (49), federally qualified health center (50), state or local public health clinic (71) and rural health clinic (72).</td>
</tr>
</tbody>
</table>

A. In vivo testing (skin tests): this testing correlates the performance and evaluation of selective cutaneous and mucous membrane tests with the patient’s history, physician examination, and other observations.

1. Percutaneous Testing (scratch, puncture, prick) and is used to evaluate immunoglobulin E (IgE) mediated hypersensitivity. Percutaneous tests require medical supervision, since there is a small but significant risk of anaphylaxis. Overall, skin testing is quick, safe, and cost-effective. It remains the test of choice in most clinical situations where immediate hypersensitivity reactions are suspected.

Percutaneous testing is the usual preferred method for allergy testing. Medicare covers percutaneous (scratch, prick or puncture) testing when IgE-mediated reactions occur with any of the following:

a. Inhalants.
b. Foods. (Patients present with signs and symptoms such as urticarial, angioedema, esosinophilic esophagitis, or anaphylaxis after ingestion of specific foods. Testing for food allergies in patients who present with wheezing is occasionally required.)
c. Hymenoptera (stinging insects).
d. Specific drugs (penicillins, macromolecular agents, enzymes, and egg-containing vaccines). Skin testing is unreliable with other drugs.
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<tbody>
<tr>
<td>J5/J8</td>
<td>MolDX: Biomarkers in Cardiovascular Risk Assessment</td>
<td>L36523</td>
<td>MolDX-003</td>
<td>05/01/2017</td>
</tr>
</tbody>
</table>

The Contractor Determination Number: CV-050 is being changed to MolDX-003.

Added Note #1 and renumbered previous Note #1 to Note #2:

Note #1: There is no Medicare benefit for screening CV risk assessment testing for asymptomatic (without signs or symptoms of disease) patients. Screening asymptomatic patients for cardiovascular risk is statutorily excluded by Medicare and will not be addressed in this policy.

Updated the source of Information section with:


The following information was removed under these headings:

**Lipoprotein(a) (Lp(a))**

Removed: Due to the level of evidence, there will be no coverage for intermediate risk because there is no data to suggest that more aggressive risk factor modification improves patient health outcomes.

**Summary of Lipoprotein Testing**
Removed: Consequently, lipoprotein testing is considered investigational and not covered.

| J5/J8    | MolDX: Molecular RBC Phenotyping | L36795           | MolDX-012    | 06/15/2017     |

Added 0001U CPT code and removed CPT 81403.

CPT/HCPCS Codes
Group 1 Paragraph:
Group 1 Codes
0001U Red blood cell antigen typing, DNA, human erythrocyte antigen gene analysis of 35 antigens from 11 blood groups, utilizing whole blood, common RBC alleles reported

| J5/J8    | MolDX: MCOLN1 Genetic Testing Coding and Billing Guidelines | A55176          | NA           | 05/01/2017     |

The following claims submission information was added:

- Enter the appropriate DEX Z-Code™ identifier adjacent to the CPT code in the comment/narrative field for the following Part B claim field/types:
  - Loop 2400 or SV101-7 for the 5010A1 837P
  - Box 19 for paper claim
- Enter the appropriate DEX Z-Code™ identifier adjacent to the CPT code in the comment/narrative field for the following Part A claim field/types:
  - Line SV202-7 for 837I electronic claim
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<td>MolDX: STAT3 Gene Testing Coding and Billing Guidelines</td>
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<td>NA</td>
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</table>

The following claims submission information was added:
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- Enter the appropriate DEX Z-Code™ identifier adjacent to the CPT code in the comment/narrative field for the following Part A claim field/types:
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<tr>
<td>J5/J8</td>
<td>Allergy Immunotherapy</td>
<td>L36408</td>
<td>ALRG-005</td>
<td>04/01/2017</td>
</tr>
</tbody>
</table>

Added the Group 1 Paragraph: Providers are reminded to refer to the long descriptors of the CPT codes in their CPT book. Added statement to Indications #8. Rush desensitization can also be used in select patients with stinging insect allergies. Added the following diagnosis codes to Group 3 for Rapid Desensitization: 95180.

- T63.421A Toxic effect of venom of ants, accidental (unintentional), initial encounter
- T63.421D Toxic effect of venom of ants, accidental (unintentional), subsequent encounter
- T63.421S Toxic effect of venom of ants, accidental (unintentional), sequela
- T63.422A Toxic effect of venom of ants, intentional self-harm, initial encounter
- T63.422D Toxic effect of venom of ants, intentional self-harm, subsequent encounter
- T63.422S Toxic effect of venom of ants, intentional self-harm, sequela
- T63.423A Toxic effect of venom of ants, assault, initial encounter
- T63.423D Toxic effect of venom of ants, assault, subsequent encounter
- T63.423S Toxic effect of venom of ants, assault, sequela
- T63.424A Toxic effect of venom of ants, undetermined, initial encounter
- T63.424D Toxic effect of venom of ants, undetermined, subsequent encounter
- T63.424S Toxic effect of venom of ants, undetermined, sequela
- T63.441A Toxic effect of venom of bees, accidental (unintentional), initial encounter
- T63.441D Toxic effect of venom of bees, accidental (unintentional), subsequent encounter
- T63.441S Toxic effect of venom of bees, accidental (unintentional), sequela
- T63.442A Toxic effect of venom of bees, intentional self-harm, initial encounter
- T63.442D Toxic effect of venom of bees, intentional self-harm, subsequent encounter
- T63.442S Toxic effect of venom of bees, intentional self-harm, sequela

T63.441A  Toxic effect of venom of bees, accidental (unintentional), initial encounter
T63.441D  Toxic effect of venom of bees, accidental (unintentional), subsequent encounter
T63.441S  Toxic effect of venom of bees, accidental (unintentional), sequela
T63.442A  Toxic effect of venom of bees, intentional self-harm, initial encounter
T63.442D  Toxic effect of venom of bees, intentional self-harm, subsequent encounter
T63.442S  Toxic effect of venom of bees, intentional self-harm, sequela
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<tr>
<td>T63.443A</td>
<td>Toxic effect of venom of bees, assault, initial encounter</td>
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<td>WPS</td>
<td>Spring 2017</td>
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<td>T63.443D</td>
<td>Toxic effect of venom of bees, assault, subsequent encounter</td>
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<td>T63.461A</td>
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<td>T63.461D</td>
<td>Toxic effect of venom of wasps, accidental (unintentional), subsequent encounter</td>
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<tr>
<td>T63.461S</td>
<td>Toxic effect of venom of wasps, accidental (unintentional), sequela</td>
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<td>T63.462A</td>
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</table>

**J5/J8 Drug Administration Coding**

- **A54176**
- **N/A**
- **05/16/2017**

Added natalizumab, Tysabri, J2323 to the list of drugs that should not be billed using a chemotherapy administration code. Corrected spelling error of Stelara®.

**J5/J8 Drugs and Biologics (Non-chemotherapy) & Billing and Coding Guidelines**

- **L34741**
- **INJ-041**
- **04/01/2017**

Group 4 Paragraph: J2778 Ranibizumab (Lucentis™), 0.1 mg Myopic Choroidal Neovascularization (mCNV) FDA approval 01/05/2017
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</thead>
<tbody>
<tr>
<td>J5/J8</td>
<td>MolDX: Molecular Diagnostic Tests (MDT)</td>
<td>L36807</td>
<td>MolIDX-004</td>
<td>05/16/2017</td>
</tr>
</tbody>
</table>

Added the following CPT codes to this LCD effective 05/16/2017:

CPT/HCPCS Codes

Group 1 Paragraph:

Group 1 Codes

- 0001U: Rbc dna hea 35 ag 11 bld grp
- 0002U: Onc clrc 3 ur metab alg plp
- 0003U: Onc ovar 5 prtn ser alg scor
- 86152: cell enumeration & id
- 86153: cell enumeration phys interp
- 86505-86507: Microbiology

CPT codes 88380 and 88381 will no longer require a DEX-Z Code™ and have been removed from this policy. This change is effective 04/01/2017.

Documentations Requirements:
The medical record must include the following information:
- A physician’s order with appropriate signature;
- Supervising physician with appropriate signature;
- Medication Administration record with appropriate signature

Effective 01/01/2017 claims for unused drugs or biologicals from single use vials or single use packages that are opened and the entire dose/quantity is not administered and the remainder is discarded shall be submitted using the JW modifier. See Billing & Coding Guidelines.

Billing & Coding Guidelines Medicare Excerpts


- Claims for discarded drugs or biologicals amount not administered to any patient shall be submitted using the JW modifier. Unused drugs or biologicals from single use vials or single use packages that are opened and the entire dose/quantity is not administered and the remainder is discarded. (except those provided under the Competitive Acquisition Program (CAP) for Part B drugs and biologicals).
- Providers must document the discarded drugs or biologicals in the patient’s medical record.
- This modifier, billed on a separate line, will provide payment for the amount of discarded drugs or biologicals.

See CR 9603
## Non-Coronary Vascular Stents

### Added diagnosis codes:
- I82.411 Acute embolism and thrombosis of right femoral vein
- I82.412 Acute embolism and thrombosis of left femoral vein
- I82.413 Acute embolism and thrombosis of femoral vein, bilateral
- I82.421 Acute embolism and thrombosis of right iliac vein
- I82.422 Acute embolism and thrombosis of left iliac vein
- I82.423 Acute embolism and thrombosis of iliac vein, bilateral

### Effective Date: 04/01/2017

## Chemotherapy Drugs and their Adjuncts

### C.17. Ipilimumab (Yervoy™) (J9228)
- Malignant melanoma of skin (C43.10, C43.20, C43.30, C43.60, C43.70, C43.9, C69.90-C69.92) Effective 03/02/2017.

Per NCCN:
- Adjuvant treatment of patients with cutaneous melanoma with pathologic involvement of regional lymph nodes of more than 1 mm who have undergone complete resection, including total lymphadenectomy. FDA approval 10/28/2015
- for stage III sentinel lymph node positive metastasis >1 mm following a complete lymph node dissection
- for stage III disease with clinically positive node(s) following wide excision of primary tumor and a complete therapeutic lymph node dissection
- following complete lymph node dissection and/or complete resection of nodal recurrence.

### C.23. Nivolumab (Opdivo) (J9299)
- For the treatment of locally advanced or metastatic urothelial carcinoma who:
  - have disease progression during or following platinum-containing chemotherapy

### Effective Date: 03/02/2017

---

### March 2017

<table>
<thead>
<tr>
<th>Contract</th>
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<th>WPS Policy #</th>
<th>Effective Date</th>
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<tbody>
<tr>
<td>J5/J8</td>
<td>Chemotherapy Drugs and their Adjuncts</td>
<td>L35053</td>
<td>HONC-010</td>
<td>03/01/2017</td>
</tr>
</tbody>
</table>

### C.17. Ipilimumab (Yervoy™) (J9228)
- Subsequent systemic therapy for patients with performance status 0-2 as a single agent or in combination with ipilimumab for:
  - relapse within 6 months following complete or partial response or stable disease with initial treatment
  - primary progressive disease

### C.23. Nivolumab (OPDIVO) (J9299)
- For the treatment of locally advanced or metastatic urothelial carcinoma who:
  - have disease progression during or following platinum-containing chemotherapy
• have disease progression within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy. C61, C65.1, C65.2, C65.9, C66.1, C66.2, C66.9, C67.0-C67.9, C68.0, C68.1, C68.8, D09.0, Z85.51, Z85.59 (FDA approval date 02/02/2017) Effective date 02/02/2017.
C. 29. Pembrolizumab (Keytruda)(J9271) recurrent or metastatic Head and Neck Squamous Cell Carcinoma (HNSCC) with disease progression on or after platinum-containing chemotherapy. (C02.0-C02.3, C78.89) effective 03/02/2017.
D. 1. Atezolizumab (Tecentriq®) Added ®.

J5/J8 Electrocardiographic (EKG or ECG) Monitoring (Holter or Real-Time Monitoring)
L34636 CV-016 03/01/2017
For clarification, added the following paragraphs: Group 1 Paragraph: Memory Loop recordings (codes 93268, 93270, 93271 and 93272); added Group 2 Paragraph: Other up to 48-hour recordings (codes 93224, 93225, 93226, 93227, 93228, and 93229); and added Group 3 Paragraph: More than 48 hours up to 21 day recordings (codes 0295T, 0296T, 0297T and 0298T).

J5/J8 MolDX: FDA-Approved EGFR Tests
A55193 NA 03/01/2017
The following information has been added to this article:

1. Effective 6/01/16 cobs EGFR Mutation Test is a real-time PCR test for the qualitative detection of defined mutations of the epidermal growth factor receptor (EGFR) gene in non-small cell lung cancer (NSCLC) patients. Defined EGFR mutations are detected using DNA isolated from formalin-fixed paraffinembedded tumor tissue (FFPET) or circulating-free tumor DNA (cfDNA) from plasma derived from EDTA anticoagulated peripheral whole blood.

The test is indicated as a companion diagnostic to aid in selecting NSCLC patients for treatment with the targeted therapies listed in the Table below in accordance with the approved therapeutic product labeling:

<table>
<thead>
<tr>
<th>Drug</th>
<th>FFPET</th>
<th>Plasma</th>
</tr>
</thead>
<tbody>
<tr>
<td>TARCEVA ® (erlotinib)</td>
<td>Exon 19 deletions and L858R</td>
<td>Exon 19 deletions and L858R</td>
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<tr>
<td>Contract</td>
<td>Policy Title</td>
<td>CMS MCD Policy #</td>
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<td>----------</td>
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</tr>
<tr>
<td>J5/J8</td>
<td>TAGRISSO™ (osimertinib)</td>
<td>T790M</td>
</tr>
</tbody>
</table>

Patients with positive cobas® EGFR Mutation Test v2 test results using plasma specimens for the presence of EGFR exon 19 deletions or L858R mutations are eligible for treatment with TARCEVA® (erlotinib).

Patients who are negative for these mutations by this test should be reflexed to routine biopsy and testing for EGFR mutations with the FFPET sample type.

Enter DEX Z-Code™ identifier adjacent to the CPT code in the comment/narrative field for the following Part A claim field/types:

- Line SV202-7 for 837I electronic claim
- Block 80 for the UB04 claim form

---

**Reworded Group 3 paragraph:**

Reworded Group 3 paragraph: CPT codes CYP2C9 and VKORC1 are non-covered for all indications per this policy. However, CYP2C9 and VKORC1 can be covered in accordance with NCD 90.1 and should be reported with HCPCS code G9143 warfarin responsiveness testing.

**Group 3 Codes:**
- 81227 CYP2C9 (CYTOCHROME P450, FAMILY 2, SUBFAMILY C, POLYPEPTIDE 9) (EG, DRUG METABOLISM), GENE
- 81355 VKORC1 (VITAMIN K EPOXIDE REDUCTASE COMPLEX, SUBUNIT 1) (EG, WARFARIN METABOLISM), GENE ANALYSIS, COMMON VARIANTS (EG, -1639/3673)

**Added:**

Group 4 Paragraph: CYP gene panels (testing for more than 1 CYP gene on same date of service) is a single unit of service (UOS=1). All CYP panels should be billed with 81479 and are non-covered.

**Group 4 Codes:**
- 81479 Unlisted Molecular Pathology Procedure

---

**MolDX: Genetic Testing for CYP2C19, CYP2D6, CYP2C9, and VKORC1**

Reworded Group 3 paragraph:

**Group 3 Paragraph:** CPT codes CYP2C9 and VKORC1 are non-covered for all indications per this policy. However, CYP2C9 and VKORC1 can be covered in accordance with NCD 90.1 and should be reported with HCPCS code G9143 warfarin responsiveness testing.

**Group 3 Codes:**
- 81227 CYP2C9 (CYTOCHROME P450, FAMILY 2, SUBFAMILY C, POLYPEPTIDE 9) (EG, DRUG METABOLISM), GENE
- 81355 VKORC1 (VITAMIN K EPOXIDE REDUCTASE COMPLEX, SUBUNIT 1) (EG, WARFARIN METABOLISM), GENE ANALYSIS, COMMON VARIANTS (EG, -1639/3673)

**Added:**

Group 4 Paragraph: CYP gene panels (testing for more than 1 CYP gene on same date of service) is a single unit of service (UOS=1). All CYP panels should be billed with 81479 and are non-covered.

**Group 4 Codes:**
- 81479 Unlisted Molecular Pathology Procedure

---

**MolDX: MMACHC Test Coding and Billing Guidelines**

The following instructions for Part A claim submission were added. Enter DEX Z-Code™ identifier adjacent to the CPT code in the comment/narrative field for the following Part A claim field/types:

- Line SV202-7 for 837I electronic claim
- Block 80 for the UB04 claim form

---

**MolDX: NRAS Genetic Testing**

The following information was added to the policy:

**ICD-10 Codes that Support Medical Necessity**

**Group 1 Paragraph:** Although not specifically addressed in the ICD-10-CM Official Guidelines for Coding and Reporting 2016, when an encounter is for management of a complication associated with a neoplasm (NRAS testing for metastatic colon cancer), the complication (metastasis) is coded first, followed by
<table>
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<th>Contract</th>
<th>Policy Title</th>
<th>CMS MCD Policy #</th>
<th>WPS Policy #</th>
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<tr>
<td></td>
<td>the appropriate codes for the neoplasm. *Primary Diagnoses are listed in Group 1 and Secondary Diagnoses in Group 2. <strong>Group 1 Codes:</strong></td>
<td></td>
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<tr>
<td></td>
<td>C77.0-C77.5 Secondary and unspecified malignant neoplasm of lymph nodes</td>
<td></td>
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<tr>
<td></td>
<td>C77.6-C77.7 Secondary and unspecified malignant neoplasm of intra-abdominal lymph nodes</td>
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<td></td>
<td>C77.8 Secondary and unspecified malignant neoplasm of lymph nodes of multiple regions</td>
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<tr>
<td></td>
<td>C77.9 Secondary and unspecified malignant neoplasm of lymph node, unspecified</td>
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<tr>
<td></td>
<td>C78.00-C78.02 Secondary malignant neoplasm of unspecified lung,</td>
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<td></td>
<td>C78.1 Secondary malignant neoplasm of mediastinum</td>
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<td></td>
<td>C78.2 Secondary malignant neoplasm of pleura</td>
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<tr>
<td></td>
<td>C78.30 Secondary malignant neoplasm of unspecified respiratory organ</td>
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<td></td>
<td>C78.39 Secondary malignant neoplasm of other respiratory organs</td>
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<td></td>
<td>C78.4 Secondary malignant neoplasm of small intestine</td>
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<tr>
<td></td>
<td>C78.5-C78.7 Secondary malignant neoplasm of large intestine and rectum,</td>
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<tr>
<td></td>
<td>C79.00 Secondary malignant neoplasm of unspecified kidney and renal pelvis</td>
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<td></td>
<td>C79.01 Secondary malignant neoplasm of right kidney and renal pelvis</td>
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<td></td>
<td>C79.02 Secondary malignant neoplasm of left kidney and renal pelvis</td>
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<td></td>
<td>C79.10 Secondary malignant neoplasm of unspecified urinary organs</td>
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<td></td>
<td>C79.11 Secondary malignant neoplasm of bladder</td>
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<tr>
<td></td>
<td>C79.19 Secondary malignant neoplasm of other urinary organs</td>
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<tr>
<td></td>
<td>C79.2 Secondary malignant neoplasm of skin</td>
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<tr>
<td></td>
<td>C79.31 Secondary malignant neoplasm of brain</td>
<td></td>
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<tr>
<td></td>
<td>C79.32 Secondary malignant neoplasm of cerebral meninges</td>
<td></td>
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<tr>
<td></td>
<td>C79.40 Secondary malignant neoplasm of unspecified part of nervous system</td>
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<tr>
<td></td>
<td>C79.49 Secondary malignant neoplasm of other parts of nervous system</td>
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<tr>
<td></td>
<td>C79.51 Secondary malignant neoplasm of bone</td>
<td></td>
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<tr>
<td></td>
<td>C79.52 Secondary malignant neoplasm of bone marrow</td>
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<tr>
<td></td>
<td>C79.60 Secondary malignant neoplasm of unspecified ovary</td>
<td></td>
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<tr>
<td></td>
<td>C79.61 Secondary malignant neoplasm of right ovary</td>
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<tr>
<td>C79.62</td>
<td>Secondary malignant neoplasm of left ovary</td>
<td></td>
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<tr>
<td>C79.70</td>
<td>Secondary malignant neoplasm of unspecified adrenal gland</td>
<td></td>
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<tr>
<td>C79.71</td>
<td>Secondary malignant neoplasm of right adrenal gland</td>
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<tr>
<td>C79.72</td>
<td>Secondary malignant neoplasm of left adrenal gland</td>
<td></td>
<td></td>
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<tr>
<td>C79.81</td>
<td>Secondary malignant neoplasm of breast</td>
<td></td>
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<tr>
<td>C79.82</td>
<td>Secondary malignant neoplasm of genital organs</td>
<td></td>
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<tr>
<td>C79.89</td>
<td>Secondary malignant neoplasm of other specified sites</td>
<td></td>
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<tr>
<td>C79.9</td>
<td>Secondary malignant neoplasm of unspecified site</td>
<td></td>
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</tr>
</tbody>
</table>

**Group 2 Paragraph**: Secondary Diagnoses

**Group 2 Codes**:

- C18.0-C18.9 Malignant neoplasm of cecum
- C19 Malignant neoplasm of rectosigmoid junction
- C20 Malignant neoplasm of rectum
- Malignant neoplasm of appendix
- Malignant neoplasm of ascending colon
- Malignant neoplasm of hepatic flexure
- Malignant neoplasm of transverse colon
- Malignant neoplasm of splenic flexure
- Malignant neoplasm of descending colon
- Malignant neoplasm of sigmoid colon
- Malignant neoplasm of overlapping sites of colon
- Malignant neoplasm of colon, unspecified

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**J5/J8 MolDX: TP53 Gene Test Coding and Billing Guidelines**

A55221 NA 03/01/2017

The following instructions for Part A claim submission were added. Enter DEX Z-Code™ identifier adjacent to the CPT code in the comment/narrative field for the following Part A claim field/types:
- Line SV202-7 for 837I electronic claim
- Block 80 for the UB04 claim form

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**J5/J8 MolDX: UGT1A1 Gene Analysis Coding and Billing Guidelines**

A55222 NA 03/01/2017

The following instructions for Part A claim submission were added. Enter DEX Z-Code™ identifier adjacent to the CPT code in the comment/narrative field for the following Part A claim field/types:
- Line SV202-7 for 837I electronic claim
- Block 80 for the UB04 claim form

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**J5/J8 MolDX: VEGFR2 Tests Coding and Billing Guidelines**

A55232 NA 03/01/2017

The following information was added to the policy: Enter DEX Z-Code™ identifier adjacent to the CPT code in the comment/narrative field for the following Part A claim field/types:
- Line SV202-7 for 837I electronic claim
- Block 80 for the UB04 claim form

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**J5/J8 Polysomnography and Other Sleep Studies**

L36839 NEURO-018 03/01/2017

Added 2 ICD-10 codes to Group 2 Paragraph: 95782, 95807, 95808 and 95810

Covered for:
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<th>Contract</th>
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<th>WPS Policy #</th>
<th>Effective Date</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Group 2 Codes: F51.3 Sleepwalking, (somnambulism) and F51.4 Sleep terrors, (night terrors).</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

MLN Matters® Number: MM9880
Related Change Request (CR) #: CR 9880
Related CR Release Date: April 28, 2017
Effective Date: October 1, 2017
Related CR Transmittal #: R1833OTN
Implementation Date: October 2, 2017

Implementing the Remittance Advice Messaging for the 20 Hour Weekly Minimum for Partial Hospitalization Program Services

Provider Types Affected

This MLN Matters® Article is intended for Outpatient Prospective Payment System (OPPS) providers submitting Partial Hospitalization Program (PHP) claims to Medicare Administrative Contractors (MACs) for PHP services provided to Medicare beneficiaries.

What You Need to Know

Change Request (CR) 9880 implements informational messaging, effective October 1, 2017, that conveys supplemental and educational information to the provider submitting claims for PHP services where the patient did not receive the minimum 20 hours per week of therapeutic services his plan of care indicates is required, on claims with line item date of service (LIDOS) on or after October 1, 2017. When the minimum 20 hours per week care is not provided, MACs will return Remittance Advice Remarks Code N787 - “Alert: An eligible PHP beneficiary requires a minimum of 20 hours of PHP services per week, as evidenced in the plan of care. PHP services must be furnished in accordance with the plan of care.”

Background

Partial hospitalization services are intensive outpatient services provided in lieu of inpatient hospitalization for mental health conditions. The regulation at 42 CFR 410.43(c)(1) states that PHPs are intended for patients who require a minimum of 20 hours per week of therapeutic services as evidenced in their plan of care. Additionally, the regulation at 42

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CFR 410.43(a)(3) requires that PHP services are services that are furnished in accordance with a physician certification and plan of care as specified under 42 CFR 424.24(e).

**Additional Information**


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

**Document History**

<table>
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<th>Date</th>
<th>Description</th>
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<tbody>
<tr>
<td>April 28, 2017</td>
<td>Initial article released.</td>
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New Physician Specialty Code for Advanced Heart Failure and Transplant Cardiology, Medical Toxicology, and Hematopoietic Cell Transplantation and Cellular Therapy

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9957 establishes new physician specialty codes for Advanced Heart Failure and Transplant Cardiology (C7), Medical Toxicology (C8), and Hematopoietic Cell Transplantation and Cellular Therapy (C9). The new codes are effective on October 1, 2017. Make sure that your billing staffs are aware of these new specialty codes.

Background

Physicians self-designate their Medicare physician specialty on the Medicare enrollment application (CMS-855I or CMS-855O) or 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. The Centers for Medicare & Medicaid Services (CMS) uses specialty codes for programmatic and claims processing purposes.

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

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

**Additional Information**


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

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MLN Matters® Number: MM9878  Related Change Request (CR) #: CR 9878
Related CR Release Date: February 24, 2017  Effective Date: July 1, 2017
Related CR Transmittal #: R3725CP  Implementation Date: July 3, 2017

Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print Update

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9878 updates the Remittance Advice Remark Code (RARC) and Claim Adjustment Reason Code (CARC) lists. CR9878 also calls for an update to Medicare Remit Easy Print (MREP) and PC Print software. If you use MREP and/or PC Print software, be sure to obtain the latest version that is released on or before July 3, 2017. Make sure that your billing staffs are aware of these changes.

Background

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

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The Centers for Medicare & Medicaid Services (CMS) instructs MACs to conduct updates based on the code update schedule that is published three times per year – around March 1, July 1, and November 1.

CR9878 provides notification indicating when updates to CARC and RARC lists are made available on the Washington Publishing Company (WPC) website. Medicare’s Shared System Maintainers (SSMs) have the responsibility to implement code deactivation, 1) making sure that any deactivated code is not used in original business messages, and 2) allowing the deactivated code in derivative messages. SSMs must make sure that Medicare does not report any deactivated code on or after the effective date for deactivation as posted on the WPC website. If any new or modified code has an effective date past the implementation date specified in CR9878, MACs must implement on the date specified on the WPC website.

A discrepancy between the dates may arise as the WPC website is only updated three times per year and may not match the CMS release schedule. For CR9878, MACs and SSMs must determine the changes that are included on the code list since the last code update CR (CR 9774) or its corresponding MM Article (MM9774).

**Additional Information**


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

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Updates to the “Medicare Claims Processing Manual,” Pub. 100-04, Chapters 12, 17 and 23 to Correct Remittance Advice Messages

Provider Types Affected

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

What You Need to Know

This article is based on Change Request (CR) 9906, which revises Chapters 12, 17, and 23 of the “Medicare Claims Processing Manual” (the manual) to ensure that all remittance advice coding is consistent with national standard operating rules. It also provides a format for consistently showing remittance advice coding throughout this manual. MACs will ensure that they apply remittance advice coding as described in the revised manual sections. Make sure that your billing staffs are aware of these changes.

Background

Section 1171 of the Social Security Act requires a standard set of operating rules to regulate the health insurance industry’s use of Electronic Data Interchange (EDI) transactions. Operating Rule 360: Uniform Use of CARCs and RARCs, regulates the way in which group codes, Claims Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) may be used. The rule requires specific codes, which are to be used in combination with one another if one of the named business scenarios applies. This rule is authored by the Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE).
Medicare and all other payers must comply with the CAQH CORE-developed code combinations. The business scenario for each payment adjustment must be defined, if applicable, and a valid code combination selected for all remittance advice messages. CR9906 updates Chapters 12, 17, and 23 of the manual to reflect the standard format and to correct any non-compliant code combinations.

Additional Information


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

EDUCATION SCHEDULE

WPS GHA Learning Center

WPS GHA Provider Outreach and Education (POE) has transitioned to a new learning portal for your education needs. The WPS GHA Learning Center houses on-demand learning, information about live events, and the ability to receive Certificates of Achievement. These certificates may be submitted for consideration to earn Continuing Education Units (CEUs). For information on how to access, register as a user, and set up a profile for the Learning Center, go to our Learning Center at https://wpsgha.litmos.com/account/login/.

Event Schedule

WPS GHA offers a variety of education in a variety of formats throughout the year. To see our most current listing of seminars, teleconferences, and webinars please visit the WPS GHA Learning Center at: http://wpsgha.litmos.com/online-courses.

New offerings!

New to Medicare Teleconference Series

A Day with Medicare
07/11/2017 — Salina, KS — 8:30 am – 4:30 pm CT
07/13/2017 — Des Moines, IA — 8:30 am – 4:30 pm CT

Don't Miss This FREE Full Day Educational Opportunity!

This exciting program includes both Part A and Part B topics to gain insight into the cause for errors and how to avoid them in the future, including:

- General session
- 12 breakout sessions
- Question and answer session
- More!

Don't Get Wrapped Up in Overlapping Claims (Part A)
08/15/2017 — Topeka, KS — 8:30 am - 4:00 pm CT
10/18/2017 — St. Charles, MO — 8:30 am - 4:00 pm CT
07/24/2017 — Traverse City, MI — 8:30 am - 4:30 pm ET
07/26/2017 — Livonia, MI — 8:30 am - 4:00 pm ET

Some of the topics to be covered include:

- Billing during a leave of absence (LOA)/interrupted stay
- What “hospital bundling” includes
- How to determine the proper patient status to use on your claim
- Main cause of SNF overlaps (aside from Consolidated Billing)
- 3/1-day payment window
• End Stage Renal Disease (ESRD) Consolidated Billing
• Home Health Consolidated Billing
• What Place of Service (POS) Part B providers should use
• Steps you can take to resolve overlapping claim issues with another provider

Claims

Actions on Claims
08/17/2017 — Merrillville, IN — 8:30 am – 11:30 am CT
10/12/2017 — University Center, MI — 8:30 am – 11:30 am ET
10/26/2017 — Indianapolis, IN — 8:30 am – 11:30 am ET
11/16/2017 — Ankeny, Iowa — 8:30 am – 11:30 am CT

This course will answer those questions by covering the following:
• Action on claims that are not adjudicated
• Claim reopening process
• Claim appeal process
• Appeal dismissals and duplicate requests
• And more

Focus On: Avoiding Medicare Secondary Payer (MSP) Denials
08/15/2017 — Merrillville, IN — 1:00 pm – 4:00 pm CT
10/10/2017 — University Center, MI — 1:00 pm – 4:00 pm ET
10/24/2017 — Indianapolis, IN — 1:00 pm – 4:00 pm ET
11/14/2017 — Ankeny, Iowa — 1:00 pm – 4:00 pm CT

Our agenda will include:
• Examine the most common MSP errors
• Understand what the denials mean
• Explore ways to correct and prevent them

Focus On: Preventing UB-04 Denials
08/16/2017 — Merrillville, IN — 8:30 am – 4:00 pm CT
10/11/2017 — University Center, MI — 8:30 am – 4:00 pm ET
10/25/2017 — Indianapolis, IN — 8:30 am – 4:00 pm ET
11/15/2017 — Ankeny, IA — 8:30 am – 4:00 pm CT

Topics will include:
• Review denial data
• Examine reason code narratives
• Share best practices and claims processing tips

Focus On: Claim Determinations from Other Contractors
08/17/2017 — Merrillville, IN — 1:00 pm – 4:00 pm CT
10/12/2017 — University Center, MI — 1:00 pm – 4:00 pm ET
10/26/2017 — Indianapolis, IN — 1:00 pm – 4:00 pm ET
11/16/2017 — Ankeny, Iowa — 1:00 pm – 4:00 pm CT

The agenda will include:
• Discuss the role of other contractors
• View data showing reasons for denial
• Understand WPS GHA’s role

The World of a Claim – Where does the claim start and how does it end?
08/15/2017 — Merrillville, IN — 8:30 am – 11:30 am CT
10/10/2017 — University Center, MI — 8:30 am – 11:30 am ET
10/24/2017 — Indianapolis, IN — 8:30 am – 11:30 am ET
11/14/2017 — Ankeny, IA — 8:30 am – 11:30 am CT

The seminar will cover:
• Information to get from the patient
• Determining who to bill
• A high-level documentation overview
• An overview of Medicare claim processing
• An overview of Skilled Nursing Facility Consolidated Billing

Consolidated Billing

An Interactive Day of Skilled Nursing Facility (SNF) Consolidated Billing
08/16/2017 — Topeka, KS — 8:30 am - 4:00 pm CT
10/19/2017 — St. Charles, MO — 8:30 am - 4:00 pm CT

You will learn the whys, ifs, ands, and buts when it comes to SNF Consolidated Billing. Then, working in groups, you’ll put what you have learned into action. Using laptops, each group will determine who the responsible payer would be in a variety of situations.

Documentation

Does Your Medicare Documentation Measure Up?
08/15/2017 — Merrillville, IN — 8:30 am – 4:00 pm CT
10/10/2017 — University Center, MI — 8:30 am – 4:00 pm ET
10/24/2017 — Indianapolis, IN — 8:30 am – 4:00 pm ET
11/14/2017 — Ankeny, IA – 8:30 am – 4:00 pm CT

Join WPS GHA for a live seminar in which we will
• Identify and discuss Medicare medical review contractors
• Identify Medicare documentation guidelines
• Discuss the dos’ and don’ts of Medicare documentation
• Review actual documentation that was considered in coverage determinations

Medicare Part A Denials - Building Strong Facility Documentation
08/16/2017 — Merrillville, IN — 8:30 am – 4:00 pm CT
10/11/2017 — University Center, MI — 8:30 am – 4:00 pm ET
10/25/2017 — Indianapolis, IN — 8:30 am – 4:00 pm ET
11/15/2017 — Ankeny, IA – 8:30 am – 4:00 pm CT

In this live session, we will review the most common Part A claim review denials as well as practical documentation strategies to avoid documentation issues in your facility.

Mental Health
Outpatient Mental Health – The Basics
08/29/2017 — Kentwood (Grand Rapids), MI — 9:00 am – 12:00 pm ET

Designed for novice coders, billers, providers, office staff, and compliance staff. Participants in this seminar will hear an overview of the Medicare mental health benefit and increase their understanding of CMS national coverage policy and WPS GHA Local Coverage Determination (LCD) L34616, Psychiatry and Psychology Services.

Continue to watch the Wednesday eNews for the most current education topics available.

Important Notice Regarding 2017 Seminar Materials

In an effort to adopt consistent industry trends, beginning in 2017, WPS GHA will offer seminar materials only in an electronic format. Seminar registrants are responsible for printing and bringing their own handouts. To access, choose the Additional References tab in the Learning Center course.

MEDI CARE LEARNI NG 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. A full array of other educational products (including Web-based training courses, hard copy and downloadable publications, and CD-ROMs) are also available and can be accessed at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/index.html. You can also find other important Web sites by visiting the Physician Center Web page at: http://www.cms.gov/Center/Provider-Type/Physician­Center.html, and the All Fee-For-Service Providers Web page at: https://www.cms.gov/Center/Provider-Type/All-Fee-For-Service-Providers-Center.html.

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, continuing education credits may be awarded 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 http://www.cms.gov/Outreach-and-Education/Outreach/NPC/index.html.

QUARTERLY PROVIDER UPDATE

The Quarterly Provider Update is a comprehensive resource published by the Centers for Medicare & Medicaid Services (CMS) on the first business day of each quarter. It is intended to make it easier for providers, suppliers, and the general public to understand the changes CMS is proposing or making.

CMS publishes this update to inform the public about the following:
- Regulations and major policies currently under development during this quarter.
- Regulations and major policies completed or cancelled.
- New/Revised manual instructions


We encourage you to bookmark this web page and visit it often for this valuable information. To receive notification when regulations and program instructions are added 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 (http://www.cms.gov/Outreach-andEducation/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM3274.pdf) for more information.
April 2017 Update of the Hospital Outpatient Prospective Payment System (OPPS)

Provider Types Affected

This MLN Matters® Article is intended for providers and suppliers who submit claims to Medicare Administrative Contractors (MAC), including Home Health and Hospice (HH&H) MACs, for services provided to Medicare beneficiaries paid under the Outpatient Prospective Payment System (OPPS).

Provider Action Needed

Change Request (CR) 10005 describes changes to and billing instructions for various payment policies implemented in the April 2017 OPPS update. The April 2017 Integrated Outpatient Code Editor (I/OCE) will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier and Revenue Code additions, changes and deletions identified in CR 10005. Make sure your billing staff is aware of these changes.

Background

Key changes to and billing instructions for various payment policies implemented in the April 2017 OPPS updates are as follows:

Proprietary Laboratory Analyses (PLA) CPT Codes Effective February 1, 2017

The American Medical Association (AMA) Current Procedural Terminology (CPT) Editorial Panel established three new PLA CPT codes, specifically CPT codes 0001U, 0002U and 0003U. The long descriptors for the codes are listed in Table 1. Because the codes were effective February 1, 2017, they were not included in the January 2017 I/OCE update and the January 2017 OPPS Addendum B.

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### Table 1 – PLA CPT Codes Effective February 1, 2017

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Long Descriptor</th>
<th>OPPS SI</th>
</tr>
</thead>
<tbody>
<tr>
<td>0001U</td>
<td>Red blood cell antigen typing, DNA, human erythrocyte antigen gene analysis of 35 antigens from 11 blood groups, utilizing whole blood, common RBC alleles reported</td>
<td>A</td>
</tr>
<tr>
<td>0002U</td>
<td>Oncology (colorectal), quantitative assessment of three urine metabolites (ascorbic acid, succinic acid and carnitine) by liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring acquisition, algorithm reported as likelihood of adenomatous polyps</td>
<td>Q4</td>
</tr>
<tr>
<td>0003U</td>
<td>Oncology (ovarian) biochemical assays of five proteins (apolipoprotein A-1, CA 125 II, follicle stimulating hormone, human epididymis protein 4, transferrin), utilizing serum, algorithm reported as a likelihood score</td>
<td>Q4</td>
</tr>
</tbody>
</table>

Under the hospital OPPS, CPT code 0001U is assigned to status indicator “A” and CPT codes 0002U and 0003U are assigned to status indicator “Q4” (conditionally packaged laboratory tests) effective February 1, 2017. For more information on OPPS SI “A” and “Q4,” refer to OPPS Addendum D1 of the Calendar Year (CY) 2017 OPPS/ASC final rule for the latest definitions to the OPPS status indicators for CY 2017.

CPT codes 0001U, 0002U and 0003U have been added to the April 2017 I/OCE with an effective date of February 1, 2017. These codes, along with their short descriptors and status indicators, are also listed in the April 2017 OPPS Addendum B at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html).

### Coding Changes for Presumptive Drug Tests Effective January 1, 2017

Prior to CY 2017, HCPCS codes G0477, G0478 and G0479 were used to describe presumptive drug tests. For the CY 2017 update, the AMA CPT Editorial Panel established three new CPT codes, specifically CPT codes 80305, 80306, and 80307, to describe the same presumptive drug tests as the HCPCS G-codes. Consequently, the HCPCS G-codes were terminated on December 31, 2016. Because CPT codes 80305, 80306 and 80307 describe the same presumptive drug tests as the HCPCS G-codes, the Centers for Medicare & Medicaid Services (CMS) assigned these new CPT codes to the same OPPS status indicator as its predecessor HCPCS G-codes effective January 1, 2017. Table 2 shows the HCPCS codes, long descriptors, status indicators, and replacement codes for the HCPCS G-codes.
### Table 2 – Coding Changes for Presumptive Drug Tests Effective January 1, 2017

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Long Descriptor</th>
<th>OPPS SI</th>
<th>Add Date</th>
<th>Termination Date</th>
<th>Replacement Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0477</td>
<td>Drug test(s), presumptive, any number of drug classes; any number of devices or procedures, (e.g., immunoassay) capable of being read by direct optical observation only (e.g., dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service</td>
<td>N/A</td>
<td>01/01/2016</td>
<td>12/31/2016</td>
<td>80305</td>
</tr>
<tr>
<td>G0478</td>
<td>Drug test(s), presumptive, any number of drug classes; any number of devices or procedures, (e.g., immunoassay) read by instrument-assisted direct optical observation (e.g., dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service</td>
<td>N/A</td>
<td>01/01/2016</td>
<td>12/31/2016</td>
<td>80306</td>
</tr>
<tr>
<td>G0479</td>
<td>Drug test(s), presumptive, any number of drug classes; any number of devices or procedures by instrumented chemistry analyzers utilizing immunoassay, enzyme assay, tof, maldi, ltdt, desi, dart, ghpc, gc mass spectrometry), includes sample validation when performed, per date of service</td>
<td>N/A</td>
<td>01/01/2016</td>
<td>12/31/2016</td>
<td>80307</td>
</tr>
<tr>
<td>80305</td>
<td>Drug test(s), presumptive, any number of drug classes, any number of devices or procedures (e.g., immunoassay); capable of being read by direct optical observation only (e.g., dipsticks, cups, cards, cartridges) includes sample validation when performed, per date of service</td>
<td>Q4</td>
<td>01/01/2017</td>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Long Descriptor</th>
<th>OPPS SI</th>
<th>Add Date</th>
<th>Termination Date</th>
<th>Replacement Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>80306</td>
<td>Drug test(s), presumptive, any number of drug classes, any number of devices or procedures (e.g., immunoassay); read by instrument assisted direct optical observation (e.g., dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service</td>
<td>Q4</td>
<td>01/01/2017</td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>80307</td>
<td>Drug test(s), presumptive, any number of drug classes, any number of devices or procedures, by instrument chemistry analyzers (e.g., utilizing immunoassay [e.g., eia, elisa, emit, fpia, ia, kims, ria]), chromatography (e.g., gc, hplc), and mass spectrometry either with or without chromatography, (e.g., dart, desi, gc-ms, gc-ms/ms, lc-ms, lc-ms/ms, ldtd, maldi, tof) includes sample validation when performed, per date of service</td>
<td>Q4</td>
<td>01/01/2017</td>
<td></td>
<td>N/A</td>
</tr>
</tbody>
</table>

Because CMS was unable to delete HCPCS codes G0477, G0478 and G0479 in the January 2017 I/OCE update, CMS is deleting these codes in the April 2017 I/OCE update effective December 31, 2016. The short descriptors for CPT codes 80305, 80306 and 80307, along with their status indicators, are available in the April 2017 OPPS Addendum B.

**Clarification regarding HCPCS Code G0498**

Under the OPPS, HCPCS code G0498 is assigned status indicator “S” (Procedure or Service, Not discounted when multiple) effective January 1, 2016. HCPCS code G0498 (Chemotherapy administration, intravenous infusion technique; initiation of infusion in the office/other outpatient setting using office/other outpatient setting pump/supplies, with continuation of the infusion in the community setting (for example, home, domiciliary, rest home or assisted living) is intended to describe a service where the facility incurred a facility expense specific to the provision of the non-implantable, external infusion pump. Because HCPCS code G0498 includes the chemotherapy administration, providers should not report HCPCS code G0498 with CPT code 96416 (Initiation of prolonged chemotherapy infusion - more than 8 hours - requiring use of a portable or implantable pump). In addition, a hospital should append modifier 52 (reduced service) to HCPCS code G0498 when a component of the service is not performed.

As a reminder, hospitals are expected to report all drug administration CPT codes in a manner consistent with their descriptors, CPT instructions and correct coding principles. Also, hospitals are

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reminded to bill for all services provided using the HCPCS code(s) that most accurately describe the service(s) they provided.

**Argus Retinal Prosthesis Add-on Code (C1842)**
As stated in the January 2017 update, HCPCS code C1842 (Retinal prosthesis, includes all internal and external components; add-on to C1841) was established to resolve a claims processing issue for Ambulatory Surgery Centers (ASC) and should not be reported on institutional claims by hospital outpatient department providers. Therefore, the status indicator for HCPCS code C1842 will change from status indicator (SI)=N (Paid under OPPS; payment is packaged into payment for other services) to SI=E1 (Not paid by Medicare when submitted on outpatient claims (any outpatient bill type) in the April 2017 update. This correction to status indicator will be retroactive to January 1, 2017.

**Drugs, Biologicals and Radiopharmaceuticals**

A. **Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective April 1, 2017**
For CY 2017, payment for nonpass-through drugs, biologicals and therapeutic radiopharmaceuticals is made at a single rate of ASP + 6 percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical. In CY 2017, a single payment of ASP + 6 percent for pass-through drugs, biologicals and radiopharmaceuticals is made to provide payment for both the acquisition cost and pharmacy overhead cost of these pass-through items. Payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. Updated payment rates effective April 1, 2017, and drug price restatements are available in the April 2017 update of the OPPS Addendum A and Addendum B.

B. **Drugs and Biologicals with OPPS Pass-Through Status Effective April 1, 2017**
Seven drugs and biologicals have been granted OPPS pass-through status effective April 1, 2017. These items, along with their descriptors and Ambulatory Payment Classification (APC) assignments, are identified in Table 3.

**Table 3 – Drugs and Biologicals with OPPS Pass-Through Status Effective April 1, 2017**

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
<th>APC</th>
<th>Status Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9484</td>
<td>Injection, eteplirsen, 10 mg</td>
<td>9484</td>
<td>G</td>
</tr>
<tr>
<td>C9485</td>
<td>Injection, olaratumab, 10 mg</td>
<td>9485</td>
<td>G</td>
</tr>
<tr>
<td>C9486</td>
<td>Injection, granisetron extended release, 0.1 mg</td>
<td>9486</td>
<td>G</td>
</tr>
<tr>
<td>C9487</td>
<td>Ustekinumab, for intravenous injection, 1 mg</td>
<td>9487</td>
<td>G</td>
</tr>
<tr>
<td>C9488</td>
<td>Injection, conivaptan hydrochloride, 1 mg</td>
<td>9488</td>
<td>G</td>
</tr>
<tr>
<td>J7328</td>
<td>Hyaluronan or derivative, gel-syn, for intra-articular injection, 0.1 mg</td>
<td>1862</td>
<td>G</td>
</tr>
<tr>
<td>Q5102</td>
<td>Injection, infliximab, biosimilar, 10 mg</td>
<td>1847</td>
<td>G</td>
</tr>
</tbody>
</table>

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C. Drugs and Biologicals Based on ASP Methodology with Restated Payment Rates
Some drugs and biologicals based on ASP methodology will have payment rates that are corrected retroactively. These retroactive corrections typically occur on a quarterly basis. The list of drugs and biologicals with corrected payment rates will be accessible at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/OPPS-Restated-Payment-Rates.html on the first date of the quarter. Providers may resubmit claims that were impacted by adjustments to previous quarter’s payment files.

D. Revised Status Indicator for HCPCS Code J1130
The status indicator for HCPCS code J1130 (Injection, diclofenac sodium, 0.5 mg) will change from SI=E2 (Items and Services for which pricing information and claims data are not available) to SI=K (Paid under OPPS; separate APC payment) in the April 2017 update. This correction to status indicator will be retroactive to January 1, 2017. See Table 4.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
<th>APC</th>
<th>Status Indicator</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>J1130</td>
<td>Injection, diclofenac sodium, 0.5 mg</td>
<td>1863</td>
<td>K</td>
<td>01/01/2017</td>
</tr>
</tbody>
</table>

E. HCPCS code C9744
As a reminder to hospital providers, HCPCS code C9744 (Ultrasound, abdominal, with contrast) may be used to describe use of a contrast agent in ultrasonography of the liver, kidneys and/or bladder.

F. Reassignment of Skin Substitute Product from the Low Cost Group to the High Cost Group
Four skin substitute products have been reassigned from the low cost skin substitute group to the high cost skin substitute group based on updated pricing information. The HCPCS codes are Q4161, Q4169, Q4173 and Q4175. These products are listed in Table 5.

<table>
<thead>
<tr>
<th>CY 2017 HCPCS Code</th>
<th>CY 2017 Short Descriptor</th>
<th>CY 2017 SI</th>
<th>Low/High Cost Skin Substitute</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q4161</td>
<td>Bio-Connekt per square cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4169</td>
<td>Artacent wound, per square cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4173</td>
<td>Palingen or palingen xplus, per sq cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4175</td>
<td>Miroderm, per square cm</td>
<td>N</td>
<td>High</td>
</tr>
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G. Removal of Skin Substitute Product from the High/Low Cost Skin Substitute Table

One HCPCS code, Q4171, was inadvertently included in the High/Low Cost Skin Substitute table. Effective April 2017, Q4171 is removed from the High/Low Cost Skin Substitute table. This product is listed in Table 6.

Table 6 – Skin Substitute Product removed from High/Low Cost Skin Substitute Table  
Effective April 1, 2017

<table>
<thead>
<tr>
<th>CY 2017 HCPCS Code</th>
<th>CY 2017 Short Descriptor</th>
<th>CY 2017 SI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q4171</td>
<td>Interfyl, 1 mg</td>
<td>N</td>
</tr>
</tbody>
</table>

Coverage Determinations

As a reminder, the fact that a drug, device, procedure or service is assigned a HCPCS code and a payment rate under the OPPS does not imply coverage by the Medicare program. Instead, it only indicates how the product, procedure or service may be paid if covered by the program. Medicare Administrative Contractors (MAC) determine whether a drug, device, procedure or other service meets all program requirements for coverage. For example, MACs determine that it is reasonable and necessary to treat the beneficiary’s condition and whether it is excluded from payment.

Additional Information


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

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April Quarterly Update for 2017 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule

Provider Types Affected

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

What You Need to Know

Change Request (CR) 9988 provides the April 2017 quarterly update for the Medicare DMEPOS fee schedule, and it includes information, when necessary, to implement fee schedule amounts for new codes and correct any fee schedule amounts for existing codes.

Background

The DMEPOS fee 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 quarterly update process for the DMEPOS fee schedule is located in the “Medicare Claims Processing Manual” (Pub.100-04, 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 the Social Security Act (§1834(a), (h), and (i)). Also, 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 and casts, and intraocular lenses (IOLs) inserted in a physician's office.

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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. The Social Security Act (§1842(s)(3)(B)) provides authority for making adjustments to the fee schedule amount for enteral nutrients, equipment, and supplies (enteral nutrition) based on information from CBPs. Also, the adjusted fees apply a rural payment rule. The DMEPOS and PEN fee schedule files contain HCPCS codes that are subject to the adjustments as well as codes that are not subject to the fee schedule adjustments. Additional information on adjustments to the fee schedule amounts based on information from CBPs is available in CR 9642 (Transmittal 3551, dated June 23, 2016).

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

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

**KU Modifier for Complex Rehabilitative Power Wheelchair Accessories & Seat and Back Cushions**

Section 16005 of the 21st Century Cures Act extends the effective date through June 30, 2017, to exclude adjustments to fees using information from CBPs for certain wheelchair accessories (including seating systems) and seat and back cushions furnished in connection with Group 3 complex rehabilitative power wheelchairs (codes K0848 through K0864). As a result, the KU modifier fees have been added back to the DMEPOS fee schedule file effective January 1, 2017, and are effective for dates of service through June 30, 2017. The fees for items denoted with the HCPCS modifier ‘KU’ represent the unadjusted fee schedule amounts (the CY 2015 fee schedule amount updated by the 2016 and 2017 DMEPOS covered item update factor of 0.7 percent). The applicable complex rehabilitative wheelchair accessory codes are listed in CR 9520 (Transmittal 3535, dated June 7, 2016).

**Note for Change Request 8822 Reclassification of Certain DME to the Capped Rental Payment Category**

For dates of service on or after January 1, 2017, payment for the following HCPCS codes in all geographic areas is made on a capped rental basis: E0197, E0140, E0149, E0985, E1020, E1028, E2228, E2368, E2369, E2370, E2375, K0015, K0070, and E0955.
For dates of service on or after July 1, 2016, through December 31, 2016, these HCPCS codes were reclassified from the payment category for inexpensive and routinely purchased DME to payment on a capped rental basis in all areas except the nine Round 1 Recompete (Round 1 2014) Competitive Bidding Areas (CBAs). Program instructions on these changes were issued in CR 8822 (Transmittal 1626, dated February 19, 2016) and CR 8566 (Transmittal 1332, dated January 2, 2014). Related MLN Matters articles are at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8822.pdf and https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8566.pdf, respectively.

When submitting claims, suppliers that submit claims with more than four modifiers including when the claim is being billed with both the RT (right) and the LT (left) modifiers will include the NU (Purchase of new equipment) or RR (Rental) modifier as appropriate, the RT and LT modifiers and then the 99 modifier to signify that there are additional modifiers in use. On the narrative line, the supplier will include all applicable modifiers including the NU or RR, RT and LT modifiers.

Example

- Procedure code: E2370
- Units of Service = 2
- Modifiers: RR, LT, RT, 99 (RB, KX reported in additional narrative)

Payment for Oxygen Volume Adjustments and Portable Oxygen Equipment

CR 9848 (Transmittal 3679, dated December 16, 2016) titled Payment for Oxygen Volume Adjustments and Portable Oxygen Equipment, updated the “Medicare Claims Processing Manual” (Pub.100-04, chapter 20, section 130.6) to clarify billing when the prescribed amount of stationary oxygen exceeds 4 liters per minute (LPM) and portable oxygen is prescribed. The QF modifier is used to denote when the oxygen flow exceeds 4 LPM and portable oxygen is prescribed.

The Social Security Act (§ 1834(a)(5)(C) and (D)) requires that when there is an oxygen flow rate that exceeds 4 LPM that the Medicare payment amount be the higher of 50 percent of the stationary payment amount (codes E0424, E0439, E1390, or E1392) or the portable oxygen add-on amount (E0431, E0433, E0434, E1392, or K0738), and never both.

To facilitate this payment calculation, the QF modifier is added to the DMEPOS fee schedule file effective April 1, 2017, for both stationary and portable oxygen. The stationary oxygen QF modifier fee schedule amounts represent 100 percent of the stationary oxygen fee schedule amount. The portable oxygen QF fee schedule amounts represent the higher of 50 percent of the monthly stationary oxygen payment amount or the fee schedule amount for the portable oxygen add-on amount.
Effective April 1, 2017, the modifier “QF” should be used in conjunction with claims submitted for stationary oxygen (codes E0424, E0439, E1390, or E1391) and portable oxygen (codes E0431, E0433, E0434, E1392, or K0738) when the prescribed amount of oxygen is greater than 4 liters per minute (LPM).

Additional Information


Document History

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Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9960 revises the payment of travel allowances when billed on a per mileage basis using Health Care Common Procedure Coding System (HCPCS) code P9603 and when billed on a flat-rate basis using HCPCS code P9604 for Calendar Year (CY) 2017. Make sure that your billing staffs are aware of these changes.

Background

Medicare Part B allows payment for a specimen collection fee and travel allowance, when medically necessary, for a laboratory technician to draw a specimen from either a nursing home patient or homebound patient under Section 1833(h)(3) of the Act. Payment for these services is made based on the clinical laboratory fee schedule.

Key Changes

The travel codes allow for payment either on a per mileage basis (P9603) or on a flat-rate per trip basis (P9604). Payment of the travel allowance is made only if a specimen collection fee is also payable. The travel allowance is intended to cover the estimated travel
costs of collecting a specimen including the laboratory technician’s salary and travel expenses. MAC discretion allows the contractor to choose either a mileage basis or a flat rate, and how to set each type of allowance. Because audits have shown that some laboratories abused the per mileage fee basis by claiming travel mileage in excess of the minimum distance necessary for a laboratory technician to travel for specimen collection, many MACs established local policy to pay based on a flat-rate basis only.

Under either method, when one trip is made for multiple specimen collections (for example, at a nursing home), the travel payment component is prorated based on the number of specimens collected on that trip. This applies to both Medicare and non-Medicare patients, either at the time the claim is submitted by the laboratory or when the flat rate is set by the MAC.

- **Per Mile Travel Allowance (P9603)** - The per mile travel allowance is to be used in situations where the average trip to the patients’ homes is longer than 20 miles round trip, and is to be prorated in situations where specimens are drawn from non-Medicare patients in the same trip.

  The allowance per mile was computed using the Federal mileage rate of $0.535 per mile plus an additional $0.45 per mile to cover the technician’s time and travel costs. MACs have the option of establishing a higher per mile rate in excess of the minimum $0.99 per mile ($0.985 is rounded up for system purposes) if local conditions warrant it. The minimum mileage rate will be reviewed and updated throughout the year, as well as in conjunction with the Clinical Laboratory Fee Schedule (CLFS), as needed. At no time will the laboratory be allowed to bill for more miles than are reasonable, or for miles that are not actually traveled by the laboratory technician.

- **Per Flat-Rate Trip Basis Travel Allowance (P9604)** - The per flat-rate trip basis travel allowance is $9.85.

The Internal Revenue Service (IRS) determines the standard mileage rate for businesses based on periodic studies of the fixed and variable costs of operating an automobile.

### Additional Information


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

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MLN Matters® Number: MM9916 Rescinded  Related Change Request (CR) #: CR 9916
Related CR Release Date: February 17, 2017  Effective Date: July 1, 2017
Related CR Transmittal #: R169DEMO  Implementation Date: July 3, 2017

Episode Payment Model Operations

Note: This article has been rescinded as CR9916 was rescinded. The CR will be replaced at a later date.

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Federally Qualified Health Centers (FQHC) Prospective Payment System (PPS) - Recurring File Updates

MLN Matters Number: MM10021
Related Change Request (CR) Number: CR10021
Related CR Release Date: March 10, 2017
Effective Date: July 1, 2017
Related CR Transmittal Number: R3734CP
Implementation Date: July 3, 2017

PROVIDER TYPE AFFECTED

This MLN Matters® Article is intended for Federally Qualified Health Centers (FQHCs) submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

Change Request (CR) 10021 instructs MACs to adjust all FQHC claims (77X) for GFT FQHCs submitted with dates of service on or after January 1, 2017, through June 30, 2017, paid at the previous rate. These adjustments will be completed 45 days after the implementation of CR 10021. Make sure your billing staff is aware of these changes.

BACKGROUND

Effective for dates of service on or after January 1, 2016, Indian Health Service (IHS) and tribal facilities and organizations may seek to become certified as a Grandfathered Tribal (GFT) Federally Qualified Health Center (FQHC) if the facility or organization:

- Met the conditions of 42 CFR §413.65(m) (Requirements for a Determination That a Facility or an Organization Has Provider-Based Status) on or before April 7, 2000, and
- Had a change in their status on or after April 7, 2000 from IHS to tribal operation (or vice versa), or the realignment of a facility from one IHS or tribal hospital to another IHS or tribal hospital, and
- No longer meets the Medicare Conditions of Participation (CoPs).

These GFT FQHCs would be required to meet all FQHC certification and payment requirements. The grandfathered Prospective Payment System (PPS) rate equals the Medicare
outpatient per visit payment rate paid to them as a provider-based department, as set annually by the IHS. GFT FQHCs are paid the lesser of their charges (or a GFT FQHC PPS rate) for all FQHC services furnished to a beneficiary during a medically-necessary face-to-face FQHC visit.

**Note:** From January 1, 2017, through December 31, 2017, the GFT FQHC PPS rate is $349.

FQHC claims (TOB 77X) for GFT FQHCs that are submitted with dates of service on or after January 1, 2017, through June 30, 2017, and paid at the Calendar Year (CY) 2016 rate of $324 must be adjusted and paid at the CY 2017 rate of $349.

GFT FQHC claims that are submitted with dates of service on or after January 1, 2018, through December 31, 2018, should be paid at the CY 2017 rate of $349 until the Centers for Medicare & Medicaid Services (CMS) provides an updated payment rate for CY 2018.

The GFT FQHC PPS rate will not be adjusted by the FQHC PPS Geographic Adjustment Factors (GAFs) or be eligible for the special payment adjustments under the FQHC PPS for new patients, or patients receiving an Initial Preventive Physical Exam (IPPE) or an Annual Wellness Visit (AWV).

The rate is also ineligible for exceptions to the single per diem payment that is available to FQHCs paid under the FQHC PPS. In addition, the FQHC market basket adjustment that is applied annually to the FQHC PPS base rate, will not apply to the GFT FQHC PPS rate.

**ADDITIONAL INFORMATION**


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

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July 2017 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revision to Prior Quarterly Pricing Files

MLN Matters Number: MM10016
Related Change Request (CR) Number: 10016

Related CR Release Date: April 7, 2017
Effective Date: July 1, 2017

Related CR Transmittal Number: R3746CP
Implementation Date: July 3, 2017

PROVIDER TYPE AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 10016 provides the July 2017 quarterly update and instructs MACs to download and implement the July 2017 ASP drug pricing files and, if released by the Centers for Medicare & Medicaid Services (CMS), the revised April 2017, January 2017, October 2016, and July 2016 Average Sales Price (ASP) drug pricing files for Medicare Part B drugs. Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after July 3, 2017, with dates of service July 1, 2017, through September 30, 2017. MACs will not search and adjust claims previously processed unless brought to their attention.

BACKGROUND

The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply contractors with the ASP and Not Otherwise Classified (NOC) drug-pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the OPPS are incorporated into the Outpatient Code Editor (OCE) through separate instructions. The following files are related to this most recent update:

- July 2017 ASP and ASP NOC – Effective Dates of Service: July 1, 2017, through September 30, 2017
• April 2017 ASP and ASP NOC – Effective Dates of Service: April 1, 2017, through June 30, 2017

• January 2017 ASP and ASP NOC – Effective Dates of Service: January 1, 2017, through March 31, 2017

• October 2016 ASP and ASP NOC – Effective Dates of Services: October 1, 2016, through December 31, 2016

• July 2016 ASP and ASP NOC – Effective Dates of Service: July 1, 2016, through September 30, 2016

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

For any drug or biological not listed in the ASP or NOC drug-pricing files that is billed with the KD modifier, contractors shall determine the payment allowance limits in accordance with instructions for pricing and payment changes for infusion drugs furnished through an item of Durable Medical Equipment (DME) on or after January 1, 2017, associated with the passage of the 21st Century Cures Act.

ADDITIONAL INFORMATION


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

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July Quarterly Update for 2017 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule

MLN Matters Number: MM10071
Related Change Request (CR) # 10071

Related CR Release Date: April 28, 2017
Effective Date: July 1, 2017

Related CR Transmittal Number: R3760CP
Implementation Date: July 3, 2017

PROVIDER TYPE AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 10071 provides the July 2017 quarterly update for the Medicare DMEPOS fee schedule, and it includes information, when necessary, to implement fee schedule amounts for new codes and correct any fee schedule amounts for existing codes.

BACKGROUND

The DMEPOS fee 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 quarterly update process for the DMEPOS fee schedule is located in the Medicare Claims Processing Manual, Chapter 23, Section 60 at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf.


Also, 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 and casts and intraocular lenses (IOLs) inserted in a physician's office.

Additionally, Section 1834 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 (CBAs), based on information from competitive bidding programs (CBPs) for DME. The Social Security Act (§1842(s)(3)(B)) provides authority for making adjustments to the fee schedule amount for enteral nutrients, equipment and supplies (enteral nutrition) based on information from CBPs. Also, the adjusted fees apply a rural payment rule. The DMEPOS and PEN fee schedule files contain HCPCS codes that are subject to the adjustments as well as codes that are not subject to the fee schedule adjustments. Additional information on adjustments to the fee schedule amounts based on information from CBPs is available in CR 9642 (Transmittal 3551, dated June 23, 2016).

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

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

**KU Modifier for Complex Rehabilitative Power Wheelchair Accessories & Seat and Back Cushions**

Effective July 1, 2017, the fee schedule amounts for wheelchair accessories and seat and back cushions denoted with the HCPCS modifier ‘KU’ are deleted from the DMEPOS fee schedule file. These unadjusted fee schedule amounts have applied to wheelchair accessories and seat and back cushions furnished in connection with Group 3 complex rehabilitative power wheelchairs (codes K0848 through K0864). The fee schedule amounts associated with the KU modifier were mandated by Section 2 of Patient Access and Medicare Protection Act (PAMPA) effective for dates of service January 1, 2016 through December 31, 2016. Additionally, section 16005 of the 21st Century Cures Act extended the effective date through June 30, 2017. The list of HCPCS codes to which this statutory section applied is available in Transmittal 3535, CR 9520 dated June 7, 2016.

**Therapeutic Continuous Glucose Monitor (CGM)**

As part of this update, the fee schedule amounts for the following therapeutic CGM HCPCS codes are added to the DMEPOS fee schedule file effective for dates of service on or after July 1, 2017:

- K0553 - Supply allowance for therapeutic continuous glucose monitor (CGM), includes all supplies and accessories, 1 unit of service = 1 month's supply
- K0554 - Receiver (monitor), dedicated, for use with therapeutic continuous glucose monitor system

**ADDITIONAL INFORMATION**


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

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Outlier Limitation on Outpatient Prospective Payment System (OPPS) Community Mental Health Centers (CMHC) Services

Provider Types Affected

This MLN Matters® Article is intended for Community Mental Health Centers (CMHCs) submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 9671 instructs Medicare shared systems maintainers and MACs to implement an Outlier Limitation on Outpatient Prospective Payment System (OPPS) CMHC Services. Make sure that your billing staffs are aware of these changes.

Background

In the 2017 OPPS final rule, the Centers for Medicare & Medicaid Services (CMS) finalized a limitation on outlier payments for CMHC services under the OPPS. Under these requirements, Medicare systems accumulate a calendar year-to-date total during claims processing, for each CMHC provider, the overall total payments the CMHC provider has received and the total of outlier payments they have received. The total payment amount includes any outlier payments. These totals are then compared to determine whether a CMHC provider has been paid 8 percent of their total payments for the calendar year-to-date in outliers. Thus, an individual CMHC provider will receive no more than 8 percent of its total CMHC OPPS payments in outlier payments. To make the outlier limitation more transparent to providers, a detail file of outlier payments will be created that each CMHC
provider may review for the purpose of monitoring their payments accrued toward the outlier limitation.

MACs will use claim adjustment reason code 273 along with group code CO, rather than code 45, on the remittance advice of CMHC claims with dates of service on or after January 1, 2017, when an outlier amount is calculated but cannot be paid as a result of this rule. Also, MACs will use Remittance Advice Remark Code N523 in addition to Claim Adjustment Reason Code 273 along with group code CO on the remittance advice of CMHC claims with dates of service on or after January 1, 2017, when an outlier amount is calculated but cannot be paid.

Additional Information


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

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Payment for Moderate Sedation Services

Provider Types Affected

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

What You Need to Know

Change Request (CR) 10001 revises existing Medicare Claims Processing Manual language to bring the manual in line with current payment policy for moderate sedation and anesthesia services. Providers should refer to the revised Medicare Claims Processing Manual, Chapter 12 (Physicians/Nonphysician Practitioners), Sections 50 and 140 for information regarding the reporting of moderate sedation and anesthesia services. The revision is attached to CR10001. Make sure your billing staff is aware of these revisions.

Key Manual Changes

General Payment Rule

The fee schedule amount for physician anesthesia services furnished is, with the exceptions noted, based on allowable base and time units multiplied by an anesthesia conversion factor specific to that locality. The base unit for each anesthesia procedure is communicated to the MACs by means of the Healthcare Common Procedure Coding System (HCPCS) file released annually. The Centers for Medicare & Medicaid Services (CMS) releases the conversion factor annually. The base units and conversion factor are available at https://www.cms.gov/Center/Provider-Type/Anesthesiologists-Center.html.

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Moderate Sedation Services Furnished in Conjunction with and in Support of Procedural Services

Anesthesia services range in complexity. The continuum of anesthesia services, from least intense to most intense in complexity is as follows: local or topical anesthesia, moderate (conscious) sedation, regional anesthesia and general anesthesia. Moderate sedation is a drug induced depression of consciousness during which the patient responds purposefully to verbal commands, either alone or accompanied by light tactile stimulation. Moderate sedation does not include minimal sedation, deep sedation or monitored anesthesia care.

Practitioners will report the appropriate CPT and/or HCPCS code that accurately describes the moderate sedation services performed during a patient encounter, which are performed in conjunction with and in support of a procedural service, consistent with CPT guidance.

Other Manual Revisions to Sections 50 and 140
There are other minor revisions to these manual sections and those revised manual sections are attached to CR10001.

Additional Information

Your MAC will not search their files to either retract payment for claims already paid or to retroactively pay claims. They will adjust impacted claims that you bring to their attention.


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

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Payment for Moderate Sedation Services Furnished with Colorectal Cancer Screening Tests

MLN Matters Number: MM10075
Related Change Request (CR) Number: 10075
Related CR Release Date: April 28, 2017
Effective Date: January 1, 2017
Related CR Transmittal Number: R3763CP
Implementation Date: October 2, 2017

PROVIDER TYPE AFFECTED

This MLN Matters article is intended for physicians and other providers submitting claims to Part A and B Medicare Administrative Contractors (MACs) for sedation services furnished with colorectal cancer screening tests.

PROVIDER ACTION NEEDED

Change Request (CR) 10075 ensures accurate program payment for moderate sedation services furnished in conjunction with screening colonoscopy services for which the beneficiary should not be charged the coinsurance or deductible. The coinsurance and deductible for these services are waived, but due to coding changes and additions to the Medicare Physician Fee Schedule (MPFS) Database the payments for Calendar Year (CY) 2017 would not be accurate without this CR. Please make your billing staff aware of these changes.

BACKGROUND

Section 4104 of the Affordable Care Act defined the term “preventive services” to include “colorectal cancer screening tests” and, as a result, it waives any coinsurance that would otherwise apply under Section 1833(a)(1) of the Social Security Act for screening colonoscopies. In addition, the ACA amended Section 1833(b)(1) of the Act to waive the Part B deductible for screening colonoscopies, which includes moderate sedation services as an inherent part of the screening colonoscopy procedural service. These provisions are effective for services furnished on or after January 1, 2011.

In the CY 2017 PFS Final Rule, the Centers for Medicare & Medicaid Services (CMS) modified coding and reporting of procedural services that include moderate sedation as an inherent part of the service, including for screening colonoscopies. CR 10075 operationalizes the existing waiver of deductible and coinsurance for moderate sedation services furnished in conjunction with and in support of colorectal cancer screening tests. Effective January 1, 2017, beneficiary
coinsurance and deductible continues to not apply to the following moderate sedation claim lines when furnished in conjunction with screening colonoscopy services and when billed with Modifier 33 or Modifier PT:

- **HCPCS code G0500:** Moderate sedation services provided by the same physician or other qualified health care professional performing a gastrointestinal endoscopic service that sedation supports, requiring the presence of an independent, trained observer to assist in the monitoring of the patient’s level of consciousness and physiological status; patient age 5 years or older (additional time may be reported with 99153, as appropriate).

- **CPT code 99153:** Moderate sedation services provided by the same physician or other qualified healthcare professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent, trained observer to assist in the monitoring of the patient’s level of consciousness and physiological status; each additional 15 minutes of intra-service time (List separately in addition to code for primary service).

MACS will not search their files to either retract payment for claim lines already paid or to retroactively pay claim lines with HCPCS code G0500 or CPT code 99153. However, MACs will adjust such claims that you bring to their attention.

**ADDITIONAL INFORMATION**


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

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Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9977 informs MACs about changes to the MPFS payment files. While the changes will be implemented in Medicare systems on April 3, the changes are effective January 1, 2017. Note that MACs need not search their files to either retract payment for claims already paid or to retroactively pay claims already processed. However, the MACs will adjust such claims that you bring to their attention. Make sure that your billing staffs are aware of these changes.

Background

Payment files were issued to the MACs based upon the CY 2017 MPFS Final Rule, published in the Federal Register on November 15, 2016, to be effective for services furnished between January 1, 2017, and December 31, 2017.
Below is a summary of the changes for the April update to the 2017 MPFSDB. These changes are effective for dates of service on or after January 1, 2017.

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In addition, the following new codes have been added to the HCPCS file effective February 1, 2017. The HCPCS file coverage code is C (carrier judgment) for these new codes. Coverage and payment will be determined by the MAC (they are not part of the MPFS).

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<td>0001U</td>
<td>RBC DNA HEA 35 AG 11 BLD GRP</td>
<td>Red blood cell antigen typing, DNA, human erythrocyte antigen gene analysis of 35 antigens from 11 blood groups, utilizing whole blood, common RBC alleles reported</td>
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<td>0002U</td>
<td>ONC CLRCT 3 UR METAB ALG PLP</td>
<td>Oncology (colorectal), quantitative assessment of three urine metabolites (ascorbic acid, succinic acid and carnitine) by liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring acquisition, algorithm reported as likelihood of adenomatous polyps</td>
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CPT Code | Short Descriptor | Long Descriptor
--- | --- | ---
0003U | ONC OVAR 5 PRTN SER ALG SCOR | Oncology (ovarian) biochemical assays of five proteins (apolipoprotein A-1, CA 125 II, follicle stimulating hormone, human epididymis protein 4, transferrin), utilizing serum, algorithm reported as a likelihood score

**Additional Information**


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

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MLN Matters® Number: MM10012 Related Change Request (CR) #: CR 10012
Related CR Release Date: April 7, 2017 Effective Date: October 1, 2017
Related CR Transmittal #: R1819OTN Implementation Date: October 2, 2017

Update to Common Working File (CWF) Blood Editing on Medicare Advantage (MA) Enrollees' Inpatient Claims for Indirect Medical Education (IME) Payment

Provider Types Affected

This MLN Matters® Article is intended for approved teaching hospitals submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

What You Need to Know

Change Request (CR) 10012 informs MACs about the changes to the Common Working File (CWF) to bypass blood services editing on claims submitted by approved teaching hospitals for Medicare Advantage (MA) enrollees for Indirect Medicare Education (IME) payment (Type of Bill (TOB) 11x, Prospective Payment System (PPS) indicator Y, condition code 04 and condition code 69). CR10012 contains no new policy. It improves the implementation of existing Medicare payment policies. Make sure that your billing staffs are aware of these changes.

Background

Approved teaching hospitals submit inpatient claims for MA beneficiaries to their MAC to receive an IME payment and so Original Medicare Part A can include the inpatient days in the Medicare/Supplemental Security Income fraction. Original Medicare Part A does not track utilization of benefits for beneficiaries enrolled in an MA plan. Therefore utilization edits should not apply to an IME only inpatient claim. The Centers for Medicare & Medicaid Services was notified that when an inpatient claim from a teaching hospital for an MA beneficiary is submitted with blood revenue codes, the CWF is setting blood related edits. CR10012 corrects this problem.

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Additional Information


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