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WPS HEALTH ADMINISTRATORS

Summer 2017
July – August – September

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- Specialty- and service-specific educational articles
- Much, much more!

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Changes to the Payment Policies for Reciprocal Billing Arrangements and Fee-For-Time Compensation Arrangements (formerly referred to as Locum Tenens Arrangements)

MLN Matters Number: MM10090  Related Change Request (CR) Number: 10090
Related CR Release Date: May 12, 2017  Effective Date: June 13, 2017
Related CR Transmittal Number: R3774CP  Implementation Date: June 13, 2017

PROVIDER TYPE AFFECTED

This MLN Matters® Article is intended for physicians, physical therapists, and other providers 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) 10090, which implements the 21st Century Cures Act (Section 16006). Outpatient physical therapy services furnished by physical therapists in a Health Professional Shortage Area (HPSA), a Medically Underserved Area (MUA), or in a rural area can be billed under reciprocal billing and fee-for-time compensation arrangements in the same manner as physicians bill effective June 13, 2017.

BACKGROUND

Section 1842(b)(6)(D) of the Social Security Act (the Act) allows payment to be made to a physician for physicians’ services (and services furnished incident to such services) furnished by a second physician to patients of the first physician if the first physician is unavailable to provide the services, and the services are furnished pursuant to an arrangement that is either

- Informal and reciprocal, or
- Involves per diem or other fee-for-time compensation for such services.

In addition, the services must not be provided by the second physician over a continuous period of more than 60 days unless the regular physician is called or ordered to active duty as a member of a reserve component of the Armed Forces.

Effective June 13, 2017, this same process will be available to Medicare-enrolled physical therapists that use substitute physical therapists to furnish outpatient physical therapy services in a HPSA, MUA, or a rural area.
The purpose of CR10090 is to:

1. Implement Section 16006 of the 21st Century Cures Act, which allows outpatient physical therapy services furnished by physical therapists in a HPSA, MUA, or in a rural area to be billed under reciprocal billing and fee-for-time compensation arrangements in the same manner as physicians bill; this is effective June 13, 2017. The term "locum tenens," which has historically been used in the manual to mean fee-for-time compensation arrangements, is being discontinued because the title of section 16006 of the 21st Century Cures Act uses “locum tenens arrangements” to refer to both fee-for-time compensation arrangements and reciprocal billing arrangements. As a result, continuing to use the term "locum tenens" to refer solely to fee-for-time compensation arrangements is not consistent with the law and could be confusing to the public.

2. Update Chapter 1, Sections 30.2.1; 30.2.10; 30.2.11; 30.2.13; and 30.2.14 of the “Medicare Claims Processing Manual” by changing “Carriers” to “A/B MACs Part B” and removing all references to “UPIN” (since the terms carriers and UPIN are obsolete).

3. Update Chapter 1, Sections 30.2.10 and 30.2.11 of the “Medicare Claims Processing Manual” to clarify that when a regular physician or physical therapist is called or ordered to active duty as a member of a reserve component of the Armed Forces for a continuous period of longer than 60 days, payment may be made to that regular physician or physical therapist for services furnished by a substitute under reciprocal billing arrangements or fee-for-time compensation arrangements throughout that entire period. This policy is required by section 137 of the Medicare Improvements for Patients and Providers Act of 2008.

Note: The revised portions of Chapter 1, Section 30 of the “Medicare Claims Processing Manual” are included as an attachment to CR10090.

Q5 and Q6 Modifiers

MACs will accept claims from Physical Therapists, Provider Specialty 65 – Physical Therapist in Private Practice, for reciprocal billing arrangements, when submitted with the Q5 modifier. MACs will accept claims from Physical Therapists, Provider Specialty 65 – Physical Therapist in Private Practice, for fee-for-time compensation arrangements, when submitted with the Q6 modifier. MACs will accept claims from physical therapists that are reported with a Q5 or Q6 modifier whose descriptor references only physicians. When the descriptors are updated to include physical therapists and physicians, MACs will accept the Q5 or Q6 modifier with the updated descriptor.

Note: The Q5 and Q6 modifiers’ descriptors will be amended to include physical therapists in addition to physicians in the near future in a HCPCS quarterly update.

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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<th>Date of Change</th>
<th>Description</th>
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<tbody>
<tr>
<td>May 15, 2017</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>

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July 2017 Update of the Ambulatory Surgical Center (ASC) Payment System

MLN Matters Number: MM10138  Related Change Request (CR) Number: CR 10138
Related CR Release Date: June 9, 2017  Effective Date: July 1, 2017
Related CR Transmittal Number: R3792CP  Implementation Date: July 3, 2017

Note: This article was revised on June 9, 2017, due to the release of an updated Change Request (CR). That CR corrected an error to the ASC Payment Indicator for C9747 in Table 2 (changed from J8 to G2). All other information remains the same.

PROVIDER TYPE AFFECTED

This MLN Matters Article is intended for Ambulatory Surgical Centers (ASCs) submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

WHAT YOU NEED TO KNOW

CR 10138 informs MACs about changes to the ASC payment center and billing instructions for various payment policies implemented in the July 2017 ASC payment system update. The CR also includes HCPCS updates. Make sure your billing staffs are aware of these changes.

BACKGROUND

This article notifies the MACs about updates to the ASC payment center and billing instructions for various payment policies implemented in the July 2017 ASC payment system update, as well as HCPCS changes.

CR10138 also includes updates to payment rates for separately payable drugs and biologicals, including descriptors for newly created Level II HCPCS codes for drugs and biologicals (ASC DRUG files). CR10138 includes Calendar Year (CY) 2017 ASC payment rates for covered surgical and ancillary services (ASCFS file).

1. Category III CPT Code, Effective July 1, 2017

The American Medical Association (AMA) releases Category III Current Procedural Terminology (CPT) codes twice per year: in January, for implementation beginning the following July, and in July, for implementation beginning the following January.
For the July 2017 update, the Centers for Medicare & Medicaid Services (CMS) is implementing one (1) Category III CPT code that AMA released in January 2017 for implementation on July 1, 2017. The ASC payment rate and ASC payment indicator (ASC PI) for this code is listed in Table 1.

### Table 1 — Category III CPT Code Effective July 1, 2017

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>July 2017 ASC PI</th>
</tr>
</thead>
<tbody>
<tr>
<td>0474T</td>
<td>Insj aqueous drg dev io rsrv</td>
<td>Insertion of anterior segment aqueous drainage device, with creation of intraocular reservoir, internal approach, into the supraciliary space</td>
<td>J8</td>
</tr>
</tbody>
</table>

2. **New Separately Payable Procedure Codes**

Effective July 1, 2017, three new HCPCS codes, C9745, C9746, and C9747, have been created. These codes, along with their descriptors and ASC PI, are listed in Table 2.

### Table 2 — New Separately Payable Procedure Codes Effective July 1, 2017

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>July 2017 ASC PI</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9745</td>
<td>Nasal endo eustachian tube</td>
<td>Nasal endoscopy, surgical; balloon dilation of eustachian tube</td>
<td>J8</td>
</tr>
<tr>
<td>C9746</td>
<td>Trans imp balloon cont</td>
<td>Transperineal implantation of permanent adjustable balloon continence device, with cystourethroscopy, when performed and/or fluoroscopy, when performed</td>
<td>J8</td>
</tr>
<tr>
<td>C9747</td>
<td>Ablation, HIFU, prostate</td>
<td>Ablation of prostate, transrectal, high intensity focused ultrasound (HIFU), including imaging guidance</td>
<td>G2</td>
</tr>
</tbody>
</table>

3. **Drugs, Biologicals, and Radiopharmaceuticals**

a. **ASC Drugs and Biologicals with OPPS Pass-Through Status, Effective July 1, 2017**
For CY 2017, two new HCPCS codes, with OPPS Pass-Through Status, have been created for reporting drugs and biologicals in the ASC payment system, where there have not previously been specific codes available. These new codes are listed in Table 3.

### Table 3 — ASC Drugs and Biologicals with OPPS Pass-Through Status, Effective July 1, 2017

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>ASC PI</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9489</td>
<td>Injection, nusinersen</td>
<td>Injection, nusinersen, 0.1 mg</td>
<td>K2</td>
</tr>
<tr>
<td>C9490</td>
<td>Injection, bezlotoxumab</td>
<td>Injection, bezlotoxumab, 10 mg</td>
<td>K2</td>
</tr>
</tbody>
</table>

**b. Drugs and Biologicals with Payments Based on Average Sales Price (ASP), Effective July 1, 2017**

For CY 2017, payment for non-pass-through drugs, biologicals and therapeutic radiopharmaceuticals continues to be 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 addition, in CY 2017, a single payment of ASP + 6 percent continues to be made for pass-through drugs, biologicals and radiopharmaceuticals to provide payment for both the acquisition cost and pharmacy overhead costs 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 July 1, 2017, and drug price restatements are in the July 2017 ASC Addendum BB, available at [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html).

**c. Drugs and Biologicals Based on ASP Methodology with Restated Payment Rates**

Some drugs and biologicals based on ASP methodology may have payment rates that are corrected retroactively. These retroactive corrections typically occur on a quarterly basis. The list of drugs and biologicals with corrected payments rates will be accessible on the first date of the quarter at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/ASC-Restated-Payment-Rates.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/ASC-Restated-Payment-Rates.html). Suppliers who think they may have received an incorrect payment for drugs and biologicals impacted by these corrections may request contractor adjustment of the previously processed claims.

**d. New Drug HCPCS Codes Effective July 1, 2017**

Effective July 1, 2017, one new HCPCS code has been created for reporting drugs and biologicals in the ASC payment system, where there have not previously been specific codes available. This new code is listed in Table 4.
Table 4 — New Drug HCPCS Codes Effective July 1, 2017

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>ASC PI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q9986</td>
<td>Inj, Makena</td>
<td>Injection, hydroxyprogesterone caproate (Makena), 10 mg</td>
<td>K2</td>
</tr>
</tbody>
</table>

e. Change to ASC Payment Indicator for CPT Code 90682

The influenza vaccine associated with CPT code 90682 (Influenza virus vaccine, quadrivalent (riv4), derived from recombinant dna, hemagglutinin (ha) protein only, preservative and antibiotic free, for intramuscular use) is approved for use in the 2017-2018 flu season (see MLN Matters article MM9876 at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9876.pdf). CPT code 90682 was added to the January 2017 ASCFS with an effective date of January 1, 2017, and assigned an ASC PI of “L1” (Influenza vaccine; pneumococcal vaccine. Packaged item/service; no separate payment made). Because this code is not a payable code until the start of the 2017 flu season, the payment indicator will be retroactively corrected from ASC PI=L1 to ASC PI=Y5 (Nonsurgical procedure/item not valid for Medicare purposes because of coverage, regulation and/or statute; no payment made) effective January 1, 2017, through June 30, 2017. Effective July 1, 2017, CPT code 90682 is assigned SI=L1. ASCs are reminded that ordinarily packaged codes are not billed in the ASC payment system. This change is described in Table 5.

Table 5 — Change to ASC Payment Indicator for CPT Code 90682

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>ASC PI</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>90682</td>
<td>Riv4 vacc recombinant dna im</td>
<td>Influenza virus vaccine, quadrivalent (riv4), derived from recombinant dna, hemagglutinin (ha) protein only, preservative and antibiotic free, for intramuscular use</td>
<td>Y5</td>
<td>January 1, 2017 – June 30, 2017</td>
</tr>
<tr>
<td>90682</td>
<td>Riv4 vacc recombinant dna im</td>
<td>Influenza virus vaccine, quadrivalent (riv4), derived from recombinant dna, hemagglutinin (ha) protein only, preservative and antibiotic free, for intramuscular use</td>
<td>L1</td>
<td>July 1, 2017</td>
</tr>
</tbody>
</table>

f. Revised Status Indicator for HCPCS Code J1725

For the July 2017 update, the HCPCS Workgroup inactivated HCPCS code J1725 for Medicare reporting and replaced it with HCPCS code Q9986 (see table 4 above for Q9986 descriptors and ASC PI). Therefore, effective July 1, 2017, the ASC PI for HCPCS code J1725 (Injection,
hydroxyprogesterone caproate, 1 mg) will change from ASC PI=K2 (Drugs and biologicals paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate) to ASC PI= Y5 (Nonsurgical procedure/item not valid for Medicare purposes because of coverage, regulation and/or statute; no payment made). Table 6 describes the status indicator change and effective date for HCPCS code J1725. The payment rate for HCPCS codes Q9986 is included in the July 2017 ASC Addendum BB, available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html.

Table 6 ─ Revised Status Indicator for HCPCS Code J1725

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>ASC PI</th>
<th>Effective Date</th>
<th>Termination Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>J1725</td>
<td>Hydroxyprogesterone caproate</td>
<td>Injection hydroxyprogesterone caproate, 1 mg</td>
<td>K2</td>
<td>01/01/2012</td>
<td>06/30/2017</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>J1725</td>
<td>Hydroxyprogesterone caproate</td>
<td>Injection hydroxyprogesterone caproate, 1 mg</td>
<td>Y5</td>
<td>07/01/2017</td>
<td></td>
</tr>
</tbody>
</table>

**g. Other Changes to CY 2017 HCPCS Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals**

Effective July 1, 2017, HCPCS code Q9989 (Ustekinumab, for Intravenous Injection, 1 mg) will replace HCPCS code C9487 (Ustekinumab, for Intravenous Injection, 1 mg). The payment indicator will remain K2, “Drugs and biologicals paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate.” The HCPCS code change and effective date are described in Table 7.

Table 7 ─ Other Changes to CY 2017 HCPCS Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals Effective July 1, 2017

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>ASC PI</th>
<th>Effective Date</th>
<th>Termination Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9487</td>
<td>Ustekinumab IV inj, 1 mg</td>
<td>Ustekinumab, for Intravenous Injection, 1 mg</td>
<td>K2</td>
<td>04/01/2017</td>
<td>06/30/2017</td>
</tr>
<tr>
<td>Q9989</td>
<td>Ustekinumab IV Inj, 1 mg</td>
<td>Ustekinumab, for Intravenous Injection, 1 mg</td>
<td>K2</td>
<td>07/01/2017</td>
<td></td>
</tr>
</tbody>
</table>
4. Coverage Determinations
The fact that a drug, device, procedure or service is assigned a HCPCS code and a payment rate under the ASC payment system does not imply coverage by the Medicare program, but indicates only how the product, procedure, or service may be paid if covered by the program. Medicare Administrative Contractors (MACs) 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/.

DOCUMENT HISTORY

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<tr>
<td>June 9, 2017</td>
<td>The article was revised on due to the release of an updated CR that corrected an error to the ASC Payment Indicator for C9747 in Table 2 (changed from J8 to G2).</td>
</tr>
<tr>
<td>June 2, 2017</td>
<td>Initial Article Released</td>
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New Waived Tests

MLN Matters Number: MM10055  
Related Change Request (CR) Number: 10055
Related CR Release Date: May 12, 2017  
Effective Date: January 1, 2017
Related CR Transmittal Number: R3771CP  
Implementation Date: July 3, 2017

PROVIDER TYPE AFFECTED
This MLN Matters® Article is intended for clinical diagnostic laboratories submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED
Change Request (CR) 10055 informs MACs of new Clinical Laboratory Improvement Amendments of 1988 (CLIA) waived tests approved by the Food and Drug Administration (FDA). Since these tests are marketed immediately after approval, the Centers for Medicare & Medicaid Services (CMS) must notify MACs of the new tests so that they can accurately process claims. Make sure that your billing staffs are aware of these CLIA-related changes.

BACKGROUND
The CLIA regulations require a facility to be appropriately certified for each test performed. To ensure that Medicare & Medicaid only pay for laboratory tests categorized as waived complexity under CLIA in facilities with CLIA certificate of waiver, laboratory claims are currently edited at the CLIA certificate level.

Listed below are the latest tests approved by the Food and Drug Administration (FDA) as waived tests under CLIA. The Current Procedural Terminology (CPT) codes for the following new tests must have the modifier QW to be recognized as a waived test. However, the tests mentioned on the first page of the attached list (that is, CPT codes: 81002, 81025, 82270, 82272, 82962, 83026, 84830, 85013, and 85651) do not require a QW modifier to be recognized as a waived test.

The CPT code, effective date and description for the latest tests approved by the FDA as waived tests under CLIA are the following:

- 82465QW, 83718QW, 82947QW, 82950QW, 82951QW, 82952QW, December 22, 2016, Polymer Technology Systems, Inc., CardioChek Home Test System (CardioChek Home Chol+HDL+Glu test strips)
- 82465QW, 83718QW, December 22, 2016, Polymer Technology Systems, Inc., CardioChek Home Test System (CardioChek Home Chol+HDL test strips)
• 82465QW, 82947QW, 82950QW, 82951QW, 82952QW, December 22, 2016, Polymer Technology Systems, Inc., CardioChek Home Test System (CardioChek Home Chol+Glu test strips)

• 82465QW, 83718QW, 82947QW, 82950QW, 82951QW, 82952QW, December 22, 2016, Polymer Technology Systems, Inc., CardioChek Plus Test System (PTS Panels Chol+HDL+Glu test strips)

• 82465QW, 83718QW, December 22, 2016, Polymer Technology Systems, Inc., CardioChek Plus Test System (PTS Panels Chol+HDL test strips)

• 82465QW, 82947QW, 82950QW, 82951QW, 82952QW, December 22, 2016, Polymer Technology Systems, Inc., CardioChek Plus Test System (PTS Panels Chol+Glu test strips)

• 81003QW, January 23, 2017, Germaine Laboratories, Inc. AimStrip Urine Analyzer 2 System (AimStrip Urine Reagent Strips)

• 81003QW, January 23, 2017, Germaine Laboratories, Inc. AimStrip Urine Analyzer 2 System (Fisherbrand Urine Reagent Strips)

• 87804QW, January 23, 2017, LifeSign LLC, Status Flu A+B (Nasal and Nasopharyngeal Swabs)

• 87804QW, January 23, 2017, Sekisui Diagnostics LLC, OSOM Ultra Flu A&B Test {Nasal and Nasopharyngeal Swabs}

• 80305QW, February 2, 2017, Advin Biotech, Inc. ATTEST

• 87801QW, March 6, 2017, Alere i System Respiratory Syncytial Virus

The new waived complexity code G0475 [HIV antigen/antibody, combination assay, screening] describes the testing assigned to the waived CPT 87806QW when it is performed for screening purposes. Effective January 1, 2017, the use of G0475QW will be permitted for claims submitted by facilities with a valid, current CLIA certificate of waiver.

The new waived complexity code, 87801QW [Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; amplified probe(s) technique] is assigned to the testing performed by the Alere i System Respiratory Syncytial Virus test.

The attachment to CR1005 contains the test name, manufacturer, and use for each above listed CPT codes. You should be aware that MACs will not search their files to either retract payment or retroactively pay claims; however, they should adjust 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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<td>May 15, 2017</td>
<td>Initial article released.</td>
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New Waived Tests

MLN Matters Number: MM10198
Related Change Request (CR) Number: 10198
Related CR Release Date: July 27, 2017
Effective Date: October 1, 2017
Related CR Transmittal Number: R3812CP
Implementation Date: October 2, 2017

PROVIDER TYPE AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 10198 informs MACs of new Clinical Laboratory Improvement Amendments of 1988 (CLIA) waived tests approved by the Food and Drug Administration (FDA). Since these tests are marketed immediately following approval, the Centers for Medicare & Medicaid Services (CMS) must notify the MACs of the new tests so that they can accurately process claims. CR10198 lists 17 newly added waived complexity tests.

BACKGROUND

The CLIA regulations require a facility to be appropriately certified for each test performed. To ensure that Medicare and Medicaid only pay for laboratory tests categorized as waived complexity under CLIA in facilities with a CLIA certificate or waiver, laboratory claims are currently edited at the CLIA certificate level.

This article includes the latest tests approved by the FDA as waived tests under CLIA. The Current Procedural Terminology (CPT) codes for the following new tests must have the modifier QW to be recognized as a waived test. However, the tests mentioned on the first page of the attached list (that is, CPT codes 81002, 81025, 82270, 82272, 82962, 83026, 84830, 85013, and 85651) do not require a QW modifier to be recognized as a waived test.

The CPT code, effective date, and description for the latest tests approved by the FDA as waived tests under CLIA include:

- 87880QW, December 8, 2016, Quidel Sofia Strep A+ FIA (from throat swab only);
- 80305QW, April 28, 2017, Alere Toxicology Services Alere iCup Rx Multi-Drug Urine Test Cup;
Note: MACs will not search their files to either retract payment or retroactively pay claims; however, MACs should adjust claims if they are brought to their attention.

ADDITIONAL INFORMATION

The official instruction, CR10198, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3812CP.pdf. 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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Next Generation Accountable Care Organization (NGACO) Year Three Benefit Enhancements

MLN Matters Number: MM10044
Related Change Request (CR) Number: 10044
Related CR Release Date: August 4, 2017
Related CR Transmittal Number: R177DEMO
Effective Date: January 1, 2018
Implementation Date: January 2, 2018

PROVIDER TYPES AFFECTED

This MLN Matters® Article is intended for providers who are participating in Next Generation Accountable Care Organizations (NGACOs) and submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

Change Request (CR) 10044 provides instruction to MACs to implement two new benefit enhancements for performance year three (calendar year 2018) of the NGACO Model. MACs will process and pay claims for Asynchronous Telehealth and Post-Discharge Home Visit Waiver services when those services meet the appropriate payment requirements as outlined in CR10044. Make sure your billing staff is aware of these changes.

BACKGROUND

The aim of the NGACO Model is to improve the quality of care, population health outcomes, and patient experience for the beneficiaries who choose traditional Medicare Fee-for-Service (FFS) through greater alignment of financial incentives and greater access to tools that may aid beneficiaries and providers in achieving better health at lower costs.

In order to emphasize high-value services and support the ability of ACOs to manage the care of beneficiaries, the Centers for Medicare & Medicaid Services (CMS) is issuing the authority under Section 1115A of the Social Security Act (the Act) (Section 3021 of the Affordable Care Act) to conditionally waive certain Medicare payment requirements as part of the NGACO Model.

Asynchronous Telehealth

CMS is expanding the current telehealth waiver to include asynchronous (also known as “store-and-forward”) telehealth in the specialties of teledermatology and teleophthalmology. Asynchronous telehealth includes the transmission of recorded health history (for example, retinal scanning and digital images) through a secure electronic communications system to a
practitioner, usually a specialist, who uses the information to evaluate the case or render a service outside of a real-time interaction. Asynchronous telecommunications system in single media format does not include telephone calls, images transmitted via facsimile machines, and text messages without visualization of the patient (electronic mail). Photographs must be specific to the patients’ condition and adequate for rendering or confirming a diagnosis or treatment plan.

Payment will be permitted for telemedicine when asynchronous telehealth in single or multimedia formats, is used as a substitute for an interactive telecommunications system for dermatology and ophthalmology services. Distant site practitioners will bill for these new services using new codes, and the distant site practitioner must be an NGACO Participant or Preferred Provider.

**Asynchronous Telehealth Based on Intra-Service + 5 Minutes Post-Service Time**

- **Code 1**: G9868—Receipt and analysis of remote, asynchronous images for dermatologic and/or ophthalmologic evaluation, for use under the Next Generation ACO model, less than 10 minutes.
- **Code 2**: G9869—Receipt and analysis of remote, asynchronous images for dermatologic and/or ophthalmologic evaluation, for use under the Next Generation ACO model, 10-20 minutes.
- **Code 3**: G9870—Receipt and analysis of remote, asynchronous images for dermatologic and/or ophthalmologic evaluation, for use under the Next Generation ACO model, 20 or more minutes.

**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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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 June 9, 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.

Disclaimer

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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/.

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<td>The article was revised due to the release of an updated Change Request (CR). The CR date, transmittal number and the link to the transmittal changed.</td>
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<tr>
<td>May 10, 2017</td>
<td>The article was revised due to the release of an updated Change Request (CR). The CR date, transmittal number and the link to the transmittal changed.</td>
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<tr>
<td>February 17, 2017</td>
<td>Initial article released</td>
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October Quarterly Update to 2017 Annual Update of HCPCS Codes Used for SNF CB Enforcement

MLN Matters Number: MM10163  Related Change Request (CR) Number: 10163
Related CR Release Date: August 4, 2017  Effective Date: October 1, 2017
Related CR Transmittal Number: R3825CP  Implementation Date: October 2, 2017

PROVIDER TYPES AFFECTED

This MLN Matters® Article is intended for providers who submit claims to Medicare Administrative Contractors (MACs), including Durable Medical Equipment MACs (DME MACs), for services provided in a Skilled Nursing Facility (SNF) to Medicare beneficiaries.

PROVIDER ACTION NEEDED

Change Request (CR) 10163 provides updates to the lists of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the Consolidated Billing (CB) provision of the SNF Prospective Payment System (PPS). The CR corrects an error impacting certain claims with dates of service on or after January 1, 2015, that Medicare mistakenly denied rejected prior to implementation of CR10163. Make sure your billing staffs are aware of these changes.

BACKGROUND

CR10163 alerts providers that the Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of HCPCS codes that are excluded from the CB provision of the SNF PPS. Services excluded from SNF PPS and CB may be paid to providers, other than SNFs, for beneficiaries, even when in a SNF stay. Services not appearing on the exclusion lists submitted on claims to MACs will not be paid by Medicare to any providers other than a SNF.

For non-therapy services, SNF CB applies only when the services are furnished to a SNF resident during a covered Part A stay; however, SNF CB applies to physical and occupational therapies and speech-language pathology services whenever they are furnished to a SNF resident, regardless of whether Part A covers the stay. In order to assure proper payment in all settings, Medicare systems must edit for services provided to SNF beneficiaries both included and excluded from SNF CB. The updated lists for institutional and professional billing are available at http://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/index.html.
Certain radiation therapy codes are included as services that are not subject to SNF CB. These codes can be submitted globally (no modifier), professional component only (modifier 26), or technical component only (modifier TC).

When the codes listed below are submitted globally or just for the technical component, the claims are being rejected by Medicare's Common Working File (CWF). That is to say, they are not allowed to pay separately outside of the consolidated payment that is made to the SNF.

When submitted with the 26 modifier for just the professional component, the claims have been allowed to pay. The following are the allowable HCPCS codes: 77014, 77750, 77761, 77762, 77763, 77776, 77777, 77778, 77785, 77786, 77787, 77789, 77790, 77799, 79005, 79101, and 79445.

This error is occurring because the codes were not added by CMS to the appropriate coding lists with the 2015, 2016, and 2017 SNF CB Annual Updates. CR10163 corrects this error. Therefore, when brought to their attention, your MAC will reprocess claims with dates of service on or after January 1, 2015, that were erroneously denied/rejected.

**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: MM9911  Related Change Request (CR) #: CR 9911
Related CR Release Date: June 28, 2017  Effective Date: for claims processed on or after October 2, 2017
Related CR Transmittal #: R3802CP  Implementation Date: October 2, 2017

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

**Note:** This article was revised on July 24, 2017, to add links to related MLN Matters Articles. **SE1128** reminds all Medicare providers that they may not bill beneficiaries enrolled in the QMB program for Medicare cost-sharing. **MM9817** states that CR 9817 instructs MACs to issue a compliance letter instructing named providers and suppliers to refund any erroneous charges and recall any past or existing billing with regard to improper QMB billing. 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).

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to reflect that the beneficiary is enrolled in the QMB program and has no Medicare cost-sharing liability. Make sure that your billing staffs are aware of these changes.

Background

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

Federal law bars Medicare providers from billing a QMB individual for Medicare Part A and B deductibles, coinsurance, or copayments, under any circumstances. Sections 1902(n)(3)(B); 1902(n)(3)(C); 1905(p)(3); 1866(a)(1)(A); 1848(g)(3)(A) of the Social Security Act. State Medicaid programs may pay providers for Medicare deductibles, coinsurance, and copayments. However, as permitted by Federal law, states can limit provider payment for Medicare cost-sharing, under certain circumstances. Regardless, QMB individuals have no legal liability to pay Medicare providers for Medicare Part A or Part B cost-sharing. Providers may seek reimbursement for unpaid Medicare deductible and coinsurance amounts as a Medicare bad debt related to dual eligible beneficiaries under CMS Pub. 15-1, Chapter 3 of the “Provider Reimbursement Manual (PRM)”.

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

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

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

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

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

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

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

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

Additional Information


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

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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<td>June 29, 2017</td>
<td>The article was revised to reflect a revised CR9911 issued on June 28, 2017. In the article, the CR release date, transmittal number, and the Web address of CR9911 are revised. Clarifications were also made to the second paragraph of the Background section.</td>
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<td>May 1, 2017</td>
<td>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.</td>
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<tr>
<td>February 3, 2017</td>
<td>Initial article released</td>
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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.

WHAT YOU NEED TO KNOW

The HCPCS code set is updated on a quarterly basis. Change Request (CR) 10107 informs MACs of updating specific drug/biological HCPCS codes. Beginning on July 1, 2017, the HCPCS file will include the following new codes:

- **Q9984:**
  - Short Description: Kyleena
  - Long Description: Levonorgestrel-releasing intrauterine contraceptive system (Kyleena), 19.5 mg
  - Type of Service (TOS) Code 9

- **Q9985**
  - Short Description: Inj, hydroxyprogesterone, NOS
  - Long Description: Injection, hydroxyprogesterone caproate, not otherwise specified, 10 mg
  - TOS Code 1, P

- **Q9986**
  - Short Description: Inj, Makena
  - Long Description: Injection, hydroxyprogesterone caproate (Makena), 10 mg
  - TOS Code 1, P

- **Q9988**
  - Short Description: Platelets, pathogen reduced
  - Long Description: Platelets, pathogen reduced, each unit
• TOS Code 9

• Q9989
  • Short Description: Ustekinumab IV Inj, 1 mg
  • Long Description: Ustekinumab, for Intravenous Injection, 1 mg
  • TOS Code 1, P

Also, beginning on July 1, 2017, HCPCS code J1725 (Injection, hydroxyprogesterone caproate, 1 mg) is no longer payable for Medicare.

Make sure your billing staffs are aware of these 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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<td>May 18, 2017</td>
<td>Initial Article Released</td>
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Quarterly Influenza Virus Vaccine Code Update – January 2018

MLN Matters Number: MM10196 Revised Related Change Request (CR) Number: 10196
Related CR Release Date: August 4, 2017 Effective Date: August 1, 2017
Related CR Transmittal Number: R3827CP Implementation Date: January 2, 2018

Note: This article was revised on August 9, 2017, to correctly show in all appropriate places the code of Q2039. In the original article, Q0239 was mistakenly referenced in two places and that is corrected to show Q2039. All other information remains the same.

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 10196, from which this article was developed, provides instructions for payment and edits for the Common Working File (CWF) and the Fiscal Intermediary Shared System (FISS) to include and update new or existing influenza virus vaccine codes. The influenza virus vaccine code set is updated on a quarterly basis. This update will include one new influenza virus vaccine code: 90756. Please make sure your billing staffs are aware of this update.

BACKGROUND

Effective for claims processed with dates of service (DOS) on or after January 1, 2018, influenza virus vaccine code 90756 (Influenza virus vaccine, quadrivalent (cclIV4), derived from cell cultures, subunit, antibiotic free, 0.5mL dosage, for intramuscular use) will be payable by Medicare. This new code will be included on the 2018 Medicare Physician Fee Schedule Database file update and the annual Healthcare Common Procedure Coding System (HCPCS) update.

During the interim period of August 1, 2017, through December 31, 2017, MACs will use code Q2039 (Influenza virus vaccine, not otherwise specified) to handle bills for this new influenza virus vaccine product (Influenza virus vaccine, quadrivalent (cclIV4). Q2039 is already an active code.
The new influenza virus vaccine code 90756 will then be implemented with the January 2018 release for DOS on or after January 1, 2018.

Effective for dates of service on or after August 1, 2017, MACs will use the CMS Seasonal Influenza Vaccines Pricing website 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 Q2039 and 90756.

Medicare will issue further instructions on how to handle claims using Q2039 for the new influenza virus vaccine product between August 1, 2017, and December 31, 2017. MACs will use existing processes to handle these claims.

The new influenza virus vaccine code (90756) is not retroactive to August 1, 2017. Claims will not be accepted for influenza virus vaccine code 90756 between the DOS August 1, 2017, and December 31, 2017. If claims are received in January 2018 with code 90756 for DOS between August 1, 2017, and December 31, 2017, claims will be rejected or returned as unprocessable.

**New Vaccine Description**

**Code 90756** – Long Description: Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, antibiotic free, 0.5mL dosage, for intramuscular use TOS Code: V

- Short Description: CCIIV4 VACC ABX FREE IM
- Medium Description: CCIIV4 VACCINE ANTIBIOTIC FREE 0.5 ML DOS IM USE

**Payment Basis**

Based on reasonable cost, MACs will pay for influenza virus vaccine codes Q2039 and 90756 to:

- Hospitals (Type of Bill 12X and 13X)
- Skilled Nursing Facilities (22X and 23X)
- Home Health Agencies (34X)
- Hospital-based renal dialysis facilities (72X) and
- Critical Access Hospitals (85X)

Based on the lower of the actual charge or 95 percent of the Average Wholesale Price (AWP), MACs will pay for influenza virus vaccine codes Q2039 and 90756 to:

- Indian Service Hospitals (IHS) (12X and 13X)
- IHS Hospices (81X and 82X) and
- IHS Critical Access Hospitals (85X)
- Comprehensive Outpatient Rehabilitation Facilities (CORFs) (75X), and
- Independent RDFs (72X)

**Note:** In all cases, coinsurance and deductible to not apply.

MACS will suspend and manually price claims when the HCPC File rate is blank for:
• IHS Hospitals (12X, 13X), hospices (81X and 82X), and IHS CAHs (85X)
• CORFs (75X) and
• Independent RDFs (72X)

Messages for Denied Claims

MACs will return as unprocessable claims submitted with Q2039 for the DOS January 1, 2018, through July 31, 2018, when code 90756 should have been submitted, using the following messages:

• Claims Adjustment Reason Code (CARC): 181 – “Procedure code was invalid on the date of service.”

• Remittance Advice Remark Code (RARC): N56 – “Procedure code billed is not correct/valid for the services billed or the date of service billed.”

• Group Code: CO (Contractual Obligation)

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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<td>August 7, 2017</td>
<td>Article initially released</td>
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Quarterly Update to the National Correct Coding Initiative (NCCI) Procedure to Procedure (PTP) Edits, Version 23.3, Effective October 1, 2017

MLN Matters Number: MM10183
Related Change Request (CR) Number: CR10183
Related CR Release Date: July 14, 2017
Effective Date: October 1, 2017
Related CR Transmittal Number: R3807CP
Implementation Date: October 2, 2017

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.

PROVIDER ACTION NEEDED

Change Request (CR) 10183 informs the MACs about the update to the National Correct Coding Initiative (NCCI) procedure to procedure edits (PTP). This notice applies to Chapter 23, Section 20.9 of the Medicare Claims Processing Manual. Make sure your billing staffs are aware of these changes.

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) developed the NCCI to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment in Part B claims.

Version 23.3 will include all previous versions and updates from January 1, 1996, to the present. In the past, CCI was organized in two tables: Column 1/Column 2 Correct Coding Edits and Mutually Exclusive Code (MEC) Edits. In order to simplify the use of NCCI edit files (two tables), on April 1, 2012, CMS consolidated these two edit files into the Column One/Column Two Correct Coding edit file. Separate consolidations have occurred for the two practitioner NCCI edit files and the two NCCI edit files used for the Outpatient Code Editor (OCE). It will only be necessary to search the Column One/Column Two Correct Coding edit file for active or previously deleted edits. CMS no longer publishes a Mutually Exclusive edit file on its website for either practitioner or outpatient hospital services, since all active and deleted edits will appear in the single Column One/Column Two Correct Coding edit file on each website. The edits previously contained in the Mutually Exclusive edit file are NOT being deleted but
are being moved to the Column One/Column Two Correct Coding edit file. Refer to the CMS NCCI webpage for additional information at http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html.

The coding policies developed are based on coding conventions defined in the American Medical Association’s Current Procedural Terminology manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practice, and review of current coding practice.

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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Two New “K” Codes for Therapeutic Continuous Glucose Monitors

MLN Matters Number: MM10013 Revised Related Change Request (CR) Number: 10013
Related CR Release Date: May 18, 2017 Effective Date: July 1, 2017
Related CR Transmittal Number: R3775CP Implementation Date: July 3, 2017

Note: This article was revised on May 18, 2017, to reflect the revised CR10013 issued on May 18. 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 TYPE AFFECTED

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

WHAT YOU NEED TO KNOW

Change Request (CR) 10013 provides the two codes for therapeutic Continuous Glucose Monitors (CGM) that will be added to the Healthcare Common Procedure Coding System (HCPCS) code set, effective July 1, 2017. The addition of these codes (K0553 and K0554) will facilitate Durable Medical Equipment (DME) MAC claims processing for therapeutic CGMs. Make sure that your billing staffs are aware of these two new codes.

BACKGROUND

On January 12, 2017, the Centers for Medicare & Medicaid Services (CMS) issued a Ruling (CMS-1682-R), concluding that certain CGM, referred to as therapeutic CGMs, are considered durable medical equipment (DME).

Continuous glucose monitoring systems are considered therapeutic CGMs (and therefore DME), if the equipment:

• Is approved by the Food and Drug Administration for use in place of a blood glucose monitor for making diabetes treatment decisions (for example, changes in diet and insulin dosage)
• Is generally not useful to the individual in the absence of an illness or injury
• Is appropriate for use in the home
• Includes a durable component (a component that CMS determines can withstand repeated use and has an expected lifetime of at least 3 years) that is capable of displaying the trending of the continuous glucose measurements.

To facilitate implementation of this Ruling, the following two codes will be added to the HCPCS code set effective July 1, 2017:

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

The billing jurisdiction for both of these codes will be the DME MAC.

**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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Updated Editing of Always Therapy Services - MCS

MLN Matters Number: MM10176
Related Change Request (CR) Number: 10176

Related CR Release Date: July 27, 2017
Effective Date: January 1, 2018

Related CR Transmittal Number: R3814CP
Implementation Date: January 2, 2018

PROVIDER TYPE AFFECTED

This MLN Matters Article is intended for therapists, physicians, and certain other practitioners billing Medicare Administrative Contractors (MACs) for therapy services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

Change Request (CR) 10176 implements revised editing of Part B “Always Therapy” services to require the appropriate therapy modifier in order for the service to be accurately applied to the therapy cap. CR10176 contains no new policy. Instead, the guidelines presented in the CR improve the enforcement of longstanding, existing instructions. Make sure your billing staffs are aware of these revisions.

BACKGROUND

Services furnished under the Outpatient Therapy (OPT) services benefit – including Speech-Language Pathology (SLP), Occupational Therapy (OT), and Physical Therapy (PT) – are subject to the financial limitations, known as therapy caps, originally required under Section 4541 of the Balanced Budget Act (1997).

There are two such caps. One cap is for PT and SLP services combined and another cap is for OT services. In order to accrue incurred expenses to the correct therapy cap; the use of one of the three therapy modifiers (GN, GO, or GP) is required on a certain set of Healthcare Common Procedure Coding System (HCPCS) codes in order to identify when each OPT service is furnished under an SLP, OT, or PT plan of care, respectively.

Medicare recognizes the services furnished under the OPT services benefit as either “always” or “sometimes” therapy and publishes this list as an Annual Update on the Therapy Services Billing page at https://www.cms.gov/Medicare/Billing/TherapyServices/AnnualTherapyUpdate.html.
On professional claims, each code designated as “always therapy”:

- Must always be furnished under an SLP, OT, or PT plan of care, regardless of who furnishes them; and, as such,
- Must always be accompanied by one of the GN, GO, or GP therapy modifiers.

In addition, several “always therapy” codes have been identified as discipline-specific—requiring the GN modifier for six codes, the GO modifier for four codes, and the GP modifier for four codes, as illustrated in Tables 1-3.

**Table 1: Codes Requiring the “GN” Therapy Modifier**

<table>
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<tr>
<th>Code</th>
<th>CPT Short Descriptor</th>
<th>Therapy Modifier Required</th>
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<tbody>
<tr>
<td>92521</td>
<td>Evaluation of speech fluency</td>
<td>GN</td>
</tr>
<tr>
<td>92522</td>
<td>Evaluate speech production</td>
<td>GN</td>
</tr>
<tr>
<td>92523</td>
<td>Speech sound lang comprehend</td>
<td>GN</td>
</tr>
<tr>
<td>92524</td>
<td>Behavral quality analys voice</td>
<td>GN</td>
</tr>
<tr>
<td>92597</td>
<td>Oral speech device eval</td>
<td>GN</td>
</tr>
<tr>
<td>92607</td>
<td>Ex for speech device rx 1hr</td>
<td>GN</td>
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**Table 2: Codes Requiring the “GO” Therapy Modifier**

<table>
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<tr>
<th>Code</th>
<th>CPT Short Descriptor</th>
<th>Therapy Modifier Required</th>
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</thead>
<tbody>
<tr>
<td>97165</td>
<td>Ot eval low complex 30 min</td>
<td>GO</td>
</tr>
<tr>
<td>97166</td>
<td>Ot eval mod complex 45 min</td>
<td>GO</td>
</tr>
<tr>
<td>97167</td>
<td>Ot eval high complex 60 min</td>
<td>GO</td>
</tr>
<tr>
<td>97168</td>
<td>Ot re-eval est plan care</td>
<td>GO</td>
</tr>
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</table>
Table 3: Codes Requiring the “GP” Therapy Modifier

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<th>Code</th>
<th>CPT Short Descriptor</th>
<th>Therapy Modifier Required</th>
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<tr>
<td>97161</td>
<td>Pt eval low complex 20 min</td>
<td>GP</td>
</tr>
<tr>
<td>97162</td>
<td>Pt eval mod complex 30 min</td>
<td>GP</td>
</tr>
<tr>
<td>97163</td>
<td>Pt eval high complex 45 min</td>
<td>GP</td>
</tr>
<tr>
<td>97164</td>
<td>Pt re-eval est plan care</td>
<td>GP</td>
</tr>
</tbody>
</table>

The following “Always Therapy” HCPCS codes require a GN, GO, or GP modifier, as appropriate. Descriptors for these codes are included as an attachment to CR 10176.

92507 92508 92526 92608 92609 96125 97012 97016 97018 97022 97024 97026 97028 97032 97033 97034 97035 97036 97039 97110 97112 97113 97116 97124 97139 97140 97150 97530 97532 97533 97535 97537 97542 97750 97755 97760 97761 97762 97799 G0281 G0283 G0329

In addition to Therapists in Private Practice (TPPs) – including physical therapists, occupational therapists, and speech-language pathologists – professional claims for OPT services may be furnished by physicians and certain Non-Physician Practitioners (NPPs) – specifically, physician assistants, nurse practitioners, and certified nurse specialists.

All OPT services furnished by TPPs are always considered therapy services, regardless of whether they are designated as “always therapy” or “sometimes therapy.” As such, the appropriate therapy modifier must be included on the claim. However, it may be clinically appropriate for physicians and NPPs to furnish OPT services that have been designated “sometimes therapy” codes outside a therapy plan of care - in these cases, therapy modifiers are not required and claims may be processed without them.

During analyses of Medicare claims data for OPT services, the Centers for Medicare & Medicaid Services (CMS) found that these “always therapy” codes and modifiers are not always used in a correct and consistent manner. CMS found OPT professional claims for “always therapy” codes without the required modifiers. Also, CMS found claims that reported more than one therapy modifier for the same therapy service; for example, both a GP and GO modifier, when only one modifier was allowed.

These claims represent non-compliant billing by TPPs, physicians, and NPPs, and hamper CMS’ ability to properly track the therapy caps and analyze claims data for purposes of Medicare program improvements. The requirements in CR10176 will create new edits for Medicare professional claims processing systems to return claims when “always therapy” codes and the associated therapy modifiers are improperly reported.

Providers should expect the following:
• MACs will return/reject claims which contain an “always therapy” procedure code, but do not also contain the appropriate discipline-specific therapy modifier of GN, GO, or GP.
• MACs will also return/reject claims if any service line on the claim contains more than one occurrence of a GN, GO, or GP therapy modifier.
• MACs who are returning/rejecting such claims will use Group Code CO and Claim Adjustment Reason Code (CARC) 4 on the related remittance advice.

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 October 2017

MLN Matters Number: MM10156 Related Change Request (CR) Number: CR 10156
Related CR Release Date: June 16, 2017 Effective Date: October 1, 2017
Related CR Transmittal Number: R3797CP Implementation Date: October 2, 2017

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

Change Request (CR) 10156 informs MACs about the changes that will be included in the October 2017 quarterly release of the edit module for clinical diagnostic laboratory services. Make sure your billing staffs are aware of these changes.

BACKGROUND

CR 10156 announces the changes that will be included in the October 2017 quarterly release of the edit module for clinical diagnostic laboratory services.

CR 10156 revises several laboratory NCD code lists as follows:
- Add ICD-10-CM code E034, effective 10/1/2016, to the list of ICD-10-CM codes that are covered by Medicare for the Lipids Testing (190.23A) NCD.
- Add ICD-10-CM code E034, effective 10/1/2016, to the list of ICD-10-CM codes that are covered by Medicare for the Lipids Testing (190.23B) NCD.
- Add ICD-10-CM codes D4959 and R9349, effective 10/1/2016, to the list of ICD-10-CM codes that are covered by Medicare for the Human Chorionic Gonadotropin (190.27) NCD.
E103319, E103399, E103419, E103499, E103519, E103529, E103539, E103549, E103559, E103599, E1037X9, E113219, E113299, E113319, E113399, E113419, E113499, E113519, E113529, E113539, E113549, E113559, E1137X9, E133219, E133299, E133319, E133399, E133419, E133499, E133519, E133529, E133539, E133549, E133559, E133599, and E1337X9 from the list of ICD-10-CM codes that are covered by Medicare for the Glycated Hemoglobin/Glycated Protein (190.21) NCD.

- Delete ICD-10-CM code Z8482 from the list of ICD-10-CM codes that are covered by Medicare for the Glycated Hemoglobin/Glycated Protein (190.21) NCD.

**ADDITIONAL INFORMATION**

MACs will not search their files to either retract payment for claims already paid or retroactively pay claims, but they will adjust such 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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ICD-10 Coding Revisions to National Coverage Determinations (NCDs)

MLN Matters Number: MM10086
Related Change Request (CR) Number: 10086

Related CR Release Date: May 26, 2017
Effective Date: October 1, 2017

Related CR Transmittal Number: R1854OTN
Implementation Date: October 2, 2017, shared system edits, July 14, 2017, local edits

PROVIDER TYPE AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 10086 constitutes a maintenance update of International Classification of Diseases, Tenth Revision (ICD-10) conversions and other coding updates specific to National Coverage Determinations (NCDs). These NCD coding changes are the result of newly available codes, coding revisions to NCDs released separately, or coding feedback received. Please make sure your billing staffs are aware of these changes.

BACKGROUND

The translations from International Classification of Diseases, Ninth Revision (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. For these reasons, there may be certain ICD-9 codes that were once considered appropriate prior to ICD-10 implementation that are no longer considered acceptable.

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

CR10086 makes coding and clarifying adjustments to the following NCDs:

- NCD20.29 - Hyperbaric Oxygen (HBO)
- NCD40.7 - Outpatient Intravenous Insulin Therapy
- NCD80.2 - Photodynamic Therapy
- NCD80.2.1 - Ocular Photodynamic Therapy
- NCD80.3 - Photosensitive Drugs
- NCD80.3.1 - Verteporfin
- NCD80.11 - Vitrectomy
- NCD100.1 - Bariatric Surgery
- NCD110.4 - Extracorporeal Photopheresis
- NCD110.23 - Stem Cell Transplantation
- NCD190.3 - Cytogenetic Studies
- NCD190.11 - Home Prothrombin Time/International Normalized Ratio (PT/INR)
- NCD210.13 - Screening for Hepatitis C Virus
- NCD220.4 - Mammograms
- NCD220.6.17 - PET for Solid Tumors
- NCD270.1 - Electrical Stimulation Electromagnetic Therapy for Treatment of Wounds
- NCD20.31, 20.31.1, 20.31.2, 20.31.3 - Intensive Cardiac Rehabilitation


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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<td>June 13, 2017</td>
<td>Initial article released.</td>
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ICD-10 Coding Revisions to National Coverage Determinations (NCDs)

MLN Matters Number: MM10184
Related Change Request Number: 10184
Related CR Release Date: July 27, 2017
Effective Date: January 1, 2018
Related CR Transmittal Number: R1875OTN
Implementation Date: September 13, 2017 for local edits; January 2, 2018 - shared systems

PROPERTY 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.

PROPERTY ACTION NEEDED

Change Request (CR) 10184 outlines edits to International Classification of Diseases, 10th Revision (ICD-10) and other coding updates specific to National Coverage Determinations (NCDs) that will be included in subsequent, quarterly releases as needed. No policy-related changes are included with these updates. Any policy-related changes to NCDs continue to be implemented via the current, long-standing NCD process. The following link provides the NCD spreadsheets included with this CR10184 at https://www.cms.gov/Medicare/Coverage/DeterminationProcess/downloads/CR10184.zip.

BACKGROUND

CR10184 constitutes a maintenance update of ICD-10 conversions and other coding updates specific to NCDs. These NCD coding changes are the result of newly available codes, coding revisions to NCDs released separately, or coding feedback received.

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

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

NOTE: 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. For these reasons, there may be certain ICD-9 codes that were once considered appropriate prior to ICD-10 implementation that are no longer considered acceptable.

CR10084 makes coding and clarifying adjustments to the following NCDs:

- NCD160.18 - Vagus Nerve Stimulation
- NCD210.4.1 - Counseling to Prevent Tobacco Use
- NCD220.6.17 - Positron Emission Tomography (PET) for Solid Tumors
- NCD220.6.20 - PET Beta Amyloid in Dementia/Neurological Disorders
- NCD210.13 - Screening for Hepatitis C Virus

NOTE/CLARIFICATION: MACs will use default Council for Affordable Quality Healthcare Committee on Operating Rules (CAQH CORE) messages where appropriate:

- Remittance Advice Remark Code (RARC) N386 with Claim Adjustment Reason Code (CARC) 50, 96, and/or 119
- See latest CAQH CORE update

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

- Group Code PR (Patient Responsibility) assigning financial responsibility to the beneficiary (if a claim is received with occurrence code 32, or with occurrence code 32 and a GA modifier, indicating a signed 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 INFORMATION

The official instruction issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-
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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“Medicare Benefit Policy Manual” - Chapter 10, Ambulance Locality and Advanced Life Support (ALS) Assessment

MLN Matters Number: MM10110
Related Change Request (CR) Number: 10110
Related CR Release Date: June 16, 2017
Effective Date: September 18, 2017
Related CR Transmittal Number: R236BP
Implementation Date: September 18, 2017

PROVIDER TYPES AFFECTED

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

WHAT YOU NEED TO KNOW

Change Request (CR) 10110 which revises the “Medicare Benefit Policy Manual” (Chapter 10, Sections 10.3.5 and 30.1.1) to clarify the definitions for locality and ground ambulance services for ALS assessment. The term “locality” with respect to ambulance service means the service area surrounding the institution to which individuals normally travel or are expected to travel to receive hospital or skilled nursing services. Your MACs have the discretion to define “locality” in their service areas.

BACKGROUND

CR10110 provides clarifications of the definitions for locality and ground ambulance services for Advanced Life Support (ALS) assessment, and it revises the “Medicare Benefit Policy Manual” to clarify that:

- MACs have the discretion to define “locality” in their service areas.
- If an ALS assessment is performed, the services will be covered at the ALS emergency level if medically necessary and all other coverage requirements are met.

The Centers for Medicare & Medicaid Services (CMS) defines the term “locality” (with respect to ambulance service) as the service area surrounding the institution to which individuals normally travel (or are expected to travel) to receive hospital or skilled nursing services.
EXAMPLE: Mr. A becomes ill at home and requires ambulance service to the hospital. The small community in which he lives has a 35-bed hospital. Two large metropolitan hospitals are located some distance from Mr. A’s community and both regularly provide hospital services to the community’s residents. The community is within the “locality” of both metropolitan hospitals and direct ambulance service to either of these (as well as to the local community hospital) is covered.

ALS assessment is defined in 42 CFR 414.605 as an assessment performed by an ALS crew as part of an emergency response that was necessary because the patient’s reported condition at the time of dispatch was such that only an ALS crew was qualified to perform the assessment.

Note that an ALS assessment does not necessarily result in a determination that the patient requires an ALS level of service.

In the “Medicare Benefit Policy Manual” (Chapter 10, Section 30.1.1), CMS states that in the case of an appropriately dispatched ALS Emergency service, if the ALS crew completes an ALS Assessment, then the services provided by the ambulance transportation service provider or supplier may be covered at the ALS emergency level. This is regardless of whether the patient required ALS intervention services during the transport, provided that ambulance transportation itself was medically reasonable and necessary.

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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Medicare Coverage of Screening for Lung Cancer with Low Dose Computed Tomography (LDCT)

Note: This article was revised on June 12, 2017, to add a paragraph on page 3 to clarify that Independent Diagnostic Testing Facilities (IDTFs) may be eligible facilities. All other information is unchanged.

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) 9246 informs MACs that Medicare covers lung cancer screening with LDCT if all eligibility requirements listed in the National Coverage Determination (NCD) are met. Make sure that your billing staffs are aware of these changes.

Background

Section 1861(ddd)(1) of the Social Security Act (the Act) authorizes the Centers for Medicare & Medicaid Services (CMS) to add coverage of "additional preventive services" through the NCD process. The “additional preventive services” must meet all of the following criteria:

- Be reasonable and necessary for the prevention or early detection of illness or disability;
• Be recommended with a grade of A or B by the United States Preventive Services Task
  Force (USPSTF); and
• Be appropriate for individuals entitled to benefits under Part A or enrolled under Part B.
CMS reviewed the evidence for lung cancer screening with low dose computed tomography
(LDCT) and determined that the criteria listed above were met, enabling CMS to cover this
“additional preventive service” under Medicare Part B.
CMS issued NCD 210.14 on August 21, 2015, that provides for Medicare coverage of screening
for lung cancer with LDCT. Effective for claims with dates of service on and after February 5,
2015, Medicare beneficiaries must meet all of the following criteria:
• Be 55–77 years of age;
• Be asymptomatic (no signs or symptoms of lung cancer);
• Have a tobacco smoking history of at least 30 pack-years (one pack-year = smoking one
  pack per day for one year; 1 pack = 20 cigarettes);
• Be a current smoker or one who has quit smoking within the last 15 years; and,
• Receive a written order for lung cancer screening with LDCT that meets the requirements
described in the NCD.
Written orders for lung cancer LDCT screenings must be appropriately documented in the
beneficiary’s medical record, and must contain the following information:
• Date of birth;
• Actual pack–year smoking history (number);
• Current smoking status, and for former smokers, the number of years since quitting
  smoking;
• A statement that the beneficiary is asymptomatic (no signs or symptoms of lung cancer);
  and,
• The National Provider Identifier (NPI) of the ordering practitioner.
Counseling and Shared Decision-Making Visit
Before the first lung cancer LDCT screening occurs, the beneficiary must receive a written
order for LDCT lung cancer screening during a lung cancer screening counseling and shared
decision-making visit that includes the following elements and is appropriately documented in
the beneficiary’s medical records:
• Must be furnished by a physician (as defined in section 1861(r)(1) of the Act) or qualified
  non-physician practitioner (meaning a Physician Assistant (PA), Nurse Practitioner (NP), or
  Clinical Nurse Specialist (CNS) as defined in section 1861(aa)(5) of the Act); and
• Must include all of the following elements:
  o Determination of beneficiary eligibility including age, absence of signs or symptoms of
    lung cancer, a specific calculation of cigarette smoking pack-years; and if a former
    smoker, the number of years since quitting;
  o Shared decision-making, including the use of one or more decision aids, to include
    benefits and harms of screening, follow-up diagnostic testing, over-diagnosis, false
    positive rate, and total radiation exposure;
Counseling on the importance of adherence to annual lung cancer LDCT screening, impact of co-morbidities, and ability or willingness to undergo diagnosis and treatment;
Counseling on the importance of maintaining cigarette smoking abstinence if former smoker; or the importance of smoking cessation if current smoker and, if appropriate, furnishing of information about tobacco cessation interventions; and,
If appropriate, the furnishing of a written order for lung cancer screening with LDCT.

Written orders for subsequent annual LDCT screens may be furnished during any appropriate visit with a physician or qualified non-physician practitioner (PA, NP, or CNS).

As part of the NCD, all criteria listed in the NCD must be met to include requirements for reading radiologists and radiology imaging facilities. In addition to collecting and submitting data to a CMS-approved registry, all facilities that would like to be eligible to perform the lung cancer screening, including Independent Diagnostic Testing Facilities (IDTFs), must meet all criteria stated in the Decision Memo for Lung Cancer Screening with LDCT, which is available at https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=274. Information regarding CMS-approved registries is posted at: http://www.cms.gov/Medicare/Medicare-General-Information/MedicareApprovedFacilitie/Lung-Cancer-Screening-Registries.html on the CMS website.

Coinsurance and Deductibles

Medicare coinsurance and Part B deductible are waived for this preventive service.

Health Care Common Procedure Coding System (HCPCS) Codes

Effective for claims with dates of service on and after February 5, 2015, the following HCPCS codes are used for lung cancer screening with LDCT:

- G0296 – Counseling visit to discuss need for lung cancer screening (LDCT) using low dose CT scan (service is for eligibility determination and shared decision making)
- G0297 – Low dose CT scan (LDCT) for lung cancer screening

In addition to the HCPCS code, these services must be billed with ICD-10 diagnosis code Z87.891 (personal history of tobacco use/personal history of nicotine dependence), ICD-9 diagnosis code V15.82.

NOTE: Contractors shall apply contractor-pricing to claims containing HCPCS G0296 and G0297 with dates of service February 5, 2015, through December 31, 2015.

Institutional Billing Requirements

Effective for claims with dates of service on and after February 5, 2015, providers may use the following Types of Bill (TOBs) when submitting claims for lung cancer screening, HCPCS codes G0296 and G0297: 12X, 13X, 22X, 23X, 71X (G0296 only), 77X (G0296 only), and 85X.

Medicare will pay for these services as follows:

- Outpatient hospital departments – TOBs 12X and 13X - based on Outpatient Prospective Payment System (OPPS);
• Skilled nursing facilities (SNFs) – TOBs 22X and 23X – based on the Medicare Physician Fee Schedule (MPFS);
• Critical Access Hospitals (CAHs) - TOB 85X – based on reasonable cost;
• CAH Method II – TOB 85X with revenue code 096X, 097X, or 098X based on the lesser of the actual charge or the MPFS (115% of the lesser of the fee schedule amount and submitted charge) for HCPCS G0296 only;
• Rural Health Clinics (RHCs) - TOB 71X - based on the all-inclusive rate for HCPCS G0296 only; and
• Federally Qualified Health Centers (FQHCs) – TOB 77X - based on the PPS rate for HCPCS G0296 only.

NOTE: For outpatient hospital settings, as in any other setting, services covered under this NCD must be ordered by a primary care provider within the context of a primary care setting and performed by an eligible Medicare provider for these services.

Claim Adjustment Reason Codes (CARCs), Remittance Advice Remark Codes (RARCs), Group Codes

MACs will use the following CARCs, RARCs, and Group Codes when denying payment for LDCT lung cancer screening, HCPCS G0296 and G0297:

Submitted on a TOB other than 12X, 13X, 22X, 23X, 71X, 77X, or 85X:

• 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 (if a claim is received with a GZ modifier indicating no signed ABN is on file).
  NOTE: For modifier GZ, MACs will use CARC 50.

For TOBs 71X and 77X when HCPCS G0296 is billed on the same date of service with another visit (this does not apply to initial preventive physical exams for 71X TOBs):

• CARC 97 - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
• RARC M15 - Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
  NOTE: 77X TOBs will be processed through the Integrated Outpatient Code Editor under the current process.
• Group Code CO assigning financial liability to the provider.

Where a previous HCPCS G0297 is paid in history in a 12-month period (at least 11 full months must elapse from the date of the last screening):

• 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. If you do not have web access, you may contact the contractor to request a copy of the NCD.

• Group Code CO assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

NOTE: For modifier GZ, MACs will use CARC 50.

Because the beneficiary is not between the ages of 55 and 77 at the time the service was rendered (line-level):

• CARC 6: “The procedure/revenue code is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.”

• 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).

NOTE: For modifier GZ, MACs will use CARC 50.

Because the claim line was not billed with ICD-10 diagnosis Z87.891:

• 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 assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

NOTE: For modifier GZ, MACs will use CARC 50.

Additional Information

The official instruction, CR9246, consists of two transmittals:
1. Transmittal R3374CP, which updates the “Medicare Claims Processing Manual;” and
2. Transmittal R185NCD, which updates the “Medicare NCD Manual.”

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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<td>June 24, 2016</td>
<td>The article was revised to add a link to a related article <a href="#">MM9540</a>. That article provides an ICD-10 code that has been added for Lung Cancer Screening with Low Dose Computed Tomography (LDCT).</td>
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National Coverage Determination (NCD 20.8.4):
Leadless Pacemakers

MLN Matters Number: MM10117
Related Change Request (CR) Number: 10117
Related CR Release Date: July 28, 2017
Effective Date: January 18, 2017
Related CR Transmittal Number: R201NCD and R3815CP
Implementation Date: August 29, 2017 for local MAC system edits and January 2, 2018 for shared system edits

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 10117 informs MACs that effective January 18, 2017, the Centers for Medicare & Medicaid Services (CMS) covers leadless pacemakers through Coverage with Evidence Development (CED) when procedures are performed in CMS-approved CED studies. Please make your billing staffs aware of this determination.

BACKGROUND

The leadless pacemaker eliminates the need for a device pocket and insertion of a pacing lead which are integral elements of traditional pacing systems. The removal of these elements eliminates an important source of complications associated with traditional pacing systems while providing similar benefits. Leadless pacemakers are delivered via catheter to the heart, and function similarly to other transvenous single-chamber ventricular pacemakers. Prior to January 18, 2017, there was currently no National Coverage Determination (NCD) in effect.

On January 18, 2017, CMS issued an NCD to cover leadless pacemakers through CED. CMS covers leadless pacemakers when procedures are performed in studies approved by the Food and Drug Administration (FDA). CMS also covers, in prospective longitudinal studies, leadless pacemakers that are used in accordance with the FDA-approved label for devices that have either:
An associated ongoing FDA-approved post-approval study; or
Completed an FDA post-approval study.

For such coverage, Medicare will allow payment for claims for dates of service on or after January 18, 2017 for leadless pacemakers through CED when billed with the following CPT codes:

- 0387T – Transcatheter insertion or replacement of permanent leadless pacemaker, ventricular
- 0389T – Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report, leadless pacemaker system.
- 0390T – Peri-procedural device evaluation (in person) and programming of device system parameters before or after surgery, procedure or test with analysis, review and report, leadless pacemaker system.
- 0391T – Interrogation device evaluation (in person) with analysis, review and report, includes connection, recording and disconnection per patient encounter, leadless pacemaker system.

Effective for dates of service on or after January 18, 2017, MACs will allow the following ICD-10 diagnosis codes on claims for leadless pacemakers:

- Z00.6 – Encounter for examination for normal comparison and control in clinical research program.

Effective for dates of service on or after January 18, 2017, contractors shall return claims as unprocessable with the listed procedure codes billed without ICD-10 Z00.6 and use the following messages:

- CARC 16 - Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- RARC M76 - Missing/incomplete/invalid diagnosis or condition

Effective for claims with dates of service on or after January 18, 2017, modifier Q0 – Investigational clinical service provided in a clinical research study that is an approved clinical research study, must also be included.

Effective for dates of service on or after January 18, 2017, MACs will return claims with the procedure codes listed billed without modifier Q0 and use the following messages:

- CARC 4: “The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.”
- RARC N572: This procedure not payable unless appropriate non-payable reporting.
• Group Code – Contractual Obligation (CO).

Remember to include the 8-digit clinical trial identifier on the claim. Effective for claims with dates of service on or after January 18, 2017, MACs will return claims as unprocessable that are billed with the Q0 modifier and do not contain the 8-digit clinical trial identifier in item 23 of the CMS-1500 form or the electronic equivalent. Use the following messages:

• CARC 16: “Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)”
• RARC MA50: Missing/incomplete/invalid Investigational Device Exemption number or Clinical Trial number.
• Group Code – Contractual Obligation (CO).

Effective for dates of service in or after January 18, 2017, MACs shall only pay claims for leadless pacemakers when services are provided in one of the following Places of Service (POS):

• POS 06 – Indian Health Service Provider Based Facility
• POS 21 – Inpatient Hospital
• POS 22 – On Campus-Outpatient Hospital
• POS 26 – Military Treatment Facility

Where the proper POS code is not included and the claim is rejected/denied, the following messaging should be used:

• CARC 58: Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. 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.hhs.gov/mcd/search.asp. If you do have web access, you may contact the contractor to request a copy of the NCD.
• Group Code – Contractual Obligation (CO)

MACs will not search their files for claims for leadless pacemakers with dates of service between January 18, 2017, and the implementation date of CR10117, but may adjust claims that you bring to their attention.

All clinical research study protocols must address pre-specified research questions, adhere to standards of scientific integrity and be reviewed and approved by CMS. Approved studies will be posted to the CMS website at http://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/index.html. The process for submitting a clinical research study to Medicare is outlined in the NCD.

Leadless pacemakers are non-covered outside of CMS-approved studies.

**Note:** This revision to the Medicare NCD Manual is a National Coverage Determination (NCD). NCDs are binding on all carriers, fiscal intermediaries, and MACs with the Federal government.
that review and/or adjudicate claims, determinations, and/or decisions, quality improvement organizations, qualified independent MACs, 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).

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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Percutaneous Image-guided Lumbar Decompression (PILD) for Lumbar Spinal Stenosis (LSS)

MLN Matters Number: MM10089 Revised
Related Change Request (CR) Number: 10089
Related CR Release Date: July 25, 2017
Effective Date: December 7, 2016
Related CR Transmittal Number: R3811CP and R200NCD
Implementation Date: June 27, 2017

Note: This article was revised on July 26, 2017, to reflect the revised CR10089 issued on July 25. In the article, the transmittal numbers, CR release date, implementation date, and the Web addresses for accessing the transmittals are revised. All other information remains the same.

PROVIDER TYPE AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 10089 announces that effective for dates of service on or after December 7, 2016, Medicare will cover Percutaneous Image-guided Lumbar Decompression (PILD) under Coverage with Evidence Development (CED) for beneficiaries with Lumbar Spinal Stenosis (LSS) who are enrolled in a Centers for Medicare & Medicaid Services (CMS)-approved prospective longitudinal study. PILD procedures using an FDA-approved/cleared device that completed a CMS-approved prospective, randomized, controlled clinical trial (RCT) that met the criteria are listed in the January 2014 NCD (CR8757, see related MLN Matters article at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8757.pdf).

BACKGROUND

CMS currently covers PILD under the CED paradigm. PILD is a posterior decompression of the lumbar spine performed under indirect image guidance without any direct visualization of the surgical area. This is a procedure proposed as a treatment for symptomatic LSS unresponsive to conservative therapy. This procedure is generally described as a non-invasive procedure.
using specially designed instruments to percutaneously remove a portion of the lamina and debulk the ligamentum flavum. The procedure is performed under x-ray guidance (for example, fluoroscopic, CT) with the assistance of contrast media to identify and monitor the compressed area via epiduragram.

Section 1862(a)(1)(E) of the Social Security Act (the Act) authorizes coverage for PILD for beneficiaries with LSS under CED. On January 9, 2014, CMS posted its first NCD (150.13) covering PILD for beneficiaries with LSS when provided in a RCT meeting certain conditions under CED. Clinical studies must be designed using current validated and reliable measurement instruments and clinically appropriate comparator treatments for patients randomized to the non-PILD group.

On April 13, 2016, CMS accepted a complete formal request for a reconsideration of the NCD that limited coverage of PILD for LSS to a CMS-approved prospective RCT. After considering the related published literature and public comments as required by Section 1862(l) of the Act, CMS will expand the January 2014 NCD to cover PILD for LSS under CED through a prospective longitudinal study that meets certain criteria listed in Chapter 1, Section 150.13 of the NCD manual (Pub. 100-03). You should refer to Chapter 1, Section 310 of the NCD Manual, as well as Chapter 32, Sections 69 and 330, of the “Medicare Claims Processing Manual” (Pub. 100-04) for more information.

**NOTE:** As mentioned in MM8954, there are 2 distinct procedure codes that are to be used: G0276 only for clinical trials that are blinded, randomized, and controlled, and contain a placebo procedure control arm (use CR 8954 for claims processing instructions), and 0275T for all other approved clinical trials (use CR 8757 for claims processing instructions).

CR 10089 does not replace but rather is in addition to CR 8757 and CR 8954.

**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**

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
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<tr>
<td>June 5, 2017</td>
<td>Initial article released.</td>
</tr>
<tr>
<td>July 26, 2017</td>
<td>The article was revised on July 26, 2017, to reflect the revised CR10089 issued on July 25. In the article, the transmittal numbers, CR release date, implementation date, and the Web addresses for accessing the transmittals are revised. All other information remains the same.</td>
</tr>
</tbody>
</table>

**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.
INFORMATION ON WEBSITE

WPS GHA publishes Local Coverage Determinations (LCDs) on its website: https://www.wpsgha.com/wps/portal/mac/site/policies/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 7877
Madison, WI 53708-8788

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:

<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>J5B/J8B</td>
<td>Coenzyme Q10 Testing</td>
<td>L37193</td>
<td>PATH-044</td>
<td>10/17/2017</td>
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<td>J5B/J8B</td>
<td>Chemotherapy Agents for Non-Oncologic Conditions</td>
<td>A55639</td>
<td>NA</td>
<td>09/16/2017</td>
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<tr>
<td>J5B/J8B</td>
<td>MolDX: APC and MUTYH Gene Testing</td>
<td>L37224</td>
<td>MolDX-024</td>
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<td>J5B/J8B</td>
<td>MolDX: Decision Dx-UM (Uveal Melanoma)</td>
<td>L37210</td>
<td>MolDX-029</td>
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<td>J5B/J8B</td>
<td>MolDX: Oncotype DX® Breast Cancer for DCIS (Genomic Health™)</td>
<td>L37199</td>
<td>MolDX-026</td>
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### July 2017

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<tr>
<td>J5B/J8B</td>
<td>MoIDX: Percepta© Bronchial Genomic Classifier</td>
<td>L37195</td>
<td>MoIDX-025</td>
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<td>J5B/J8B</td>
<td>MoIDX: Prolaris™ Prostate Cancer Genomic Assay for Men with Favorable Intermediate Risk Disease</td>
<td>L37226</td>
<td>MoIDX-034</td>
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<td>MoIDX: Xpresys Lung</td>
<td>L37216</td>
<td>MoIDX-030</td>
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<td>J5B/J8B</td>
<td>Not Otherwise Classified Chemotherapy Agents (NOC)</td>
<td>A55640</td>
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<td>09/16/2017</td>
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**New Article associated with LCD L37205 Chemotherapy Drugs and their Adjuncts and A55639 Chemotherapy Agents for Non-Oncologic Conditions.**

### September 2017

<table>
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<tr>
<th>Contract</th>
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<td>MoIDX: CDH1 Genetic Testing Coding and Billing Guidelines</td>
<td>A55622</td>
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<td>J5B/J8B</td>
<td>MoIDX: Short Tandem Repeat (STR) Markers and Chimerism (codes 81265-81268) Coding and Billing Guidelines</td>
<td>A55621</td>
<td>NA</td>
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### August 2017

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<tr>
<td>J5B/J8B</td>
<td>Chemotherapy Drugs and their Adjuncts with Billing &amp; Coding Guidelines</td>
<td>L35053</td>
<td>HONC-010</td>
<td>09/15/2017</td>
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</table>

**This LCD with Billing & Coding Guidelines are being retired and replaced by a LCD with the same name of Chemotherapy Drugs and their Adjuncts, new LCD ID# L37205 and Associated Articles: A55639 Chemotherapy Agents for Non-Oncologic Conditions, A55640 Not Otherwise Classified Chemotherapy Agents (NOC).**

### 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:

### July 2017

<table>
<thead>
<tr>
<th>Contract</th>
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<tr>
<td>J5B/J8B</td>
<td>Proton Beam Therapy and Billing and Coding Guidelines</td>
<td>L34634</td>
<td>RAD-040</td>
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*65 of 111*
REVIS ED POL ICIES

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):

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September 2017

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<td>J5B/J8B</td>
<td>MoIDX: Corus® CAD Test Coding and Billing Guidelines</td>
<td>A55158</td>
<td>NA</td>
<td>07/01/2017</td>
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</table>

Added the following information based on NCD 20.8.4 Leadless Pacemakers, effective 01/18/2017. Added the following Group 3 Paragraph for coverage of Leadless Pacemakers: Effective for dates of service on or after January 18, 2017, contractors shall cover leadless pacemakers through CED when procedures are performed in CMS-approved CED studies per NCD 20.8.4.

Added the following Group 3 CPT/HCPCS codes:
0387T Transcatheter insertion or replacement of permanent leadless pacemaker, ventricular
0389T Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report, leadless pacemaker system
0390T Peri-procedural device evaluation (in person) and programming of device system parameters before or after surgery, procedure or test with analysis, review and report, leadless pacemaker system
0391T Interrogation device evaluation (in person) with analysis, review and report, includes connection, recording and disconnection per patient encounter, leadless pacemaker system

Added the following Group 3 diagnosis code:
Z00.6 Examination for examination for normal comparison and control in clinical research program

<table>
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<tr>
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<td>J5B/J8B</td>
<td>Category III Codes</td>
<td>L35490</td>
<td>PHYS-084</td>
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<tr>
<td>J5B/J8B</td>
<td>Independent Diagnostic Testing Facilities: Physician Supervision and Technician Requirements</td>
<td>A54953</td>
<td>NA</td>
<td>09/01/2017</td>
</tr>
</tbody>
</table>

Added CPT code:
92540: Basic vestibular evaluation, includes spontaneous nystagmus test with eccentric gaze fixation nystagmus, with record, positional nystagmus test, minimum of 4 positions, with record, optokinetic nystagmus test, bidirectional foveal and peripheral stimulation, with recording, and oscillating tracking test, with recording.
<table>
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<th>Contract</th>
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<td>J5B/J8B</td>
<td>Physician Qualification: Neurologist or Otolaryngologist and Technician Qualification: Audiologist.</td>
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<td>A55640</td>
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<td>CPT/HCPCS Group 1 Code table:</td>
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<td>C9485 Injection, Olaratumab, 10 mg from Group 3 Paragraph J9999/C9485 for Olaratumab (Lartruvo™);</td>
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<td>J3490: Unclassified drugs to support Article Guidance of this document.</td>
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<td>J5B/J8B</td>
<td>Vitamin D Testing</td>
<td>L34658</td>
<td>PATH-032</td>
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<td>Added “obesity” to the list of indications for the measurement of vitamin D levels in the narrative section. Added the following codes to Group 1 for 82306 (Vitamin D; 25 hydroxy):</td>
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<td>• B38.0-B38.89 – Acute pulmonary coccidioidomycosis – Other forms of coccidioidomycosis</td>
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<td>• B39.0-B39.5 – Acute pulmonary histoplasmosis capsulatii – Histoplasmosis duboisi</td>
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<td></td>
<td>• C82.00-C82.99 – Follicular lymphoma grade 1, unspecified site – Follicular lymphoma, unspecified, extranodal and solid organ sites</td>
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<td></td>
<td>• J63.2 – Berylliosis</td>
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<td></td>
<td>• M80.00XA-M80.88XS – Age-related osteoporosis with current pathological fracture, unspecified site – Other osteoporosis with current pathological fracture, vertebrae</td>
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<td></td>
<td>• Z68.30-Z68.45 – Body mass index (BMI) 30.0-30.9, adult - Body mass index (BMI) 70 or greater, adult</td>
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<td>• Z98.0 – Intestinal bypass and anastomosis status</td>
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<td>J5B/J8B</td>
<td>Drug Testing</td>
<td>L34645</td>
<td>PATH-035</td>
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<td>Added F11.23 Opioid dependence with withdrawal to Group 1 Codes.</td>
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<tr>
<td>J5B/J8B</td>
<td>Independent Diagnostic Testing Facilities – Physician Supervision and Technician Requirements</td>
<td>A54953</td>
<td>NA</td>
<td>08/01/2017</td>
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<td>CPT code 74250: X-ray exam of small bowel: Technician Qualification: Removed Physician Only Service and added Certified Radiologic Technologist (ARRT:R.T.-R) and made grammatical corrections.</td>
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<td>A55145 MolDX: BCKDHB Gene Test Coding and Billing Guidelines</td>
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<td>A55147 MolDX: bioTheranostics Cancer TYPE ID®</td>
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<td>A55148 MolDX: BLM Gene Analysis Coding and Billing Guidelines</td>
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<td>A55146</td>
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<td>MolDX: CHD7 Gene Analysis Coding and Billing Guidelines</td>
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<td>MolDX: Mitochondrial Nuclear Gene Tests Coding and Billing Guidelines</td>
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<td>MolDX: Next Generation Sequencing Coding and Billing Guidelines</td>
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<td>A55235</td>
<td>MolDX: Arrhythmogenic Right Ventricular</td>
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### Dysplasia/Cardiomyopathy (ARVD/C) Testing Coding and Billing Guidelines

- A55196 MolDX: Next Generation Sequencing (NGS) and Tier 1 and Tier 2 Coding and Billing Guidelines
- A55135 MolDX: Billing and Coding for Lynch Syndrome Testing Services
- A55245 MolDX: OncoCee™ Billing and Coding Guidelines

The following instructions for claim submission were added:
* 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

### Visual Electrophysiology Testing

- Added the following diagnosis codes to Group 1 for 95930 (Visual Evoked Potential (VEP) testing):
  - H47.521 Disorders of visual pathways in (due to) neoplasm, right side
  - H47.522 Disorders of visual pathways in (due to) neoplasm, left side
  - H53.011 Deprivation amblyopia, right eye
  - H53.012 Deprivation amblyopia, left eye
  - H53.013 Deprivation amblyopia, bilateral
  - H53.021 Refractive amblyopia, right eye
  - H53.022 Refractive amblyopia, left eye
  - H53.023 Refractive amblyopia, bilateral
  - H53.031 Strabismic amblyopia, right eye
  - H53.032 Strabismic amblyopia, left eye
  - H53.033 Strabismic amblyopia, bilateral

### Drug Administration Coding

- Added J3590 bezlotoxumab, Zinplava™. Added subcutaneous injection, 1mg to J3357. Changed J3590 to Q9989 for Ustekinumab, for Intravenous Injection, 1 mg effective 07/1/2017.

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<tr>
<td>J5B/J8B</td>
<td>Drug Administering Coding</td>
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<td>J5B/J8B</td>
<td>Drugs and Biologics (Non-chemotherapy)</td>
<td>INJ-041</td>
<td>L34741</td>
<td>07/01/2017</td>
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Added the following diagnosis codes to Group 2 Table to Proliferative diabetic retinopathy in patients without diabetic macular edema with FDA approval/effective date 04/15/2017. The Group 2 Paragraph now states:

Group 2 Paragraph: J2778 Ranibizumab (Lucentis™), 0.1 mg:
- Neovascular (Wet) Age-Related Macular Degeneration
- Diabetic macular edema
- Proliferative diabetic retinopathy in patients with or without diabetic macular edema.

Group 2 Codes:
E10.3291 Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, right eye
E10.3292 Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, left eye
E10.3293 Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, bilateral
E10.3391 Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, right eye
E10.3392 Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, left eye
E10.3393 Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, bilateral
E10.3491 Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, right eye
E10.3492 Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, left eye
E10.3493 Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, bilateral
E11.3291 Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, right eye
E11.3292 Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, left eye
E11.3293 Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, bilateral
E11.3391 Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, right eye
E11.3392 Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, left eye
E11.3393 Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, bilateral
E11.3491 Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, right eye
E11.3492 Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, left eye
E11.3493 Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, bilateral
E13.3291 Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, right eye
E13.3292 Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, left eye
E13.3293 Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, bilateral
E13.3391 Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, right eye
E13.3392 Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, left eye
E13.3393 Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, bilateral
E13.3491 Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, right eye
E13.3492 Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, left eye
E13.3493 Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, bilateral

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<td>J0178 Aflibercept (Eylea), 1 mg. FDA indications no longer match</td>
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<td>Ranibizumab/Lucentis(J2778) and a separate table (Group 3) added to include the appropriate indications and related diagnosis codes as previously listed in Group 2. No change in coverage in Group 3.</td>
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<td>Group 3 Paragraph: J0178 Aflibercept (Eylea), 1mg</td>
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<td>H35.3220-H35.3223, H35.3230-H35.3233.</td>
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<td>Prior Groups 3-20 have been renumbered to accommodate the new Group 3 for Aflibercept (Eylea).</td>
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<th>L35996</th>
<th>NEURO-016</th>
<th>07/01/2017</th>
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<td>Under Definitions, added the following sentence for clarification: &quot;All time intervals are determined on a rolling basis. For example, the limitation of coverage to five sessions in a year refers to a rolling 12 month period. The year begins with the first session and completes one year later. The next rolling year begins with the first session after completion of the preceding rolling year.&quot;</td>
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<td>In Group 12: removed asterisk for code G61.89 (Other inflammatory polyneuropathies), removed asterisk clarification after Group 12 for code G61.89 (Medical Necessity ICD-10 Codes Asterisk Explanation</td>
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|          | The following instructions for claim submission were added: 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 | |
| J5B/J8B  | MolDX: 9p21 Genotype Test Coding and Billing Guideline | A55138 | NA | 07/01/2017 |
|          | The following instructions for claim submission were added: 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 | |
| J5B/J8B  | MolDX: Afirma™ Assay by Veracyte Update | A55139 | NA | 07/01/2017 |
|          | The following instructions for claim submission were added: 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:  
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  - 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 | |
| J5B/J8B  | MolDX: AlloMap Billing and Coding Guidelines | A55140 | NA | 07/01/2017 |
|          | The following instructions for claim submission were added: 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 | |
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The following instructions for claim submission were added:
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 A claim field/types:
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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 B claim field/types:
- Line SV202-7 for 837I electronic claim
- Block 80 for the UB04 claim form
The following instructions for claim submission were added:
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:
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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:
- Line SV202-7 for 837I electronic claim
- Block 80 for the UB04 claim form

J5B/J8B  MoIDx: BCR-ABL Coding and Billing Guidelines  |  A55233  |  NA  |  07/01/2017
---|---|---|---
The following instructions for claim submission were added:
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

J5B/J8B  MoIDx: CYP2B6 Test Coding and Billing Guidelines  |  A55234  |  NA  |  07/01/2017
---|---|---|---
The following instructions for claim submission were added:
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

J5B/J8B  MoIDx: Genetic Testing for CYP2C19, CYP2D6, CYP2C9, and VKORC1  |  L36398  |  NA  |  07/01/2017
---|---|---|---
Added the following diagnosis codes to Group 1 Paragraph:

ICD-10 Codes that Support Medical Necessity:
Group 1 Paragraph: 81225
Group 1 Codes:
I25.111 Atherosclerotic heart disease of native coronary artery with angina pectoris with documented spasm
I25.118 Atherosclerotic heart disease of native coronary artery with other forms of angina pectoris
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- 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

The following instructions for claim submission were added:
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:
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- Box 19 for paper claim

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- Line SV202-7 for 837I electronic claim
- Block 80 for the UB04 claim form
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|          | • 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               |                 |              |                |
| J5B/J8B | **MolDX: know error® Billing and Coding Guidelines Update** | A55172          | NA           | 07/01/2017     |
|          | The following instructions for claim submission were added: 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               |                 |              |                |
| J5B/J8B | **MolDX: LPA-Aspirin Genotype Coding and Billing Guidelines** | A55173          | NA           | 07/01/2017     |
|          | The following instructions for claim submission were added: 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               |                 |              |                |
| J5B/J8B | **MolDX: LPA-Intron 25 Genotype Coding and Billing Guidelines** | A55174          | NA           | 07/01/2017     |
|          | The following instructions for claim submission were added: 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:  
<p>|          | • Line SV202-7 for 837I electronic claim        |                 |              |                |
|          | • Block 80 for the UB04 claim form               |                 |              |                |</p>
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The following instructions for claim submission were 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 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

| J5B/J8B  | MoIDX: L1CAM Gene Sequencing Coding and Billing Guidelines | A55192 | NA | 07/01/2017 |

The following instructions for claim submission were added:
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

| J5B/J8B  | MoIDX: RPS19 Gene Tests Coding and Billing Guidelines | A55205 | NA | 07/01/2017 |

The following instructions for claim submission were added:
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

| J5B/J8B  | Polysomnography and Other Sleep Studies | L36839 | NEURO-018 | 07/01/2017 |

G. Sleep Center or Laboratory Credentials: reformatted bullet points to left margin.
No change in coverage.

- All centers billing sleep studies must maintain proper certification documentation as defined above.
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<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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<td></td>
<td>• The sleep clinic must be affiliated with a hospital or be under the direction and control of a physician (MD/DO), even though the diagnostic test may be performed in the absence of direct physician supervision. This information must be documented and available upon request.</td>
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<td>• Sleep disorder clinics may at times render therapeutic as well as diagnostic services. Therapeutic services may be covered in a hospital outpatient setting or in a freestanding facility provided they meet the pertinent requirements for the particular type of services and are reasonable and necessary for the patient, and are performed under the direct supervision of a physician. (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 70, D. Coverage of Therapeutic Services).</td>
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</table>
Electronic Data Interchange (EDI)

MEDI CARE REMI T EASY PRINT JULY 2017

The latest version of Medicare Remit Easy Print (MREP) software (version 4.5) is available to download from the CMS website: https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/AccessstoDataApplication/MedicareRemitEasyPrint.html.

This version includes the latest Code Group Information (Codes.ini 3-1-17).

If you are an electronic biller who does not receive Electronic Remittance Advice (ERA) and would like to, please complete a Provider Management of ERA Enrollment at https://edi.wpsic.com/fv/r/6715601400/7596.

If you already receive ERAs and want to try the MREP software, please download the MREP software at http://cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/AccessstoDataApplication/MedicareRemitEasyPrint.html.

If you currently do not have a WPS Submitter ID and want to receive ERA to use in the MREP software, you will need to register in WPS Community Manager to receive a direct WPS Submitter ID and follow the email steps to complete an ERA Authorization Agreement. Please go to the following website to begin: https://communitymanager.wpsic.com:16811/tcm/

At the home page, select Register Here at the bottom of the page.

Once you have your WPS Submitter ID and you are approved for ERA, please download the MREP software at http://cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/AccessstoDataApplication/MedicareRemitEasyPrint.html.

If you have questions about this or any other Medicare electronic billing issue, please contact EDI at:
J5 – (866) 518-3285
J8 – (866) 234-7331

Take advantage of this software. Begin using MREP today.

PC-ACE PRO 32 BILLING SOFTWARE FOR VACCINATION BILLING

WPS GHA has a HIPAA-compliant software product, PC-Ace Pro32, available for vaccination billing. This software has the ability to submit roster billing and will allow you to submit your Medicare claims electronically.

Please review the minimum requirements to ensure you will be able to use PC-Ace.

PC-Ace Pro32 for Windows

Minimum System Requirements
Before you install PC-Ace Pro32 software, your computer must meet these minimum requirements.

- SVGA monitor resolution (800 x 600)
- Windows 8, Windows 7, Vista or XP operating system
- Adobe Acrobat Reader Version 4.0 or later (for overlaid claim printing)

Note: When the Windows "Large Fonts" display setting is enabled, the screen resolution must be 1024 x 768 or higher. The Institutional Claim Form and Professional Claim Form will not display properly at lower screen resolutions.

Software Cost

PC-Ace Pro32 is free to use for Medicare billers. WPS Electronic Data Interchange (EDI) will provide:

- Telephone support
- User Manual updates
- Periodic software updates

PC-Ace Pro32 software can be downloaded from our website.

If you are interested in using this HIPAA compliant software, please contact our EDI hotline at the numbers below. You can also reach our Help desk at the following email address:

EDI Medicare B@wpsic.com
EDI Medicare A@wpsic.com

J5: (866) 518-3285
J8: (866) 234-7331

If you are currently using the PC-Ace Pro32 billing software, you can now download the most current upgrade at http://www.wpsic.com/edi/pcacepro32.shtml.
Claim Status Category and Claim Status Codes Update

MLN Matters Number: MM10043  Related Change Request (CR) # 10043
Related CR Release Date: May 26, 2017  Effective Date: October 1, 2017
Related CR Transmittal Number: R3782CP  Implementation Date: October 2, 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) 10043 informs MACs about system changes to update, as needed, the Claim Status and Claim Status Category Codes used for the Accredited Standards Committee (ASC) X12 276/277 Health Care Claim Status Request and Response and ASC X12 277 Health Care Claim Acknowledgment transactions. Make sure that your billing staffs are aware of these changes.

BACKGROUND

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires all covered entities to use only Claim Status Category Codes and Claim Status Codes approved by the National Code Maintenance Committee in the ASC X12 276/277 Health Care Claim Status Request and Response transaction standards adopted under HIPAA for electronically submitting health care claims status requests and responses. These codes explain the status of submitted claim(s). Proprietary codes may not be used in the ASC X12 276/277 transactions to report claim status. This Recurring Update Notification (RUN) can be found in Chapter 31, Section 20.7.

The National Code Maintenance Committee meets at the beginning of each ASC X12 trimester meeting (January/February, June, and September/October) and makes decisions about additions, modifications, and retirement of existing codes. The Committee has decided to allow the industry 6 months for implementation of newly added or changed codes. The codes sets are available at http://www.wpc-edi.com/reference/codelist/healthcare/claim-status-category-codes/ and http://www.wpc-edi.com/reference/codelist/healthcare/claim-status-codes/.
Included in the code lists are specific details, including the date when a code was added, changed, or deleted. All code changes approved during the June 2017 committee meeting will be posted on these sites on or about July 1, 2017. MACs must complete entry of all applicable code text changes and new codes, and terminate use of deactivated codes by the implementation date of CR 10043.

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

These code changes are to be used in editing of all ASC X12 276 transactions processed on or after the date of implementation and to be reflected in the ASC X12 277 transactions issued on and after the date of implementation of this CR 10043.

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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Implement Operating Rules - Phase III Electronic Remittance Advice (ERA) Electronic Funds Transfer (EFT): CORE 360 Uniform Use of Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC) and Claim Adjustment Group Code (CAGC) Rule - Update from Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE)

MLN Matters Number: MM10041
Related Change Request (CR) Number: 10041
Related CR Release Date: May 26, 2017
Effective Date: October 1, 2017
Related CR Transmittal Number: R3781CP
Implementation Date: October 2, 2017

PROVIDER TYPE AFFECTED

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

PROVIDER ACTION NEEDED

This article is based on Change Request (CR) 10041 which instructs MACs and Medicare’s Shared System Maintainers (SSMs) to update systems based on the CORE 360 Uniform Use of Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC) and Claim Adjustment Group Code (CAGC) Rule publication. These system updates reflect the Committee on Operating Rules for Information Exchange (CORE) Code Combination List for June 2017. Make sure that your billing staff is aware of these changes.

In addition, if you use the PC Print or Medicare Remit Easy Print (MREP) software supplied by your MAC, be sure to obtain the updated version of that software when it is available.
BACKGROUND

The Department of Health and Human Services (DHHS) adopted the Phase III CAQH CORE, EFT and ERA Operating Rule Set that was implemented on January 1, 2014, under the Patient Protection and Affordable Care Act (ACA) of 2010.

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

Through the ACA, Congress sought to promote implementation of electronic transactions and achieve cost reduction and efficiency improvements by creating more uniformity in the implementation of standard transactions. This was done by mandating the adoption of a set of operating rules for each of the HIPAA transactions. The ACA defines operating rules and specifies the role of operating rules in relation to the standards.

Change Request (CR) 10041 deals with the regular update in CAQH CORE defined code combinations per Operating Rule 360 - Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule.

CAQH CORE will publish the next version of the Code Combination List on or about June 10, 2017. This update is based on the CARC and RARC updates as posted at the Washington Publishing Company (WPC) website on or about March 1, 2017. This will also include updates based on Market Based Review (MBR) that CAQH CORE conducts once a year to accommodate code combinations that are currently being used by Health Plans including Medicare as the industry needs them.

You can find CARC and RARC updates at CARC/RARC News and CAQH CORE defined code combination updates at CAQH/CORE News.

Note: Per ACA mandate, all health plans including Medicare must comply with CORE 360 Uniform Use of CARCs and RARCs (835) rule or CORE developed maximum set of CARC/RARC and CAGC combinations for a minimum set of 4 Business Scenarios. Medicare can use any code combination if the business scenario is not one of the 4 CORE defined business scenarios. With the 4 CORE defined business scenarios, Medicare must use the code combinations from the lists published by CAQH CORE.

ADDITIONAL INFORMATION

The official instruction, CR10041, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-
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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Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP), and PC Print Update

MLN Matters Number: MM10040  Related Change Request (CR) Number: 10040
Related CR Release Date: May 26, 2017  Effective Date: October 1, 2017
Related CR Transmittal Number: R3780CP  Implementation Date: October 2, 2017

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) 100040 updates the remittance advice remark code (RARC) and claims adjustment reason code (CARC) lists and also instruct ViPS Medicare System (VMS) and Fiscal Intermediary Shared System (FISS) maintainers to update Medicare Remit Easy Print (MREP) and PC Print. Make sure that your billing staffs are aware of these changes and obtain the updated MREP and PC Print software if they use that software.

BACKGROUND

The Health Insurance Portability and Accountability Act (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, which provide either supplemental explanation for a monetary adjustment or policy information that generally applies to the monetary adjustment, are required in the remittance advice and coordination of benefits transactions.

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

CMS provides a CR as a code update notification indicating when updates to CARC and RARC lists are made available on the Washington Publishing Company (WPC) website. Shared
System Maintainers (SSMs) have the responsibility to implement code deactivation, making sure that any deactivated code is not used in original business messages and allowing the deactivated code in derivative messages. SSMs must make sure that Medicare does not report any deactivated code on or after the effective date for deactivation as posted on the WPC website. If any new or modified code has an effective date past the implementation date specified in the CR, MACs must implement those updates on the date specified on the WPC website, which is at [http://wpc-edi.com/Reference/](http://wpc-edi.com/Reference/).

A discrepancy between the dates may arise as the WPC website is only updated three times per year and may not match the CMS release schedule. For CR10040, the MACs and the SSMs must get the complete list for both CARCs and RARCs from the WPC website to obtain the comprehensive lists for both code sets and determine the changes included on the code list since the last code update CR (CR 9878).

**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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Suppression of the Standard Paper Remittance Advice (SPR) in 45 days if also Receiving Electronic Remittance Advice (ERA)

MLN Matters Number: MM10151
Related Change Request (CR) Number: 10151
Related CR Release Date: August 4, 2017
Effective Date: January 1, 2018
Related CR Transmittal Number: R1890OTN
Implementation Date: January 2, 2018

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

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

BACKGROUND

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

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


**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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Internet Only Manual Update to Pub. 100-04, Chapter 15

MLN Matters Number: MM10143
Related Change Request (CR) Number: 10143
Related CR Release Date: June 23, 2017
Effective Date: July 25, 2017
Related CR Transmittal Number: R3800CP
Implementation Date: July 25, 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

Change Request (CR) 10143 corrects errors in Chapter 15, Section 20.1.4 of the Medicare Claims Processing Manual.

BACKGROUND

CR10143 corrects errors in Chapter 15, Section 20.1.4 of the Medicare Claims Processing Manual. These changes are being made to correct minor typographical errors. No policy, processing, or system changes are anticipated. The change specifies that the year that is associated with the Medicare Modernization Act 2003

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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EDUCATION SCHEDULE

WPS GHA Learning Center

WPS GHA Provider Outreach and Education (POE) has a 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!

A Day with Medicare
09/19/2017 — South Bend, IN — 8:30 am – 4:30 pm ET

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 and keynote speaker
- 12 different breakout sessions
- Question and answer session

Claims

Actions on Claims
10/05/2017 – Overland Park, KS – 9:00 am – 12:00 pm 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, IA — 8:30 am – 11:30 am CT

At the conclusion of this course, you will know what action to take on claims that are not adjudicated, understand the claim reopening and appeals process and identify ways to avoid appeal dismissals and duplicate requests.

CMS-1500 Billing Denials
10/11/2017 — University Center, MI — 8:30 am – 11:30 am 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

We will discuss how to correct and avoid the claim denials including the top reasons claims are unprocessable and provide resources to help you work through those denials.

Don’t Get Wrapped Up in Overlapping Claims (Part B)
10/18/2017 — St. Charles, MO — 1:00 pm - 4:00 pm CT

Some of the topics to be covered include the 3/1 day (72/24 hour) payment window, End Stage Renal Disease (ESRD) Consolidated Billing, Home Health Consolidated Billing, what Place of Service (POS)
Part B providers should use and steps you can take to resolve overlapping claim issues with another provider.

**Focus On: Avoiding Medicare Secondary Payer (MSP) Denials**
- 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, IA — 1:00 pm – 4:00 pm CT

Our agenda will include examining the most common MSP errors, understanding what the denials mean and explore ways to correct and prevent them.

**Focus On: Claim Determinations from Other Contractors**
- 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, IA — 1:00 pm – 4:00 pm CT

Join us as we discuss the role of other contractors, understand their relationship with WPS GHA, and view data showing reasons for denial including ways to avoid them.

**The World of a Claim**
- 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 begin with discussing the necessary information to obtain from the patient and determining who to bill. We will also present a high-level overview of documentation, a summary of the sequence of Medicare claim processing and an overview of Skilled Nursing Facility Consolidated Billing.

**Consolidated Billing**

**An Interactive Day of Skilled Nursing Facility (SNF) Consolidated Billing**
- 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?**
- 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 — 1:00 pm – 4:00 pm CT

Join WPS GHA for a live seminar in which we will identify and discuss Medicare medical review contractors, become familiar with Medicare documentation guidelines and talk over the do’s and don’ts of them. We will also review actual documentation that was considered in coverage determinations.

**Medicare Part B Denials – Are Your Physicians Measuring Up?**
- 10/12/2017 — University Center, MI — 8:30 am – 4:00 pm ET
- 10/26/2017 — Indianapolis, IN — 8:30 am – 4:00 pm ET
- 11/16/2017 — Ankeny, IA — 8:30 am – 4:00 pm CT

In this live session, we will review the most common Part B claim review denials as well as practical documentation strategies to avoid documentation issues for your physician/office.
Physician Documentation for Home Health
11/16/2017 — Overland Park, KS — 9:00 am – 3:30 pm CT

This presentation is a collaboration between WPS GHA, the Medicare Part B contractor and CGS, the Home Health & Hospice contractor. It will include instruction on the face-to-face visit requirement, the certification, recertification, and the supervision currently submitted to Medicare as Care Plan Oversight services and the requirements for the medical record documentation.

Upcoming clinical and denial courses being planned
12/12/2017 and 12/13/2017 – Seattle, WA - 8:30 am – 4:00 pm PT

Watch for more information about these classes! Clinical and billing staff will host seminars for all provider types that will analyze current medical review and payment issues occurring in your area and discuss ways to keep them from happening to you.

Important Notice Regarding Seminar Materials

In an effort to adopt consistent industry trends, 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 within the course in the Learning Center.

MEDI CARE LEAR NI 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/Physician-Center.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.
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.

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

MLN Matters Number: MM10071 Revised Related Change Request (CR) # 10071
Related CR Release Date: August 2, 2017 Effective Date: July 1, 2017
Related CR Transmittal Number: R3824CP Implementation Date: July 3, 2017

Note: This article was revised on August 3, 2017, to reflect an updated Change Request (CR). That CR updated the policy section on complex rehabilitative power wheelchair accessories & seat and back cushions (page 2 of this article). The CR release date, transmittal number and link to the CR was also changed. All other information is the same.

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

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**

Suppliers should continue to use the KU modifier when billing for wheelchair accessories and seat and back cushions furnished in connection with Group 3 complex rehabilitative power wheelchairs (codes K0848 through K0864) with dates of service on or after July 1, 2017. The fee schedule amounts associated with the KU modifier were not adjusted using information from the competitive bidding program in accordance with Section 2 of Patient Access and Medicare Protection Act (PAMPA) for dates of service January 1, 2016 through December 31, 2016. Section 16005 of the 21st Century Cures Act then extended the effective date through June 30, 2017. Effective for dates of service on or after July 1, 2017, taking into consideration the exclusion at section 1847(a)(2)(A) of the Social Security Act, the policy for these items is revised. As a result, payment for these items furnished in connection with a Group 3 complex rehabilitative power wheelchair and billed with the KU modifier will be based on the unadjusted fee schedule amounts updated in accordance with section 1834(a)(14) of the Act. The list of HCPCS codes associated with the KU modifier is available in Transmittal 3713, CR 9966, dated February 3, 2017. The updated DMEPOS fee schedule files have been released.
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/](https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/).

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<td>August 2, 2017</td>
<td>The article was revised on August 3, 2017, to reflect an updated CR. That CR updated the policy section on complex rehabilitative power wheelchair accessories &amp; seat and back cushions (page 2 of this article). The CR release date, transmittal number and link to the CR were also changed.</td>
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MCS Implementation of the Restructured Clinical Lab Fee Schedule

MLN Matters Number: MM10057 Related Change Request (CR) Number: CR10057
Related CR Release Date: May 12, 2017 Effective Date: January 1, 2018
Related CR Transmittal Number: Implementation Date: January 2, 2018
R1846OTN

Note: This article was revised on July 18, 2017, to add a reference to a related MLN Matters Article, MM9837. MM9837 informs MACs about the changes to the Fiscal Intermediary Shared System (FISS) to incorporate the revised CLFS, containing the National fee schedule rates. All other information is unchanged.

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 10057 instructs Medicare's Multi-Carrier System (MCS) maintainer to incorporate into the shared system, the revised Clinical Lab Fee Schedule (CLFS) containing the National fee schedule rates. Make sure 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 clinical laboratory fee schedule (CLFS). The Centers for Medicare & Medicaid Services (CMS) published Final Rule 81 FR 41035, pages 41035-41101 on June 23, 2016, which implemented the provisions of the new legislation.

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 were required to submit data to CMS which describes negotiated payment rates with private payers for any corresponding volumes of tests on the CLFS. 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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October 2017 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions To Prior Quarterly Pricing Files

MLN Matters Number: MM10187  
Related Change Request (CR) Number: 10187

Related CR Release Date: July 21, 2017  
Effective Date: October 1, 2017

Related CR Transmittal Number: R3809CP  
Implementation Date: October 2, 2017

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

Change Request (CR) 10187 instructs MACs to download and implement the October 2017 and, if released, the revised July 2017, April 2017, January 2017, and October 2016, ASP drug pricing files for Medicare Part B drugs via the Centers for Medicare & Medicaid Services (CMS) Data Center (CDC). Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after October 1, 2017, with dates of service October 1, 2017, through December 31, 2017. Make sure your billing staffs are aware of these changes.

BACKGROUND

The ASP methodology is based on quarterly data submitted to the 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 Outpatient Prospective Payment System (OPPS) are incorporated into the Outpatient Code Editor (OCE) through separate instructions available in Chapter 4, section 50 of the Medicare Claims Processing Manual, at [https://www.cms.gov/regulations-and-Guidance/Guidance/Manuals.downloads/clm104c04.pdf](https://www.cms.gov/regulations-and-Guidance/Guidance/Manuals.downloads/clm104c04.pdf).

- File: October 2017 ASP and ASP NOC -- Effective Dates of Service: October 1, 2017, through December 31, 2017
• File: July 2017 ASP and ASP NOC -- Effective Dates of Service: July 1, 2017, through September 30, 2017
• File: April 2017 ASP and ASP NOC -- Effective Dates of Service: April 1, 2017, through June 30, 2017
• File: January 2017 ASP and ASP NOC -- Effective Dates of Service: January 1, 2017, through March 31, 2017
• File: October 2016 ASP and ASP NOC -- Effective Dates of Service: October 1, 2016, through December 31, 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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Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - July CY 2017 Update

MLN Matters Number: MM10104
Related Change Request (CR) Number: 10104
Related CR Release Date: May 12, 2017
Effective Date: January 1, 2017
Related CR Transmittal Number: R3772CP
Implementation Date: July 3, 2017

PROVIDER TYPE 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.

PROVIDER ACTION NEEDED

Change Request (CR) 10104 informs MACs about the release of payment files based upon the calendar year (CY) 2017 Medicare Physician Fee Schedule (MPFS) Final Rule. 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. Section 1848(c)(4) of the Social Security Act authorizes the Secretary to establish ancillary policies necessary to implement relative values for physicians’ services.

Following is a summary of the changes for the July update to the 2017 MPFSDB.

Effective for dates of service (DOS) on and after January 1, 2017, except as noted otherwise.

<table>
<thead>
<tr>
<th>CPT/HCPCS</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>20245</td>
<td>Global Days = 000</td>
</tr>
<tr>
<td>52441</td>
<td>Endo Base = 52000</td>
</tr>
<tr>
<td>64897</td>
<td>Co-Surgery = 1</td>
</tr>
<tr>
<td>64902</td>
<td>Co-Surgery = 1</td>
</tr>
<tr>
<td>J1725</td>
<td>Status = I, effective for DOS on or after July 1, 2017</td>
</tr>
<tr>
<td>P9072</td>
<td>Status = I, effective for DOS on or after July 1, 2017</td>
</tr>
</tbody>
</table>
The following new codes have been added to the HCPCS file effective May 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).

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>0004U</td>
<td>Nfct ds dna 27 resist genes</td>
<td>Infectious disease (bacterial), DNA, 27 resistance genes, PCR amplification and probe hybridization in microarray format (molecular detection and identification of AmpC, carbapenemase and ESBL coding genes), bacterial culture colonies, report of genes detected or not detected, per isolate</td>
</tr>
<tr>
<td>0005U</td>
<td>Onco prst8 3 gene ur alg</td>
<td>Oncology (prostate) gene expression profile by real-time RT-PCR of 3 genes (ERG, PCA3, and SPDEF), urine, algorithm reported as risk score</td>
</tr>
</tbody>
</table>

The following new codes from CR 10107 have also been added to the MPFSDB effective July 1, 2017 (see MLN Matters article MM10107 (when it is available) for code descriptions and additional information):

<table>
<thead>
<tr>
<th>CODE</th>
<th>ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q9984</td>
<td>Procedure Status = N; there are no RVUs, payment policy indicators do not apply</td>
</tr>
<tr>
<td>Q9985</td>
<td>Procedure Status = E; there are no RVUs, payment policy indicators do not apply</td>
</tr>
<tr>
<td>Q9986</td>
<td>Procedure Status = E; there are no RVUs, payment policy indicators do not apply</td>
</tr>
<tr>
<td>Q9988</td>
<td>Procedure Status = X; there are no RVUs, payment policy indicators do not apply</td>
</tr>
<tr>
<td>Q9989</td>
<td>Procedure Status = E; there are no RVUs, payment policy indicators do not apply</td>
</tr>
</tbody>
</table>
The following new HCPCS and CPT Category III codes have been added effective July 1, 2017.

<table>
<thead>
<tr>
<th>Code</th>
<th>Modifier</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>MPFSDB Indicator Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q9987</td>
<td></td>
<td>Pathogen test for platelets</td>
<td>Pathogen(s) test for platelets</td>
<td>Procedure Status X; there are no RVUs, payment policy indicators do not apply.</td>
</tr>
<tr>
<td>0469T</td>
<td></td>
<td>Rta polarize scan oc scr bi</td>
<td>Retinal polarization scan, ocular screening with on-site automated results, bilateral</td>
<td>Procedure Status N; there are no RVUs, payment policy indicators do not apply.</td>
</tr>
<tr>
<td>0470T</td>
<td>TC, 26</td>
<td>Oct skn img acquisj i&amp;r 1st</td>
<td>Optical coherence tomography (OCT) for microstructural and morphological imaging of skin, image acquisition, interpretation, and report; first lesion</td>
<td>Procedure Status C; PC/TC indicator 1; there are no RVUs, no other payment policy indicators apply.</td>
</tr>
<tr>
<td>0471T</td>
<td>TC, 26</td>
<td>Oct skn img acquisj i&amp;r addl</td>
<td>Optical coherence tomography (OCT) for microstructural and morphological imaging of skin, image acquisition, interpretation, and report; each additional lesion (List separately in addition to code for primary procedure)</td>
<td>Procedure Status C; PC/TC indicator 1; there are no RVUs, no other payment policy indicators apply.</td>
</tr>
<tr>
<td>0472T</td>
<td></td>
<td>Prgrmg io rta eltrd ra</td>
<td>Device evaluation, interrogation, and initial programming of intra-ocular retinal electrode array (eg, retinal prosthesis), in person, with iterative adjustment of the implantable device to test functionality, select optimal permanent programmed values with analysis, including visual training, with review and report by a qualified health care professional</td>
<td>Procedure Status C; there are no RVUs, payment policy indicators do not apply.</td>
</tr>
<tr>
<td>Code</td>
<td>Modifier</td>
<td>Short Descriptor</td>
<td>Long Descriptor</td>
<td>MPFSDB Indicator Information</td>
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<td>--------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>0473T</td>
<td></td>
<td>Reprgrmg io rta eltrd ra</td>
<td>Device evaluation and interrogation of intra-ocular retinal electrode array (eg, retinal prosthesis), in person, including reprogramming and visual training, when performed, with review and report by a qualified health care professional</td>
<td>Procedure Status C; there are no RVUs, payment policy indicators do not apply.</td>
</tr>
<tr>
<td>0474T</td>
<td></td>
<td>Insj aqueous drg dev io rsvr</td>
<td>Insertion of anterior segment aqueous drainage device, with creation of intraocular reservoir, internal approach, into the supraciliary space</td>
<td>Procedure Status C; there are no RVUs, payment policy indicators do not apply.</td>
</tr>
<tr>
<td>0475T</td>
<td></td>
<td>Rec ftl car sgl 3 ch i&amp;r</td>
<td>Recording of fetal magnetic cardiac signal using at least 3 channels; patient recording and storage, data scanning with signal extraction, technical analysis and result, as well as supervision, review, and interpretation of report by a physician or other qualified health care professional</td>
<td>Procedure Status C; there are no RVUs, payment policy indicators do not apply.</td>
</tr>
<tr>
<td>0476T</td>
<td></td>
<td>Rec ftl car sgl elec tr data</td>
<td>Recording of fetal magnetic cardiac signal using at least 3 channels; patient recording, data scanning, with raw electronic signal transfer of data and storage</td>
<td>Procedure Status C; there are no RVUs, payment policy indicators do not apply.</td>
</tr>
<tr>
<td>0477T</td>
<td></td>
<td>Rec ftl car sgl xrtj alys</td>
<td>Recording of fetal magnetic cardiac signal using at least 3 channels; signal extraction, technical analysis, and result</td>
<td>Procedure Status C; there are no RVUs, payment policy indicators do not apply.</td>
</tr>
<tr>
<td>Code</td>
<td>Modifier</td>
<td>Short Descriptor</td>
<td>Long Descriptor</td>
<td>MPFSDB Indicator Information</td>
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<td>------------------------------</td>
</tr>
<tr>
<td>0478T</td>
<td>Rec ftl car 3 ch rev i&amp;r</td>
<td>Recording of fetal magnetic cardiac signal using at least 3 channels; review, interpretation, report by physician or other qualified health care professional</td>
<td>Procedure Status C; there are no RVUs, payment policy indicators do not apply.</td>
<td></td>
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**ADDITIONAL INFORMATION**


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WPS GHA PROVIDER SERVICES

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<td>P.O. Box 8580</td>
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<tr>
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<td>Madison, WI 53708-8580</td>
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<td>(866) 234-7331</td>
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