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Claims Processing Actions to Implement Certain Provisions of the Bipartisan Budget Act of 2018

MLN Matters Number: MM10531 Revised  Related Change Request (CR) Number: 10531
Related CR Release Date: April 4, 2018  Effective Date: January 1, 2018
Related CR Transmittal Number: R2051OTN  Implementation Date: April 2, 2018 – date to begin reprocessing claims

Note: This article was revised on April 5, 2018, to reflect a revised CR10531, which was revised on April 4 to include page 2 of Attachment B - Rural Add on Rate Tables. In the article, the CR release date, transmittal number, and the Web address for CR10531 are revised. All other information remains the same.

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.

WHAT YOU NEED TO KNOW

Change Request (CR) 10531 provides direction to MACs to reprocess claims related to several provisions of the Bipartisan Budget Act of 2018, referred to as Medicare Extenders. Specifically, the CR provides guidance to MACs regarding Medicare Fee For Service (FFS) claims reprocessing requirements and timeframes. Make sure your billing staffs are aware of these changes.

BACKGROUND

On February 9, 2018, Congress passed the Bipartisan Budget Act of 2018 which contains a number of provisions that extend certain Medicare FFS policies, including Ambulance add-on payment provisions, the Work Geographic Practice Cost Index (GPCI) Floor, and the three percent Home Health (HH) Rural Add-on Payment. In addition, the Act permanently repeals the outpatient therapy caps beginning on January 1, 2018, while retaining the requirement to submit the KX modifier for services in excess of the prior cap amounts. Due to the retroactive effective dates of these provisions, your MAC will reprocess various Medicare FFS claims impacted by this legislation.

Section 421(a) of the Medicare Modernization Act (MMA), as amended by Section 50208 of the Social Security Act, provides an increase of 3 percent of the payment amount otherwise made
under Section 1895 of the Social Security Act for home health services furnished in a rural area (as defined in Section 1886(d)(2)(D) of the Act), with respect to episodes and visits ending on or after April 1, 2010, and before January 1, 2019. The statute waives budget neutrality related to this provision.

As a result of the Work GPCI floor changes, certain Federally Qualified Health Center (FQHC) Geographic Adjustment Factors (GAFs) will change, which may result in a change to some FQHC payments. For Inpatient Prospective Payment System (IPPS) hospitals, temporary changes to the low-volume hospital payment adjustment and the Medicare-Dependent Hospital (MDH) program have been extended. In addition, for the Long-Term Care Hospital Prospective Payment (LTCH PPS), the blended payment rate for site neutral payment rate cases is extended for certain LTCH hospital discharges. Separate instructions addressing these payment updates are forthcoming.

On January 25, 2018, the Centers for Medicare & Medicaid Services (CMS) instructed MACs to release for processing held therapy claims with the KX modifier with dates of receipt January 1-10, 2018, CMS also instructed the MACs to institute a “rolling hold” for all new therapy claims with the KX modifier. On February 12, 2018, CMS provided direction regarding new Medicare Physician Fee Schedule (MPFS) files and abstract files due to the extension of the Work GPCI Floor, as well as a revised 2018 Ambulance Fee Schedule (AFS) file. CMS also instructed the MACs to ensure legislative effective indicators were set correctly in Medicare systems to apply therapy policies. Given that legislation has been enacted, CMS is instructing the MACs to reprocess affected claims that were processed using the previous MPFS files.

As stipulated in Section 421(a) of the MMA, the 3 percent rural add-on is applied to the national, standardized episode rate, national per-visit payment rates, Low-Utilization Payment Adjustment (LUPA) add-on payments, and the Non-Routine Supplies (NRS) conversion factor when home health services are provided in rural (non-CBSA) areas for episodes and visits ending on or after April 1, 2010, and before January 1, 2019. Refer to Tables 1 through 4 of the attachment to CR10531 for the Calendar Year (CY) 2018 rural payment rates. CR10531 is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R2047OTN.pdf.

Section 1848(e)(1)(E) of the Social Security Act stipulates that after calculating the work geographic index for purposes of MPFS payment for services furnished, the Secretary shall increase the work geographic index to 1.00 for any locality for which such work geographic index is less than 1.00. This provision expired on December 31, 2017, and the locality-specific anesthesia conversion factors for CY 2018 were calculated without this work geographic index floor of 1.00 in place.

Section 50201 of the Bipartisan Budget Act of 2018 restored the work geographic index floor of 1.00 and retroactively dated this restoration to January 1, 2018. In accordance with the law, CMS has updated the locality-specific anesthesia conversion factors for CY 2018 to include the work geographic index floor of 1.00. These updated locality-specific anesthesia conversion factors also have a retroactive effective date of January 1, 2018.

CR10531 reminds the MACs to be aware that Section 1848(b)(4) of the Social Security Act
limits MPFS payment for the technical portion of most imaging procedures to the amount paid under the Outpatient Prospective Payment System (OPPS) system. This policy applies to the technical component (and technical portion of global payment) of imaging services, including X-ray, ultrasound, nuclear medicine, MRI, CT, and fluoroscopy services. The MPFS payment rates for some of these services does not reflect the most recent updates to the OPPS rates that were updated in December of 2017. CMS corrected these rates in new MPFS files and informed the MACs of the corrections on February 12, 2018. These MPFS files also contain the updates for the GPCI. This correction is unrelated to the passage of this Act, but CMS is taking the opportunity to address this issue now since new MPFS files are required as a result of the Act.

The instructions to the MACs to reprocess claims contain the following specifics:

- The MACs will reprocess therapy claims with the KX modifier containing Dates of Service in Calendar Year 2018, which were denied prior to the implementation of the updated legislative effective dates issued on January 25, 2018. NOTE: For institutional claims, these claims will include revenue codes 042x, 043x, or 044x and modifiers GN, GO, or GP.
- The MACs will reprocess therapy claims with the KX modifier which were denied due to an invalid date provided by CMS on February 12, 2018.
- The MACs will reprocess 2018 therapy claims which cannot be automatically reprocessed only if you bring such claims to the attention of your MAC.
- The MACs reprocess MPFS claims for localities and States impacted by the Work GPCI Floor fee increase for Dates of Service in CY 2018. Please refer to the chart in Attachment A - Localities and States Impacted by the Work GPCI Floor – 2018 – in CR10531.
- The MACs will reprocess 2018 MPFS claims for localities and States impacted by the Work GPCI Floor fee increase for Dates of Service in CY 2018 which cannot be automatically reprocessed only if you bring such claims to your MAC’s attention. Please refer to the chart in Attachment A - Localities and States Impacted by the Work GPCI Floor – 2018.
- The MACs will reprocess ground AFS claims using the revised 2018 AFS file for Dates of Service in Calendar Year 2018.
- The MACs will reprocess claims which cannot be automatically reprocessed only if you bring such claims to your MAC’s attention.
- MACs will reprocess home health claims with the following criteria:
  - Type of Bill 32X
  - Claim “Through” dates on or after January 1, 2018
  - Value code 61 amounts in the range 999xx
  - Receipt dates prior to the installation of the revised home health Pricer, which reflects the extension of the 3% rural add-on for CY 2018.
- MACs will automatically reprocess claims impacted by the OPPS cap for Dates of Service in Calendar Year 2018. The MACs will reprocess claims which cannot be automatically reprocessed only if you bring such claims to your MAC’s attention.
- The MACs will automatically reprocess anesthesia claims for localities and States impacted by the Work GPCI Floor fee increase for Dates of Service in CY 2018. Please refer to the chart in Attachment A - Localities and States Impacted by the Work GPCI
Floor – 2018. The MACs will reprocess claims which cannot be automatically reprocessed only if you bring such claims to your MAC’s attention.

- MACs shall ensure all reprocessing actions have been initiated within 6 months of the issuance of CR10531:
  - For therapy and MPFS adjustments
  - For ground ambulance service claims with a date of service on or after 1/1/2018
  - For OPPS adjustments
  - For anesthesia adjustments

- MACs shall ensure all reprocessing actions have been initiated within 6 months of the implementation date of the Pricer for HH rural add-on adjustments.

**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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Adjustments to Qualified Medicare Beneficiary (QMB) Claims Processed Under CR 9911

MLN Matters Number: MM10494
Related Change Request (CR) Number: CR10494
Related CR Release Date: March 16, 2018
Effective Date: December 20, 2018, for Part B MAC claims and September 20, 2018, for Part A and DME MAC claims
Related CR Transmittal Number: R2042OTN
Implementation Date: December 20, 2018, for Part B MAC claims and September 20, 2018, for Part A and DME MAC claims

PROVIDER TYPE AFFECTED

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

PROVIDER ACTION NEEDED

This article is based on Change Request (CR) 10494 which directs MACs to mass adjust QMB claims impacted by CR9911. (An article related to CR9911 is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm9911.pdf.) Make sure that your billing staff is aware of these upcoming claims adjustments.

BACKGROUND

CR9911 incorporates claims processing system modifications implemented on October 2, 2017, to generate QMB information in Remittance Advises (RAs) and Medicare Summary Notices. Providers may use RAs to bill State Medicaid Agencies and other secondary payers outside the Coordination of Benefits Agreement (COBA) crossover process, but CR9911 RAs lacked the formatting and specificity that States require to process QMB cost-sharing claims.

To address these issues, on December 8, 2017, the Centers for Medicare & Medicaid Services (CMS) temporarily suspended the CR9911 claims processing system modifications. See “QMB Remittance Advice Issue” at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MM9911Update112017.pdf.
Through CR10433, CMS will reintroduce QMB information in the RA starting July 2018 and modify CR9911 to avoid disrupting claims processing by secondary payers. CR10433 will be effective for claims processed on or after July 2, 2018. A related article is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm10433.pdf.

Under CR10494, MACs will initiate non-monetary mass adjustments for claims impacted by CR 9911 QMB RA changes, which include claims that were paid after October 2, 2017 and up to December 31, 2017, and that have not been voided or replaced. MACs will issue replacement RAs without the CR 9911 changes and re-process QMB cost-sharing claims by secondary payers by December 20, 2018, for Part B/MAC claims and by September 20, 2018, for Part A/MAC and Durable Medical Equipment MAC claims.

Providers may use the new RAs to resubmit State Medicaid QMB cost-sharing claims that States initially failed to pay due to CR 9911 QMB RA changes. To avoid duplicate claims, providers should not resubmit claims that secondary payers successfully processed through direct claims submission or the COBA process.

Note that although mass-adjusted claims may not cross over, this solution targets affected providers who attempted to bill supplemental payers directly using CR9911 QMB RAs because their QMB cost-sharing claims either did not cross over or crossed over to supplemental payers but failed to process. The goal is to produce replacement Medicare RAs that providers can submit to supplemental payers to coordinate benefits as necessary.

Make sure your billing staff is 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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Appropriate Use Criteria for Advanced Diagnostic Imaging – Voluntary Participation and Reporting Period - Claims Processing Requirements – HCPCS Modifier QQ

MLN Matters Number: MM10481 Related Change Request (CR) Number: 10481
Related CR Release Date: March 2, 2018 Effective Date: July 1, 2018
Related CR Transmittal Number: R2040OTN Implementation Date: July 2, 2018

PROVIDER TYPE AFFECTED

This MLN Matters Article is intended for physicians, facilities and other practitioners billing Part B services to Medicare Administrative Contractors (MACs) for advanced diagnostic imaging provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

Change Request (CR) 10481 informs the MACs of the appropriate Healthcare Common Procedure Coding System (HCPCS) modifier (QQ) that may be reported on the same claim line as the Current Procedural Terminology (CPT) code for an advanced diagnostic imaging service that is furnished in an applicable setting and paid for under an applicable payment system.

BACKGROUND

The Protecting Access to Medicare Act (PAMA) of 2014, Section 218(b), established a new program to increase the rate of appropriate advanced diagnostic imaging services provided to Medicare beneficiaries. Examples of such advanced imaging services include computerized tomography, positron emission tomography, nuclear medicine, and magnetic resonance imaging. Under this program, at the time a practitioner orders an advanced imaging service for a Medicare beneficiary, he/she will be required to consult a qualified Clinical Decision Support Mechanism (CDSM). CDSMs are the electronic portals through which practitioners access appropriate use criteria (AUC) during the patient workup. The CDSM will provide the ordering professional with a determination of whether the order adheres, or does not adhere, to AUC, or if there is no AUC applicable. A list of qualified CDSMs is available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Appropriate-Use-Criteria-Program/index.html.
A consultation must take place for an applicable imaging service ordered by an ordering professional that would be furnished in an applicable setting and paid under an applicable payment system. Please note that the applicable setting is where the imaging service is furnished, not the setting where the imaging service is ordered.

Applicable settings include physician offices, hospital outpatient departments (including emergency departments), ambulatory surgical centers, and any other provider-led outpatient setting determined appropriate by the Secretary of Health and Human Services (at this time, no other settings have been identified). Applicable payment systems include the physician fee schedule (PFS), the hospital outpatient prospective payment system (OPPS), and the ambulatory surgical center payment system.

When this program is more fully implemented (expected January 1, 2020), consultation with a qualified CDSM will be required and detailed information regarding the ordering professional’s consultation must be appended to the furnishing professional’s claim. This includes the ordering practitioner’s National Provider Identifier (NPI) and documenting which CDSM was consulted (there are multiple qualified CDSMs available). The Centers for Medicare and Medical Services (CMS) does not have guidance at this time regarding what the claims-based reporting requirements will be in 2020. In addition, this program will include exceptions to consulting CDSMs that include:

1. The ordering professional having a significant hardship,
2. Situations in which the patient has an emergency medical condition, or,
3. An applicable imaging service ordered for an inpatient, and for which payment is made under Part A.

Ultimately, this program will result in identified outlier ordering professionals being subject to prior authorization.

Regulatory language for this program is in 42 Code of Federal Regulation 414.94 titled Appropriate Use Criteria for Advanced Diagnostic Imaging Services. In the calendar year 2018 PFS final rule, CMS stated that the program would begin with a voluntary participation period. During this period, ordering professionals may choose to consult qualified CDSMs; and furnishing professionals may choose to report limited consultation information on their Medicare claims.

Effective July 1, 2018, HCPCS modifier QQ (Ordering Professional Consulted A Qualified Clinical Decision Support Mechanism For This Service And The Related Data Was Provided To The Furnishing Professional) is available for this reporting. The modifier may be:

- Used when the furnishing professional is aware of the result of the ordering professional’s consultation with a CDSM for that patient,
- Reported on the same claim line as the CPT code for an advanced diagnostic imaging service furnished in an applicable setting and paid for under an applicable payment system, and,
- Reported on both the facility and professional claim.
You should be aware that, effective for claims with dates of service on or after July 1, 2018, your MACs will accept the new QQ modifier on the same claim line as any CPT codes that fall within the ranges shown below.

Please note that the QQ modifier may also appear on the same claim line as a CPT code that falls outside the range; and, until further notice, MACs will continue to pay claims for services within, or outside, the CPT code range shown below regardless of the presence of the QQ modifier.

**Magnetic Resonance Imaging**
70336, 70540, 70542, 70543, 70544, 70545, 70546, 70547, 70548, 70549, 70551, 70552, 70553, 70554, 70555, 71550, 71551, 71552, 71555, 72141, 72142, 72146, 72147, 72148, 72149, 72156, 72157, 72158, 72159, 72195, 72196, 72197, 72198, 73218, 73219, 73220, 73221, 73222, 73223, 73225, 73518, 73719, 73720, 73721, 73722, 73723, 73725, 74181, 74182, 74183, 74185, 75557, 75559, 75561, 75563, 75565, 76498

**Computerized Tomography**
70450, 70460, 70470, 70480, 70481, 70482, 70486, 70487, 70488, 70490, 70491, 70492, 70496, 70498, 71250, 71260, 71270, 71275, 72125, 72126, 72127, 72128, 72129, 72130, 72131, 72132, 72133, 72191, 72192, 72193, 72194, 73200, 73201, 73202, 73206, 73700, 73701, 73702, 73706, 74150, 74160, 74170, 74174, 74175, 74176, 74177, 74178, 74261, 74262, 74712, 74713, 75571, 75572, 75573, 75574, 75635, 75638, 76497

**Single-Photon Emission Computed Tomography**
76390

**Nuclear Medicine**
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Changes to the End-Stage Renal Disease (ESRD) Facility Claim (Type of Bill 72X) to Accommodate Dialysis Furnished to Beneficiaries with Acute Kidney Injury (AKI)

Note: This article was revised on May 18, 2018, to update language on page 4. The Non-ESRD HCPCS codes and ESRD modifiers were updated. All other information is unchanged.

Provider Types Affected

This MLN Matters® Article is intended for End Stage Renal Disease (ESRD) Facilities that submit claims to Medicare Administrative Contractors (MACs) for renal dialysis services provided to Medicare beneficiaries.

What You Need to Know

Change Request (CR) 9598 implements changes to the ESRD Facility claim (Type of Bill 72x) to accommodate dialysis furnished to beneficiaries with Acute Kidney Injury (AKI). This MLN Matters Article summarizes these changes. Make sure that your billing staffs are aware of these changes.

Background

On June 29, 2015, The Trade Preferences Extension Act of 2015 was enacted in which Section 808 amended Section 1861(s)(2)(F) of the Social Security Act (42 U.S.C. 1395x(s)(2)(F)) by extending renal dialysis services paid under Section 1881(b)(14) to beneficiaries with AKI effective January 1, 2017.
Beginning January 1, 2017, ESRD facilities will be able to furnish dialysis to AKI patients. The AKI provision was signed into law on June 29, 2015. (See Sec. 808 Public Law 114-27.)

The provision provides Medicare payment beginning on dates of service January 1, 2017, and after to ESRD facilities, that is, hospital-based and freestanding, for renal dialysis services furnished to beneficiaries with AKI (both adult and pediatric). Medicare will pay ESRD facilities for the dialysis treatment using the ESRD Prospective Payment System (PPS) base rate adjusted by the applicable geographic adjustment factor, that is, wage index. In addition to the dialysis treatment, the ESRD PPS base rate pays ESRD facilities for the items and services considered to be renal dialysis services as defined in 42 CFR 413.171 and there will be no separate payment for those services.

Renal dialysis services as defined in 42 CFR 413.171, would be considered to be renal dialysis services for patients with AKI. No separate payment would be made for renal dialysis drugs, biologicals, laboratory services, and supplies that are included in the ESRD PPS base rate when they are furnished by an ESRD facility to an individual with AKI.

Items and services furnished to beneficiaries with AKI that are not considered to be renal dialysis services as defined in 42 CFR 413.171, are separately payable. Specifically, drugs, biologicals, laboratory services, supplies, and other services that ESRD facilities are certified to furnish and that would otherwise get furnished to a beneficiary with AKI in a hospital outpatient setting will be paid separately using the applicable Part B fee schedule. This includes vaccines. ESRD facilities may provide vaccines to beneficiaries with AKI and seek reimbursement under the applicable CMS vaccination policies discussed in Chapter 18 of the “Medicare Claims Processing Manual.”

For payment under Medicare, ESRD facilities shall report all items and services furnished to beneficiaries with AKI by submitting the 72x type of bill with condition code 84 - Dialysis for Acute Kidney Injury (AKI) on a monthly basis. Since ESRD facilities bill Medicare for renal dialysis services by submitting the 72x type of bill for ESRD beneficiaries, condition code 84 will differentiate an ESRD PPS claim from an AKI claim. AKI claims will require one of the following diagnosis codes:

1. N17.0 - Acute kidney failure with tubular necrosis
2. N17.1 - Acute kidney failure acute cortical necrosis
3. N17.2 - Acute kidney failure with medullary necrosis
4. N17.8 - Other acute kidney failure
5. N17.9 - Acute kidney failure, unspecified
6. T79.5XXA - Traumatic anuria, initial encounter
7. T79.5XXD - Traumatic anuria, subsequent encounter
8. T79.5XXS - Traumatic anuria, sequela
9. N99.0 - Post-procedural (acute)(chronic) renal failure

In addition, ESRD facilities are required to include revenue code 082x, 083x, 084x, or 085x for the modality of dialysis furnished with the HCPCS code G0491 (Long descriptor –
Dialysis procedure at a Medicare certified ESRD facility for Acute Kidney Injury without ESRD; Short descriptor – dialysis Acu Kidney no ESRD). Beneficiaries with AKI are able to receive either peritoneal dialysis or hemodialysis in an ESRD facility. Based on the level of care required for these beneficiaries, at this time, CMS is not extending the home dialysis benefit to beneficiaries with AKI.

AKI claims will not have limits on how many dialysis treatments can be billed for the monthly billing cycle, however, there will only be payment for one treatment per day across settings, except in the instance of uncompleted treatments. If a dialysis treatment is started, that is, a patient is connected to the machine and a dialyzer and blood lines are used, but the treatment is not completed for some unforeseen, but valid reason, the facility is paid based on the full base rate. An example includes medical emergencies such as rushing a dialysis patient to an emergency room mid-treatment. This is a rare occurrence and must be fully documented to your MAC’s satisfaction.

Applicability of Other ESRD and CMS Adjustments

ESRD Network Fee
The ESRD Network Fee reduction is not applicable to claims for beneficiaries with AKI. The operationalization of this policy occurs via CR 9814 effective April 1, 2017 and claims submitted between January 1, 2017 and March 31, 2017 will be adjusted once the CR is implemented.

ESRD Quality Incentive Program (QIP)
The ESRD QIP is not applicable for beneficiaries with AKI at this time.

Sequestration Adjustments
The 2 percent sequestration adjustment is applicable to claims for beneficiaries with AKI. This is a global CMS adjustment and as such applies to AKI claims.

ESRD Conditions for Coverage (CfCs)
The ESRD CfCs at 42 CFR part 494 are health and safety standards that all Medicare participating dialysis facilities must meet. These standards set baseline requirements for patient safety, infection control, care planning, staff qualifications, record keeping, and other matters to ensure that all patients, including ESRD and AKI patients, receive safe and appropriate care.

Low Volume Payment Adjustment (LVPA)
AKI dialysis treatments count toward the LVPA threshold when determining total number of treatments provided when a facility prepares the low volume attestation to determine eligibility for the LVPA, however, claims for patients with AKI will not receive the adjustment.

Home or Self-Dialysis Training Add-On Payment Adjustment
The home or self-dialysis training add-on is not applicable to claims for treatments provided to patients with AKI.
Billing for Physicians’ Services for Patients with AKI

Physicians are able to bill separately for services provided to patients with AKI. CMS expects providers to follow correct coding guidelines and use the appropriate HCPCS or CPT codes for the items and services provided to the patient.

The following CPT codes are available for ESRD facilities and physician’s offices to use when billing for physicians’ services provided in either an ESRD facility (place of service 65) or a physician’s office (place of service 11):

- 90935 - Hemodialysis procedure with single evaluation by a physician or other qualified health care professional
- 90937 - Hemodialysis procedure requiring repeated evaluation(s) with or without substantial revision of dialysis prescription
- 90945 - Dialysis procedure other than hemodialysis (eg, peritoneal dialysis, hemofiltration, or other continuous replacement therapies), with single evaluation by a physician or other qualified health care professional
- 90947 - Dialysis procedure other than hemodialysis (eg, peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies) requiring repeated evaluations by a physician or other qualified health care professional, with or without substantial revision of dialysis prescription

Please note: this is not an exhaustive list – as indicated above, CMS expects facilities and physician’s offices to bill the appropriate codes.

Payment for Erythropoietin Stimulating Agents (ESAs) and the ESA Monitoring Policy for AKI Patients

ESAs are included in the bundled payment amount for treatments administered to patients with AKI. The Non-ESRD HCPCS codes should be used (J0881, J0883, J0885, J0888 and Q0138). This policy was implemented with CR 9987.

The ESA monitoring policy has not yet been extended to AKI patients receiving treatment in an ESRD facility. Since this policy is not applicable to these treatments, the value codes used to report hemoglobin and hematocrit levels are not required when billing for ESAs.

Telehealth

Unless other criteria are met, telehealth is only available for ESRD beneficiaries at this time. Please see https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfactsh.pdf.

Modifier, Value Code, Condition Code, and Occurrence Codes

- Urea reduction ratio and vascular access modifiers are not required on ESRD facility claims for patients with AKI.
- ESRD specific modifiers, including JA, JB, and JE should not be included on AKI claims.
- ESRD facilities are not required to report the Kt/v reading value or the date of the last reading (occurrence code 51) for patients with AKI.
- ESRD facilities are not required to report a patient’s height and weight (value
codes A8 and A9) for patients with AKI.

Additional Information


The official instruction, CR9987, issued to your MAC regarding this change is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9987.pdf.


42 CFR 413.171 is available at https://www.ecfr.gov/cgi-bin/retrieveECFR?gp&SID=3233f9c843c3f74275cab5dcbcf088c&mc=true&amp;n=pt42.2.413&amp;r=PART&amp;tv=HTML&amp;se42.2.413 1171.


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, 2018</td>
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<td>This article was revised to add a link to MM10281. That article updates the AKI payment policy regarding Transitional Drug Add-on Payment Adjustments (TDAPA).</td>
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<td>June 19, 2017</td>
<td>This article was revised on June 19, 2017 to refer to code G0491 as a HCPCS code rather than a CPT code. In addition, a clarification was made on pages 3 and 4 in the paragraphs relating to the ESRD Conditions of Coverage and the Low Volume Payment Adjustment. Information regarding home or self-dialysis training add-on payment adjustments, billing for physician services, payment for erythropoietin stimulating agents, telehealth, and modifiers, value codes, condition codes, and occurrence codes is also added starting on page 4.</td>
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<td>The article was revised to add a link to MLN Matters article MM9807 which implements the payment for renal dialysis services furnished to beneficiaries with AKI in ESRD Facilities for CY2017. All other information is unchanged.</td>
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Diagnosis Code Update for Add-on Payments for Blood Clotting Factor Administered to Hemophilia Inpatients

MLN Matters Number: MM10474 Revised
Related Change Request (CR) Number: 10474
Related CR Release Date: March 1, 2018
Effective Date: July 1, 2018
Related CR Transmittal Number: R3990CP
Implementation Date: July 2, 2018

Note: This article was revised on March 2, 2018, to reflect the revised CR10474 issued on March 1. In the article, the CR release date, transmittal number and the Web address for accessing the CR are revised. All other information remains the same.

PROVIDER TYPES AFFECTED

This MLN Matters® article is intended for providers who submit claims to Medicare Administration Contractors (MACs) for inpatient services to Medicare beneficiaries with hemophilia.

WHAT YOU NEED TO KNOW

Change Request (CR) 10474 provides updates to diagnosis codes required in order to allow add-on payments under the Inpatient Prospective Payment System (IPPS) for blood clotting factor administered to hemophilia inpatients. The add-on payment criteria for blood clotting factors administered to hemophilia inpatients will be updated July 1, 2018, by terminating International Classification of Diseases, Clinical Modification (ICD-CM) code D68.32, effective with that date. The list of ICD-CM codes that will continue to receive the add-on payment can be found in Section 20.7.3, of Chapter 3 of the “Medicare Claims Processing Manual”. Make sure your billing staffs are aware of this update.

BACKGROUND

The September 1, 1993, IPPS final rule (58 FR 46304) states that payment will be made for the blood clotting factor only if an ICD-CM diagnosis code for hemophilia is included on the bill.

Effective July 1, 2018, code D68.32 (Antiphospholipid antibody with hemorrhagic disorder) is TERMINATED. Therefore, providers that include diagnosis code D68.32 on inpatient claims with discharge dates after July 1, 2018, will not receive the add-on 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/.

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Healthcare Provider Taxonomy Codes (HPTCs) April 2018 Code Set Update

MLN Matters Number: MM10402 Related Change Request (CR) Number: 10402

Related CR Release Date: February 16, 2018 Effective Date: July 1, 2018

Related CR Transmittal Number: R3977CP Implementation Date: July 2, 2018

PROVIDER TYPES AFFECTED

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

WHAT YOU NEED TO KNOW

Change Request (CR) 10402 directs MACs to obtain the most recent Healthcare Provider Taxonomy Codes (HPTCs) code set and use it to update their internal HPTC tables and/or reference files. Make sure your billing staffs are aware of these changes.

BACKGROUND

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that covered entities comply with the requirements in the electronic transaction format implementation guides adopted as national standards. The institutional and professional claim electronic standard implementation guides (X12 837-I and 837-P) each require use of valid codes contained in the HPTC set when there is a need to report provider type or physician, practitioner, or supplier specialty for a claim.

You should note that:

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

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

Although the NUCC generally posts their updates on the WPC webpage 3 months prior to the effective date, changes are not effective until April 1 or October 1, as indicated in each update. The changes to the code set include the addition of a new code and addition of definitions to existing codes. When reviewing the HCPT code set online, revisions made since the last release are identifiable by these color codes:

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

ADDITIONAL INFORMATION


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

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Institutional Billing for No Cost Items

MLN Matters Number: MM10521  Related Change Request (CR) Number: 10521
Related CR Release Date: March 30, 2018  Effective Date: January 1, 2009
Related CR Transmittal Number: R4013CP  Implementation Date: June 29, 2018

PROVIDER TYPES AFFECTED

This MLN Matters® article is intended for Institutions (Part A) billing Medicare Administrative Contractors (MACs) for no cost items provided to Medicare beneficiaries.

WHAT YOU NEED TO KNOW

Change Request (CR) 10521 provides clarification of the billing instructions specific to drugs provided at no cost when claims processing edits prevent drug administration charges from being billed when the claim does not contain a covered/billable drug charge. This is not a new policy but a reminder of the policy in place. Please make sure your billing staffs are aware of this clarification.

Background

The Medicare Claims Processing Manual Chapter 32 - Billing Requirements for Special Services section 67.2 outlines institutional billing for no cost items as follows.

Institutional providers should not have to report the usage of a no cost item. However, for some claims (for example, Outpatient Prospective Payment System (OPPS) claims), providers may be required to bill a no cost item due to claims processing edits that require an item (even if received at no cost) to be billed along with an associated service (for example, a specified device must be reported along with a specified implantation procedure).

For OPPS claims, when a drug is provided at no cost, claims processing edits prevent drug administration charges from being billed when the claim does not contain a covered/billable drug charge. Therefore, for drugs provided at no cost in the hospital outpatient department, providers must report the applicable drug HCPCS code and appropriate units with a token charge of less than $1.01 for the item in the covered charge field and mirror this less than $1.01 amount reported in the non-covered charge field. Providers must also bill the corresponding drug administration charge with the appropriate drug administration CPT or HCPCS code.
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 Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes - April 2018 Update

MLN Matters Number: MM10454 Revised
Related Change Request (CR) Number: 10454
Related CR Release Date: March 7, 2018
Effective Date: April 1, 2018
Related CR Transmittal Number: R3997CP
Implementation Date: April 2, 2018

Note: This article was revised on March 8, 2018, to reflect an updated Change Request (CR). That CR provided additional instructions for the MACs, regarding use of the long descriptors. The CR date, transmittal number and link to the transmittal also changed. All other information is unchanged.

**PROVIDER TYPES AFFECTED**

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

**WHAT YOU NEED TO KNOW**

The HCPCS code set is updated on a quarterly basis. Change Request (CR) 10454 informs MACs of the April 2018 updates of specific biosimilar biological product HCPCS code, modifiers used with these biosimilar biologic products and an autologous cellular immunotherapy treatment. Be sure your staffs are aware of these updates.

**BACKGROUND**

CR 10454 describes updates associated with the following biosimilar biological product HCPCS codes and modifiers. The April 2018 HCPCS file includes three new HCPCS codes: Q5103, Q5104, and Q2041. Also, the April 2018 HCPCS file includes a revision to the descriptor for HCPCS code Q5101.

Effective for services as of April 1, 2018, The April 2018 HCPCS file includes these revised/new HCPCS codes:

- **HCPCS Code: Q5101**
  - Short Description: Injection, zarxio
  - Long Description: Injection, filgrastim-sndz, biosimilar, (zarxio), 1 microgram

- **HCPCS Code: Q5103**
• Short Description: Injection, inflectra
• Long Description: Injection, infliximab-dyyb, biosimilar, (inflectra), 10 mg
• Type of Service (TOS) Code: 1,P
• Medicare Physician Fee Schedule Database (MPFSDB) Status Indicator: E

• HCPCS Code: Q5104
  • Short Description: Injection, renflexis
  • Long Description: Injection, infliximab-abda, biosimilar, (renflexis), 10 mg
  • TOS Code: 1, P
  • MPFSDB Status Indicator: E

Effective for claims with dates of service on or after April 1, 2018, HCPCS code Q5102 (which describes both currently available versions of infliximab biosimilars) will be replaced with two codes, Q5103 and Q5104. Thus, Q5102 Injection, infliximab, biosimilar, 10 mg, will be discontinued, effective March 31, 2018.

Also, beginning on April 1, 2018, modifiers that describe the manufacturer of a biosimilar product (for example, ZA, ZB and ZC) will no longer be required on Medicare claims for HCPCS codes for biosimilars. However, please note that HCPCS code Q5102 and the requirement to use biosimilar modifiers remain in effect for dates of service prior to April 1, 2018.

Medicare Part B policy changes for biosimilar biological products were discussed in the Calendar Year (CY) 2018 Physician Fee Schedule (PFS) final rule at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1676-F.html. Effective January 1, 2018, newly approved biosimilar biological products with a common reference product will no longer be grouped into the same billing code. The rule also stated that instructions for new codes for biosimilars that are currently grouped into a common payment code and the use of modifiers would be issued.

**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-

MLN Matters Number: MM10624 Revised
Related Change Request (CR) Number: 10624
Related CR Release Date: May 11, 2018
Effective Date: July 1, 2018
Related CR Transmittal Number: R4048CP
Implementation Date: July 2, 2018

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

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 10624 informs MACs of updated drug/biological HCPCS codes. The HCPCS code set is updated on a quarterly basis. The July 2018 HCPCS file includes 4 new HCPCS codes: Q9991, Q9992, Q9993 and Q9995. Please make sure your billing staffs are aware of these updates.

BACKGROUND

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

- **Q9991**
  - Short Description: Buprenorph x r 100 mg or less
  - Long Description: Injection, buprenorphine extended-release (sublocade), less than or equal to 100 mg
  - Type of Service (TOS) Code: 1
  - Medicare Physician Fee Schedule Data Base (MPFSDB) Status Indicator: E

- **Q9992**
  - Short Description: Buprenorphine x r over 100 mg
- Long Description: Injection, buprenorphine extended-release (sublocade), greater than 100 mg
- TOS Code: 1
- MPFSDB Status Indicator: E
- Q9993
  - Short Description: Inj., triamcinolone ext rel
  - Long Description: Injection, triamcinolone acetonide, preservative-free, extended-release, microsphere formulation, 1 mg
  - TOS Code: 1,P
  - MPFSDB Status Indicator: E
- Q9995
  - Short Description: Inj. emicizumab-kxwh, 0.5 mg
  - Long Description: Injection, emicizumab-kxwh, 0.5 mg
  - TOS Code: 1
  - MPFSDB Status Indicator: E

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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Reinstating the Qualified Medicare Beneficiary Indicator in the Medicare Fee-For-Service Claims Processing System from CR9911

MLN Matters Number: MM10433 Revised Related Change Request (CR) Number: 10433
Related CR Release Date: March 6, 2018 Effective Date: July 1, 2018
Related CR Transmittal Number: R3993CP Implementation Date: For claims processed on or after July 2, 2018

Note: This article was revised on March 13, 2018, to reflect an updated Change Request (CR). That CR added CARCs 66, 247, and 248 (page 3 below). DME MACs were added to the “Providers Affected” section and the QMB enrollment numbers were also updated on page 2 to reflect 2016 statistics. Pharmacies were also included in the “Background” section. The CR date, transmittal number and link to the transmittal also changed. All other information is unchanged.

PROVIDER TYPES AFFECTED

This MLN Matters® Article is intended for providers and suppliers who submit claims to Part A/B and DME Medicare Administrative Contractors (MACs).

WHAT YOU NEED TO KNOW

Effective with CR 10433, the Centers for Medicare & Medicaid Services (CMS) will reintroduce Qualified Medicare Beneficiary (QMB) information in the Medicare Remittance Advice (RA) and Medicare Summary Notice (MSN). CR 9911 modified the Fee-For-Service (FFS) systems to indicate the QMB status and zero cost-sharing liability of beneficiaries on RAs and MSNs for claims processed on or after October 2, 2017. On December 8, 2017, CMS suspended CR 9911 to address unforeseen issues preventing the processing of QMB cost-sharing claims by States and other secondary payers outside of the Coordination of Benefits Agreement (COBA) process. CR 10433 remediates these issues by including revised “Alert” Remittance Advice Remark Codes (RARC) in RAs for QMB claims without adopting other RA changes that impeded claims processing by secondary payers. CR 10433 reinstates all changes to the MSNs under CR 9911. Please make sure your billing staff is aware of these changes.

BACKGROUND

Federal law bars Medicare providers and suppliers, including pharmacies, from billing an individual enrolled in the QMB program for Medicare Part A and Part B cost-sharing under any
circumstances. (See Sections 1902(n)(3)(B), 1902(n)(3)(C), 1905(p)(3), 1866(a)(1)(A), and 1848(g)(3)(A) of the Social Security Act.) The QMB program is a State Medicaid benefit that assists low-income Medicare beneficiaries with Medicare Part A and Part B premiums and cost-sharing, including deductibles, coinsurance, and copays. In 2016, 7.5 million individuals (more than one out of 8 beneficiaries) were enrolled in the QMB program.

Providers and suppliers, including pharmacies, may bill State Medicaid agencies for Medicare cost-sharing amounts. However, as permitted by Federal law, States may limit Medicare cost-sharing payments, under certain circumstances. Be aware, persons enrolled in the QMB program have no legal liability to pay Medicare providers for Medicare Part A or Part B cost-sharing.

**System Changes to Assist Providers under CR 9911**

To help providers more readily identify the QMB status of their patients, CR 9911 introduced a QMB indicator in the claims processing system for the first time. CR 9911 is part of the CMS ongoing effort to give providers tools to comply with the statutory prohibition on collecting Medicare A/B cost-sharing from QMBs.

Through CR 9911, CMS indicated the QMB status and zero cost-sharing liability of beneficiaries in the RA and MSN for claims processed on or after October 2, 2017. In particular, CR 9911 changed the MSN to include new messages for QMB beneficiaries and reflect $0 cost-sharing liability for the period they are enrolled in QMB. In addition, CMS modified the RA to include new Alert RARCs to notify providers to refrain from collecting Medicare cost-sharing because the patient is a QMB (N781 is associated with deductible amounts and N782 is associated with coinsurance).

Additionally, CR 9911 changed the display of patient responsibility on the RA by replacing Claim Adjustment Group Code “Patient Responsibility” (PR) with Group Code “Other Adjustment” (OA). CMS zeroed out the deductible and coinsurance amounts associated with Claim Adjustment Reason Code (CARC) 1 (deductible) and/or 2 (coinsurance) and used CARC 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 the patient if collected. (Use only with Group code OA).”)

However, the changes to the display of patient liability in the RAs for QMB claims caused unforeseen issues affecting the processing of QMB cost-sharing claims directly submitted by providers to states and other payers secondary to Medicare. Providers rely on RAs to bill State Medicaid Agencies and other secondary payers outside the Medicare COBA claims crossover process. States and other secondary payers generally require RAs that separately display the Medicare deductible and coinsurance amounts with the Claim Adjustment Group Code “PR” and associated CARC codes and could not process claims involving the RA changes from CR 9911. Barriers to the processing of secondary claims have additional implications for institutional providers that claim bad debt under the Medicare program since they must obtain a Medicaid Remittance Advice to seek reimbursement for unpaid deductibles and coinsurance as a Medicare bad debt for QMBs.
To address these issues, on December 8, 2017, CMS suspended the CR 9911 system changes causing the claims processing systems to suspend the RA and MSN changes for QMB claims under CR 9911.

**Reintroduction of QMB information in the MA and MSN under CR 10433**

Effective with CR 10433, the claims processing systems will reintroduce QMB information in the RA without impeding claims processing by secondary payers.

The RA for QMB claims will retain the display of patient liability amounts needed by secondary payers to process QMB cost-sharing claims.

**All Medicare's FFS systems will discontinue the practice of outputting Claim Adjustment Group Code OA with CARC 209 in place of CARCs 1 and 2, as well as CARCs 66, 247, and 248, on the ERAs and on SPRs, as applicable.**

The shared systems shall include the revised Alert RARCs N781 and N782 in association with CARCs 1 and or 2 on the RA. These RARCs designate that the beneficiary is enrolled in the QMB program and may not be billed for Medicare cost sharing amounts. Additionally, for QMB claims, the Part A and B shared systems shall include the revised Alert RARC N781 in association with CARC 66 (blood deductible). The revised Alert RARCs are as follows:

- N781 - Alert: Patient is a Medicaid/ Qualified Medicare Beneficiary. Review your records for any wrongfully collected deductible. This amount may be billed to a subsequent payer.
- N782 – Alert: Patient is a Medicaid/ Qualified Medicare Beneficiary. Review your records for any wrongfully collected coinsurance. This amount may be billed to a subsequent payer.

CR 9911 changes to the MSN by including QMB messages and reflecting $0 cost-sharing liability for the period beneficiaries are enrolled in QMB.

**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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Revisions to the Telehealth Billing Requirements for Distant Site Services

MLN Matters Number: MM10583 Related Change Request (CR) Number: 10583
Related CR Release Date: April 27, 2018 Effective Date: October 1, 2018
Related CR Transmittal Number: R4026CP Implementation Date: October 1, 2018

PROVIDER TYPE AFFECTED

This MLN Matters® Article is intended for providers who submit claims to Medicare Administrative Contractors (MACs) for telehealth services provided to Medicare beneficiaries

PROVIDER ACTION NEEDED

Change Request (CR) implements requirements for billing modifier GT for Telehealth Distant Site Services. As of January 1, 2018, the GT modifier is only allowed on institutional claims billed by a Critical Access Hospital (CAH) Method II. Make sure your billing staffs are aware of this requirement.

BACKGROUND

Previous guidance instructed providers to submit claims for telehealth services using the appropriate procedure code along with the telehealth modifier GT (via interactive audio and video telecommunications systems). In the Calendar Year (CY) 2017 Physician Fee Schedule (PFS) final rule, payment policies regarding Medicare’s use of a new Place of Service (POS) Code describing services furnished via telehealth (POS 02) were finalized and implemented through CR9726. The new POS code became effective January 1, 2017.

In the CY 2018 PFS final rule, the requirement to use the GT modifier was eliminated for all professional claims. CR10152, which implemented that policy, included a business requirement instructing MACs to be aware that the GT modifier is only allowed for distant site services billed by Method II CAHs on type of bill 85X with a revenue code 96X, 97X, or 98X or with a service line that contains HCPCS code Q3014. As of January 1, 2018, the GT modifier is only allowed on institutional claims billed under CAH Method II. If the GT modifier is billed by other provider types, the claim line will be rejected with the following remittance codes:
- Group Code CO - Contractual obligation
- Claim Adjustment Reason Code 4 - The procedure code is inconsistent with the modifier used or a required modifier is missing. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 07/01/2017

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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The Supplemental Security Income (SSI)/Medicare Beneficiary Data for Fiscal Year 2016 for Inpatient Prospective Payment System (IPPS) Hospitals, Inpatient Rehabilitation Facilities (IRFs), and Long Term Care Hospitals (LTCH)

MLN Matters Number: MM10527
Related Change Request (CR) Number: 10527
Related CR Release Date: March 16, 2018
Effective Date: April 16, 2018
Related CR Transmittal Number: R2043OTN
Implementation Date: April 16, 2018

PROVIDER TYPE AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 10527 informs MACs about updated data for determining the disproportionate share adjustment for IPPS hospitals and the low-income patient adjustment for IRFs, as well as payments, as applicable, for LTCH discharges (for example, discharges paid the IPPS comparable amount under the short-stay outlier payment adjustment). Make sure that your billing staffs are aware of these changes.

BACKGROUND

Section 9105 of the Consolidated Omnibus Budget Reconciliation Act of 1985 provides that for discharges occurring on or after May 1, 1986, an additional payment must be made to IPPS hospitals serving a disproportionate share of low-income patients. The additional payment is determined by multiplying the federal portion of the Diagnosis-Related Group (DRG) payment by the DSH adjustment factor, and beginning for discharges occurring on or after October 1, 2014, the additional payment is determined by multiplying the DRG payment by the DSH adjustment factor reduced by 75 percent. (See 42 CFR 412.106.)

Under the IRF PPS, IRFs will receive an additional payment amount to account for the cost of furnishing care to low-income patients. The additional payment is determined by multiplying the federal prospective payment by the low-income patient adjustment formula (See 42 CFR 412.624(e)(2)).
Under the LTCH PPS, the payment adjustment for Short-Stay Outlier (SSO) cases at 42 CFR 412.529 requires the calculation of an amount comparable to the amount that would otherwise be paid under the IPPS (that is, the "IPPS comparable amount."). This calculation includes an "IPPS Comparable" DSH adjustment, where applicable, that is determined using the best available SSI data at the time of claim payment (See 42 CFR 412.529(d)(4)).

**Updated Date Files**

The SSI/Medicare beneficiary data for hospitals are available electronically and contain the name of the hospital, Centers for Medicare & Medicaid Services (CMS) certification number, SSI days, total Medicare days, and the ratio of days for patients entitled to Medicare Part A attributable to SSI recipients. The files are located at the following CMS website addresses:

- IPPS: [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.html)

- IRF: [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/SSIData.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/SSIData.html)

- LTCH: [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/download.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/download.html)

The data is used for settlement purposes for IPPS hospitals and IRFs with cost reporting periods beginning and during Fiscal Year (FY) 2016 (cost reporting periods beginning on or after October 1, 2015, and before October 1, 2016), except when explicitly directed otherwise by CMS.

**ADDITIONAL INFORMATION**


If you have any questions, please contact your MAC at their toll-free number. That number is available at [https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/](https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/).
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MLN Matters Number: MM10550
Related CR Release Date: April 13, 2018
Related CR Transmittal Number: R243BP and R4021CP
Related Change Request (CR) Number: 10550
Effective Date: July 16, 2018
Implementation Date: July 16, 2018

PROVIDER TYPES AFFECTED

This MLN Matters Article is intended for Skilled Nursing Facilities (SNF), ambulance providers and suppliers providing ambulance services to patients and billing Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries who are not in a covered Part A stay.

PROVIDER ACTION NEEDED

Change Request (CR) 10550 provides clarification on coverage of an ambulance transport for a SNF resident in a stay not covered by Part A, who has Part B benefits, to the nearest supplier of medically necessary services not available at the SNF, including the return trip. These clarifications relate to Chapter 10 of the Medicare Benefit Policy Manual, and Chapter 15, of the Medicare Claims Processing Manual. The revised manual sections are attachments to CR10550. Make sure your billing staffs are aware of these clarifications.

BACKGROUND

In the June 17, 1997, ambulance proposed rule (62 FR 32720), the Centers for Medicare & Medicaid Services (CMS) proposed a provision under Part B that permits ambulance transportation from a SNF to the nearest supplier of medically necessary services not available at the SNF where the beneficiary is an inpatient, including the return trip. CMS finalized this proposal in the January 25, 1999, final rule (64 FR 3648) at 42 CFR 410.40(e)(3).

CMS is revising the Medicare Benefit Policy Manual and Medicare Claims Processing Manual to clarify that a medically necessary ambulance transport from an SNF to the nearest supplier of medically necessary services not available at the SNF where the beneficiary is a resident (including the return trip) may be covered under Part B. This applies to beneficiaries who are in
an SNF stay not covered by Part A, but who has Part B benefits.

For example, this includes ambulance transport of such residents from the SNF (modifier N) to the nearest diagnostic or therapeutic site, other than a physician’s office or hospital, such as an Independent Diagnostic Testing Facility (IDTF), cancer treatment center, radiation therapy center, or wound care center, as reported with ambulance modifier D. For SNF residents receiving Part A benefits, this type of ambulance service is subject to SNF consolidated billing.

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

MLN Matters Number: MM10473 Revised
Related Change Request (CR) Number: 10473
Related CR Release Date: February 28, 2018
Effective Date: July 1, 2018
Related CR Transmittal Number: R2039OTN
Implementation Date: April 2, 2018 for local MAC; July 2, 2018 - for shared system edits

Note: This article was revised on March 1, 2018, to reflect an updated Change Request (CR). That CR corrected instructions in business requirement 7 (NCD210.3), including the spreadsheet for MACs. The CR release date, transmittal number and link to the transmittal also changed. All other information remains the same.

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

CR 10473 constitutes a maintenance update of the International Classification of Diseases, Tenth Revision (ICD-10) conversions and other coding updates specific to National Coverage Determinations (NCDs). These NCD coding changes are the result of newly available codes, coding revisions to NCDs released separately, or coding feedback received. Please follow the link below for the NCD spreadsheets included with this CR: https://www.cms.gov/Medicare/Coverage/DeterminationProcess/downloads/CR10473.zip

BACKGROUND

Previous NCD coding changes appear in ICD-10 quarterly updates available at https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html, along with other CRs implementing new policy NCDs. Edits to ICD-10 and other coding updates specific to NCDs will be included in subsequent quarterly releases and individual CRs as appropriate. No policy-related changes are included with the ICD-10 quarterly updates. Any policy-related changes to NCDs continue to be implemented via the current, long-standing NCD process.
Coding (as well as payment) is a separate and distinct area of the Medicare Program from coverage policy/criteria. Revisions to codes within an NCD are carefully and thoroughly reviewed and vetted by the Centers for Medicare & Medicaid Services and are not intended to change the original intent of the NCD. The exception to this is when coding revisions are released as official implementation of new or reconsidered NCD policy following a formal national coverage analysis.

**NOTE:** The translations from ICD-9 to ICD-10 are not consistent one-to-one matches, nor are all ICD-10 codes appearing in a complete General Equivalence Mappings (GEMs) mapping guide or other mapping guides appropriate when reviewed against individual NCD policies. In addition, for those policies that expressly allow MAC discretion, there may be changes to those NCDs based on current review of those NCDs against ICD-10 coding. For these reasons, there may be certain ICD-9 codes that were once considered appropriate prior to ICD-10 implementation that are no longer considered acceptable.

CR10473 makes coding and clarifying adjustments to the following NCDs:

1. NCD20.5 Extracorporeal Immunoabsorption (ECI) Using Protein A Columns
2. NCD110.18 Aprepitant
3. NCD110.21 Erythropoiesis Stimulating Agents (ESAs)
4. NCD150.3 Bone Mineral Density Studies
5. NCD190.1 Histocompatibility Testing
6. NCD190.11 PT/INR
7. NCD210.3 Colorectal Cancer Screening
8. NCD210.4.1 Counseling to Prevent Tobacco Use
9. NCD210.6 Hepatitis B Virus Screening
10. NCD220.4 Mammograms
11. NCD220.6.17 PET for Solid Tumors
12. NCD250.4 Actinic Keratosis (AKs)

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

- Remittance Advice Remark Codes (RARC) N386 with Claim Adjustment Reason Code (CARC) 50, 96, and/or 119.
- Group Code PR (Patient Responsibility) assigning financial responsibility to the beneficiary (if a claim is received with occurrence code 32, or with occurrence code 32 and a GA modifier, indicating a signed Advance Beneficiary Notice (ABN) is on file).
- Group Code CO (Contractual Obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).
- For modifier GZ, use CARC 50
ADDITIONAL INFORMATION


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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International Classification of Diseases, Tenth Revision (ICD-10) and Other Coding Revisions to National Coverage Determinations (NCDs)

MLN Matters Number: MM10622
Related Change Request (CR) Number: 10622
Related CR Release Date: May 4, 2018
Effective Date: October 1, 2018
Related CR Transmittal Number: R2076OTN
Implementation Date: October 1, 2018

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 10622 constitutes a maintenance update of International Classification of Diseases, 10th Revision (ICD-10) conversions and other coding updates specific to National Coverage Determinations (NCDs). These NCD coding changes are the result of newly available codes, coding revisions to NCDs released separately, or coding feedback received. Please follow the link below for the NCD spreadsheets included with this CR: https://www.cms.gov/Medicare/Coverage/DeterminationProcess/downloads/CR10622.zip.

BACKGROUND

Previous NCD coding changes appear in ICD-10 quarterly updates that are available at https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html, along with other CRs implementing new policy NCDs. Edits to ICD-10, and other coding updates specific to NCDs, will be included in subsequent quarterly releases as needed.

No policy-related changes are included with these updates. Any policy-related changes to NCDs continue to be implemented via the current, long-standing NCD process.

Coding (as well as payment) is a separate and distinct area of the Medicare Program from coverage policy/criteria. Revisions to codes within an NCD are carefully and thoroughly reviewed and vetted by the Centers for Medicare & Medicaid Services (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 one-to-one matches, nor are all ICD-10 codes appearing in a complete General Equivalence Mappings (GEMs) mapping guide or other mapping guides appropriate when reviewed against individual NCD policies. In addition, for those policies that expressly allow MAC discretion, there may be changes to those NCDs based on current review of those NCDs against ICD-10 coding. For these reasons, there may be certain ICD-9 codes that were once considered appropriate prior to ICD-10 implementation that are no longer considered acceptable.

CR10622 makes coding and clarifying adjustments to the following NCDs:

- NCD 110.18 Aprepitant
- NCD 150.3 Bone Mineral Density Studies
- NCD 190.11 Prothrombin Time/International Normalized Ratio (PT/INR)
- NCD 220.6.16 Positron Emission Tomography (PET) for Infection/Inflammation
- NCD 220.6.17 PET for Solid Tumors
- NCD 220.13 Percutaneous Image-Guided Breast Biopsy

When denying claims associated with the attached NCDs, except where otherwise indicated, A/B 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 Advance Beneficiary Notice (ABN) is on file).
- Group Code CO (Contractual Obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file). For modifier GZ, use CARC 50 and Medicare Summary Notice (MSN) 8.81 per instructions in CR 7228/TR 2148.

**ADDITIONAL INFORMATION**


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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Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF ABN)

MLN Matters Number: MM10567
Related CR Release Date: March 30, 2018
Related CR Transmittal Number: R4011CP
Related Change Request (CR) Number: 10567
Effective Date: April 30, 2018
Implementation Date: April 30, 2018

PROVIDER TYPE AFFECTED

This MLN Matters Article is intended for Skilled Nursing Facilities (SNFs) billing Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

This article informs you about Change Request (CR) 10567, which advises you that the Centers for Medicare & Medicaid Services (CMS) has revised the Skilled Nursing Facility Notice of Non-coverage (SNF ABN), Form CMS-10055. With this revision, CMS is discontinuing the five Skilled Nursing Facility (SNF) Denial Letters (namely, the Intermediary Determination of Noncoverage, the UR Committee Determination of Admission, the UR Committee Determination on Continued Stay, the SNF Determination on Admission and the SNF Determination on Continued Stay), and the Notice of Exclusion from Medicare Benefits (NEMB-SNF), Form CMS-20014. Please ensure that your billing staffs are aware of these changes.

Please note that the Notice of Medicare Non-Coverage (NOMNC), Form CMS-10123 is not being discontinued with this revised SNF ABN. More information on the NOMNC is available at https://www.cms.gov/Medicare/Medicare-General-Information/BNI/FFS-Expedited-Determination-Notices.html.

BACKGROUND

The authorization for these requirements are Section 1879 of the Social Security Act and 42 Code of Federal Regulations (CFR) 411,404(b) and (c), which specify written notice requirements. These requirements are fulfilled by the SNF ABN.

In order for SNFs to transfer liability to an Original Medicare beneficiary for items or services paid under Medicare Part A (SNF Prospective Payment System (PPS)), the SNF must issue a
SNF ABN for:

- An item or service that is usually paid for by Medicare, but may not be paid for in this particular instance because it is not medically reasonable and necessary, or
- Custodial care.

Attached to CR10567 is a revised Chapter 30 of the Medicare Claims Processing Manual. This revised manual chapter provides details on SNF ABN standards and also provides information about:

- Situations in which a SNF ABN should be given
- Situations in which a SNF ABN is not needed to transfer financial liability to the beneficiary
- SNF ABN specific delivery issues
- Special rules for SNF ABNs
- Establishing when beneficiary is on Notice of Non-coverage

Note: Further details are available at [https://www.cms.gov/Medicare/Medicare-General-Information/BNI/FFS-SNFABN.html](https://www.cms.gov/Medicare/Medicare-General-Information/BNI/FFS-SNFABN.html). You may download the revised Form CMS-10055 in the Downloads section of that webpage.

SNFs will continue to use the Advance Beneficiary Notice of Non-coverage (ABN, Form CMS-R-131) for items or services that Medicare may be deny under Medicare Part B.

Please note that SNFs may start to implement this new notice any time up to the implementation date of CR10567. Upon the CR10567 implementation on April 30, 2018, the use of the new notice is mandatory.

The revised notice incorporates suggestions for changes made by users of the ABN and by beneficiary advocates based on experience with the current form, refinements made to similar liability notices through consumer testing and other means, as well as related Medicare policy changes and clarifications.

**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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Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD)

MLN Matters Number: MM10295 Revised
Related CR Release Date: May 11, 2018
Related CR Transmittal Number: R207NCD and R4049CP
Related Change Request (CR) Number: 10295
Effective Date: May 25, 2017
Implementation Date: July 2, 2018

Note: The article was revised on May 15, 2018, to clarify that one of the requirements of the SET program is it must be conducted in a hospital outpatient setting or in a physician’s office. 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) 10295 informs MACs that effective May 25, 2017, the Centers for Medicare & Medicaid Services (CMS) issued a National Coverage Determination (NCD) to cover Supervised Exercise Therapy (SET) for beneficiaries with Intermittent Claudication (IC) for the treatment of symptomatic Peripheral Artery Disease (PAD). Make sure your billing staffs are aware of these changes.

BACKGROUND

SET involves the use of intermittent walking exercise, which alternates periods of walking to moderate-to-maximum claudication, with rest. SET has been recommended as the initial treatment for patients suffering from IC, the most common symptom experienced by people with PAD.

Despite years of high-quality research illustrating the effectiveness of SET, more invasive treatment options (such as, endovascular revascularization) have continued to increase. This has been partly attributed to patients having limited access to SET programs. There is currently no NCD in effect.

CMS issued the NCD to cover SET for beneficiaries with IC for the treatment of symptomatic PAD. Up to 36 sessions over a 12-week period are covered if all of the following components of
a SET program are met:

The SET program must:

- Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication
- Be conducted in a hospital outpatient setting or a physician’s office
- Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD
- Be under the direct supervision of a physician (as defined in Section 1861(r)(1)) of the Social Security Act (the Act), physician assistant, or nurse practitioner/clinical nurse specialist (as identified in Section 1861(aa)(5) of the Act) who must be trained in both basic and advanced life support techniques.

Beneficiaries must have a face-to-face visit with the physician responsible for PAD treatment to obtain the referral for SET. At this visit, the beneficiary must receive information regarding cardiovascular disease and PAD risk factor reduction, which could include education, counseling, behavioral interventions, and outcome assessments.

MACs have the discretion to cover SET beyond 36 sessions over 12 weeks and may cover an additional 36 sessions over an extended period of time. MACs shall accept the inclusion of the KX modifier on the claim line(s) as an attestation by the provider of the services that documentation is on file verifying that further treatment beyond the 36 sessions of SET over a 12-week period meets the requirements of the medical policy. SET is non-covered for beneficiaries with absolute contraindications to exercise as determined by their primary attending physician.

**Coding Requirements for SET**

Providers should use Current Procedural Terminology (CPT) 93668 (Under Peripheral Arterial Disease Rehabilitation) to bill for these services with appropriate International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10) Code as follows:

- I70.211 – right leg
- I70.212 – left leg
- I70.213 – bilateral legs
- I70.218 – other extremity
- I70.311 – right leg
- I70.312 – left leg
- I70.313 – bilateral legs
- I70.318 – other extremity
- I70.611 – right leg
- I70.612 – left leg
- I70.613 – bilateral legs
- I70.618 – other extremity
• I70.711 – right leg
• I70.712 – left leg
• I70.713 – bilateral legs
• I70.718 – other extremity

Medicare will deny claim line items for SET services when they do not contain one of the above ICD-10 codes using the following messages:

• Claim Adjustment Reason Code (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.
• Remittance Advice Remark Code (RARC) N386: This decision was based on a National Coverage Determination 20.35 (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.
• Group Code CO (Contractual Obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

Institutional claims for SET must be submitted on Type of Bills (TOB) 13X or 85X. MACs will deny line items on institutional claims that are not submitted on TOB 13X or 85X using the following messages:

• CARC 58: “Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. NOTE: Refer to the 832 Healthcare Policy Identification Segment (loop 2110 Service payment Information REF), if present.
• RARC N386: “This decision was based on a National Coverage Determination 20.35 (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.
• Group Code CO (Contractual Obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

Medicare will pay claims for SET services containing CPT code 93668 on Types of Bill (TOBs) 13X under OPPS and 85X on reasonable cost, except it will pay claims for SET services containing CPT 93668 with revenue codes 096X, 097X, or 098X when billed on TOB 85X Method II Critical Access Hospitals (CAHs) based on 115% of the lesser of the fee schedule amount or the submitted charge.

Medicare will reject claims with CPT 93668 which exceed 36 sessions within 84 days from the date of the first session when the KX modifier is not included on the claim line OR any SET session provided after 84 days from the date of the first session and the KX modifier is not included on the claim and use the following messages:

• CARC 96: Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] 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 N640: Exceeds number/frequency approved/allowed within time period.
- 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.
- Group Code PR (Patient Responsibility) assigning financial liability to the beneficiary if a claim is received with a GA modifier indicating a signed ABN is on file.

MACs will deny/reject claim lines for SET exceeding 73 sessions using the following codes:

- CARC 119: Benefit maximum for this time period or occurrence has been reached.
- RARC N386: “This decision was based on a National Coverage Determination 20.35 (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.
- Group Code CO (Contractual Obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.
- Group Code PR (Patient Responsibility) assigning financial liability to the beneficiary if a claim is received with a GA modifier indicating a signed ABN is on file.

Medicare’s Common Working File (CWF) will display remaining SET sessions on all CWF provider query screens (HIQA, HIHQ, ELGH, ELGA, and HUQA). The Multi-Carrier System Desktop Tool will also display remaining SET sessions in a format equivalent to the CWF HIMR screen(s).

**ADDITIONAL INFORMATION**

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<tr>
<td>May 14, 2018</td>
<td>The article was revised to reflect a revised CR issued on May 11. The CR was revised to remove place of service code edit requirements. The article was revised accordingly. Also, in the article, the CR release date, transmittal numbers and the Web address of the CR are revised. All other information remains the same.</td>
</tr>
<tr>
<td>April 11, 2018</td>
<td>The article was revised to clarify that the SET program must be provided in a physician’s office (Place of Service code 11). All other information remains the same.</td>
</tr>
<tr>
<td>April 5, 2018</td>
<td>The article was revised to reflect a revised CR. The MAC implementation date, CR release date, transmittal numbers and the Web addresses of the transmittals were revised. In addition, the article and CR were revised to delete place of service codes 19 and 22 as acceptable places of service for CPT 93668. All other information remains the same.</td>
</tr>
<tr>
<td>March 5, 2018</td>
<td>The article was revised to reflect a revised CR. The MAC implementation date, CR release date, transmittal numbers and the Web addresses of the transmittals were revised. All other information remains the same.</td>
</tr>
<tr>
<td>February 6, 2018</td>
<td>Initial article released.</td>
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https://www.wpsgha.com/wps/portal/mac/site/policies/guides-and-resources

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Omaha, NE 68101

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Visit our website at the 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>J5/J8</td>
<td>Endometrial Hyperplasia Treatment with Intrauterine Device (Hormone-Eluting)</td>
<td>A55951</td>
<td>NA</td>
<td>06/01/2018</td>
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May 2018 – There are no new Policies/Articles for May 2018

April 2018 – There are no new Policies/Articles for April 2018

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 link below for more information:
June 2018 – There are no retired policies for June 2018

May 2018

<table>
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<tr>
<th>Contract</th>
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<tr>
<td>J5/J8</td>
<td>MolDX: Chromosome 1p/19q Deletion Analysis</td>
<td>L37009</td>
<td>MolDX-021</td>
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April 2018

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<tr>
<td>J5/J8</td>
<td>Infectious Disease Molecular Diagnostic Testing</td>
<td>DL37007</td>
<td>PATH-043</td>
<td>04/01/2018</td>
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REVISED POLICIES

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

Visit our website at the link below for more information:

June 2018

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<tr>
<td>J5/J8</td>
<td>Category III Codes</td>
<td>L35490</td>
<td>PHYS-084</td>
<td>06/01/2018</td>
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</tbody>
</table>

Created a Group 4 Paragraph for CPT codes: The following lists Category III services determined by WPS GHA to be reasonable and medically necessary. Coverage will only be allowed when the service is delivered in clinical situations meeting medical necessity.

Created a Group 4 table of Codes for CPT codes.

Group 4 Codes:
0501T Noninvasive estimated coronary fractional flow reserve (FFR) derived from coronary computed tomography angiography data using computation fluid dynamics physiologic simulation software analysis of functional data to assess the severity of coronary artery disease; data preparation and transmission, analysis of fluid dynamics and simulated maximal coronary hyperemia, generation of estimated FFR model, with anatomical data review in comparison with estimated FFR model to reconcile discordant data, interpretation and report
0502T Data preparation and transmission
<table>
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<tr>
<td>0503T</td>
<td>Analysis of fluid dynamics and simulated maximal coronary hyperemia, and generation of estimated FFR model</td>
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<tr>
<td>0504T</td>
<td>Anatomical data review in comparison with estimated FFR model to reconcile discordant data, interpretation and report.</td>
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</table>

Created a Group 5 Paragraph: The following ICD-10 Codes are used to support medical necessity with CPT codes 0501T, 0502T, 0503T and 0504T.

Created a Group 5 table of diagnosis codes:

<table>
<thead>
<tr>
<th>Code</th>
<th>Diagnosis</th>
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<tbody>
<tr>
<td>C38.0</td>
<td>Malignant neoplasm of heart</td>
</tr>
<tr>
<td>C45.2</td>
<td>Mesothelioma of pericardium</td>
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<tr>
<td>C79.89</td>
<td>Secondary malignant neoplasm of other specified sites</td>
</tr>
<tr>
<td>C79.9</td>
<td>Secondary malignant neoplasm of unspecified site</td>
</tr>
<tr>
<td>D15.1</td>
<td>Benign neoplasm of heart</td>
</tr>
<tr>
<td>I20.0</td>
<td>Unstable angina</td>
</tr>
<tr>
<td>I20.1</td>
<td>Angina pectoris with documented spasm</td>
</tr>
<tr>
<td>I20.8</td>
<td>Other forms of angina pectoris</td>
</tr>
<tr>
<td>I24.0</td>
<td>Acute coronary thrombosis not resulting in myocardial infarction</td>
</tr>
<tr>
<td>I25.10</td>
<td>Atherosclerotic heart disease of native coronary artery without angina pectoris</td>
</tr>
<tr>
<td>I25.110</td>
<td>Atherosclerotic heart disease of native coronary artery with unstable angina pectoris</td>
</tr>
<tr>
<td>I25.111</td>
<td>Atherosclerotic heart disease of native coronary artery with angina pectoris with documented spasm</td>
</tr>
<tr>
<td>I25.118</td>
<td>Atherosclerotic heart disease of native coronary artery with other forms of angina pectoris</td>
</tr>
<tr>
<td>I25.119</td>
<td>Atherosclerotic heart disease of native coronary artery with unspecified angina pectoris</td>
</tr>
<tr>
<td>I25.2</td>
<td>Old myocardial infarction</td>
</tr>
<tr>
<td>I25.3</td>
<td>Aneurysm of heart</td>
</tr>
<tr>
<td>I25.41</td>
<td>Coronary artery aneurysm</td>
</tr>
<tr>
<td>I25.42</td>
<td>Coronary artery dissection</td>
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<tr>
<td>I25.5</td>
<td>Ischemic cardiomyopathy</td>
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<td>I25.6</td>
<td>Silent myocardial ischemia</td>
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<tr>
<td>I25.700</td>
<td>Atherosclerosis of coronary artery bypass graft(s), unspecified, with unstable angina pectoris</td>
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<tr>
<td>I25.701</td>
<td>Atherosclerosis of coronary artery bypass graft(s), unspecified, with angina pectoris with documented spasm</td>
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<td>I25.708</td>
<td>Atherosclerosis of coronary artery bypass graft(s), unspecified, with other forms of angina pectoris</td>
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<td>I25.709</td>
<td>Atherosclerosis of coronary artery bypass graft(s), unspecified, with unspecified angina pectoris</td>
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<td>I25.710</td>
<td>Atherosclerosis of autologous vein coronary artery bypass graft(s) with unstable angina pectoris</td>
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<tr>
<td>I25.711</td>
<td>Atherosclerosis of autologous vein coronary artery bypass graft(s) with angina pectoris with documented spasm</td>
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<td>I25.718</td>
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<td>I25.721</td>
<td>Atherosclerosis of autologous artery coronary artery bypass graft(s) with angina pectoris with documented spasm</td>
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<td>Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with unstable angina pectoris</td>
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<td>I25.812</td>
<td>Atherosclerosis of bypass graft of coronary artery of transplanted heart without angina pectoris</td>
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<td>I25.89</td>
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<td>Hemopericardium, not elsewhere classified</td>
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<td>Pericardial effusion (noninflammatory)</td>
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<td>Other specified diseases of pericardium</td>
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<td>Other nonrheumatic mitral valve disorders</td>
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<td>Chronic right heart failure</td>
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<td>Double outlet right ventricle</td>
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<td>Double outlet left ventricle</td>
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<td>Double inlet ventricle</td>
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<td>Isomerism of atrial appendages</td>
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<td>Atrioventricular septal defect</td>
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<td>Tetralogy of Fallot</td>
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<td>Congenital insufficiency of aortic valve</td>
</tr>
<tr>
<td>Q23.2</td>
<td>Congenital mitral stenosis</td>
</tr>
<tr>
<td>Q23.3</td>
<td>Congenital mitral insufficiency</td>
</tr>
<tr>
<td>Q23.4</td>
<td>Hypoplastic left heart syndrome</td>
</tr>
<tr>
<td>Q23.8</td>
<td>Other congenital malformations of aortic and mitral valves</td>
</tr>
<tr>
<td>Q23.9</td>
<td>Congenital malformation of aortic and mitral valves, unspecified</td>
</tr>
<tr>
<td>Q24.0</td>
<td>Dextrocardia</td>
</tr>
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<td>Contract</td>
<td>Policy Title</td>
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</tr>
<tr>
<td>Q24.1</td>
<td>Levocardia</td>
</tr>
<tr>
<td>Q24.2</td>
<td>Cortriatriatum</td>
</tr>
<tr>
<td>Q24.3</td>
<td>Pulmonary infundibular stenosis</td>
</tr>
<tr>
<td>Q24.4</td>
<td>Congenital subaortic stenosis</td>
</tr>
<tr>
<td>Q24.5</td>
<td>Malformation of coronary vessels</td>
</tr>
<tr>
<td>Q24.8</td>
<td>Other specified congenital malformations of heart</td>
</tr>
<tr>
<td>Q24.9</td>
<td>Congenital malformation of heart, unspecified</td>
</tr>
<tr>
<td>Q25.0</td>
<td>Patent ductus arteriosus</td>
</tr>
<tr>
<td>Q25.1</td>
<td>Coarctation of aorta</td>
</tr>
<tr>
<td>Q25.21</td>
<td>Interruption of aortic arch</td>
</tr>
<tr>
<td>Q25.29</td>
<td>Other atresia of aorta</td>
</tr>
<tr>
<td>Q25.3</td>
<td>Supravalvular aortic stenosis</td>
</tr>
<tr>
<td>Q25.40</td>
<td>Congenital malformation of aorta unspecified</td>
</tr>
<tr>
<td>Q25.41</td>
<td>Absence and aplasia of aorta</td>
</tr>
<tr>
<td>Q25.42</td>
<td>Hypoplasia of aorta</td>
</tr>
<tr>
<td>Q25.43</td>
<td>Congenital aneurysm of aorta</td>
</tr>
<tr>
<td>Q25.44</td>
<td>Congenital dilatation of aorta</td>
</tr>
<tr>
<td>Q25.45</td>
<td>Double aortic arch</td>
</tr>
<tr>
<td>Q25.46</td>
<td>Tortuous aortic arch</td>
</tr>
<tr>
<td>Q25.47</td>
<td>Right aortic arch</td>
</tr>
<tr>
<td>Q25.48</td>
<td>Anomalous origin of subclavian artery</td>
</tr>
<tr>
<td>Q25.49</td>
<td>Other congenital malformations of aorta</td>
</tr>
<tr>
<td>Q25.5</td>
<td>Atresia of pulmonary artery</td>
</tr>
<tr>
<td>Q25.6</td>
<td>Stenosis of pulmonary artery</td>
</tr>
<tr>
<td>Q25.71</td>
<td>Coarctation of pulmonary artery</td>
</tr>
<tr>
<td>Q25.72</td>
<td>Congenital pulmonary arteriovenous malformation</td>
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<tr>
<td>Q25.79</td>
<td>Other congenital malformations of pulmonary artery</td>
</tr>
<tr>
<td>Q25.8</td>
<td>Other congenital malformations of other great arteries</td>
</tr>
<tr>
<td>Q25.9</td>
<td>Congenital malformation of great arteries, unspecified</td>
</tr>
<tr>
<td>Q26.0</td>
<td>Congenital stenosis of vena cava</td>
</tr>
<tr>
<td>Q26.1</td>
<td>Persistent left superior vena cava</td>
</tr>
<tr>
<td>Q26.2</td>
<td>Total anomalous pulmonary venous connection</td>
</tr>
<tr>
<td>Q26.3</td>
<td>Partial anomalous pulmonary venous connection</td>
</tr>
<tr>
<td>Q26.4</td>
<td>Anomalous pulmonary venous connection, unspecified</td>
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<tr>
<td>Q26.8</td>
<td>Other congenital malformations of great veins</td>
</tr>
<tr>
<td>Q26.9</td>
<td>Congenital malformation of great vein, unspecified</td>
</tr>
<tr>
<td>R06.02</td>
<td>Shortness of breath</td>
</tr>
<tr>
<td>R06.03</td>
<td>Acute respiratory distress</td>
</tr>
<tr>
<td>R07.2</td>
<td>Precordial pain</td>
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<td>R07.82</td>
<td>Intercostal pain</td>
</tr>
<tr>
<td>R07.89</td>
<td>Other chest pain</td>
</tr>
<tr>
<td>R07.9</td>
<td>Chest pain, unspecified</td>
</tr>
<tr>
<td>R94.30</td>
<td>Abnormal result of cardiovascular function study, unspecified</td>
</tr>
<tr>
<td>R94.39</td>
<td>Abnormal result of other cardiovascular function study</td>
</tr>
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Added the following information to the Utilization Guidelines: 0501T - 0504T

Fractional Flow Reserve computed tomography (FFRct) is a non-invasive method of using fluid dynamics physiologic stimulation software analysis to assess the
<table>
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<th>WPS Policy #</th>
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severity of coronary artery disease. It is reimbursable with documentation of medical necessity

Updated the Summary of Evidence, Analysis of Evidence and Bibliography sections for 0501T-0504T.

<table>
<thead>
<tr>
<th>J5/J8</th>
<th>Drugs and Biologics (Non-chemotherapy)</th>
<th>L34741</th>
<th>INJ-041</th>
<th>06/01/2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ICD-10-CM Code update: Group 20 Paragraph C9257: Bevacizumab/Avastin Added to Group 20 Codes: H44.2A1 Degenerative myopia with choroidal neovascularization, right eye H44.2A2 Degenerative myopia with choroidal neovascularization, left eye H44.2A3 Degenerative myopia with choroidal neovascularization, bilateral H44.2B1 Degenerative myopia with macular hole, right eye H44.2B2 Degenerative myopia with macular hole, left eye H44.2B3 Degenerative myopia with macular hole, bilateral H44.2C1 Degenerative myopia with retinal detachment, right eye H44.2C2 Degenerative myopia with retinal detachment, left eye H44.2C3 Degenerative myopia with retinal detachment, bilateral H44.2D1 Degenerative myopia with foveoschisis, right eye H44.2D2 Degenerative myopia with foveoschisis, left eye H44.2D3 Degenerative myopia with foveoschisis, bilateral H44.2E1 Degenerative myopia with other maculopathy, right eye H44.2E2 Degenerative myopia with other maculopathy, left eye and H44.2E3 Degenerative myopia with other maculopathy, bilateral</td>
<td></td>
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<table>
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<tr>
<th>J5/J8</th>
<th>Lumbar Epidural Injections</th>
<th>L36521</th>
<th>NEURO-017</th>
<th>01/01/2018</th>
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<tr>
<td></td>
<td>Added ICD-10 M48.061 Spinal stenosis, lumbar region without neurogenic claudication to Group 1 effective 01/01/2018.</td>
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<table>
<thead>
<tr>
<th>J5/J8</th>
<th>Not Otherwise Classified Chemotherapy Agents (NOC)</th>
<th>A55640</th>
<th>NA</th>
<th>04/01/2018</th>
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<tbody>
<tr>
<td></td>
<td>Revisions due to CR 10515: OPPS April Quarterly Update effective 04/01/2018. Removed C9399 and added C9467 to Group 1 Paragraph: J9999/C9467 Rituximab and hyaluronidase human/Rituxan Hycela, 1mg (FDA approval 06/22/2017).</td>
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<table>
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<tr>
<th>J5/J8</th>
<th>Self-Administered Drug Exclusion List (SAD List)</th>
<th>A52800</th>
<th>NA</th>
<th>07/16/2018</th>
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<tr>
<td></td>
<td>Added J3490 Abaloparatide (Tymlos™) to the CPT/HCPCS Coding table.</td>
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<table>
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<tr>
<th>J5/J8</th>
<th>MolDX: bioTheranostics Cancer TYPE ID® Update</th>
<th>A55147</th>
<th>NA</th>
<th>06/01/2018</th>
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<tbody>
<tr>
<td></td>
<td>Diagnosis code D49.59 was added to this policy effective 10/01/2016. D49.59 Neoplasm of unspecified behavior of other genitourinary organ.</td>
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</table>

<table>
<thead>
<tr>
<th>J5/J8</th>
<th>MolDX: GeneSight® Assay for Refractory Depression</th>
<th>L36799</th>
<th>MolDX-015</th>
<th>06/01/2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Corrected the Hamilton Rating Scale for Depression from “= 50%” to ≥ 50% in the paragraph below.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Summary of Evidence
GeneSight® Psychotropic is a multiplex pharmacogenomic test involving the analysis of fifty alleles (SNPs) from six different genes and a clinical outcomes-based decision support modeling tool that weights the influence of the various alleles/SNPs with respect to thirty-two different psychotropic pharmaceutical agents. The test results in the differentiation of psychoactive drugs that are likely to be effective and well-tolerated by a particular patient versus those that are not. In multiple prospective clinical studies, the use of GeneSight® to guide neuropsychiatric pharmaceutical selection and prescription has demonstrated an increased patient response to treatment from 60% to 250% (as measured by the standardized 17-item Hamilton Rating Scale for Depression or HAM-17; response is defined as ≥ 50% reduction in HAM-D17 score) versus unguided, empirical treatment (or treatment as usual).

J5/J8 MolDX: NSCLC, Comprehensive Genomic Profile Testing
L36803 MolDX-017 06/01/2018
The following information was removed under the MolDX CGP Analysis Coverage section of this LCD:

Testing is performed by a lab that satisfies the MolDx Contractor’s Analytical Performance Specifications for Comprehensive Genomic Profiling (M00118,v1).

May 2018

May 2018

Contract Policy Title CMS MCD Policy # WPS Policy # Effective Date

J5/J8 Coenzyme Q10 Testing L37193 PATH-044 05/01/2018

Removed the following sentence under Neuromuscular and Neurologic Diseases: “A 2011 review by the Cochrane Collaboration suggesting CoQ10 supplementation might benefit people with Parkinson's disease was subsequently withdrawn from publication following a review by independent editors.9”


J5/J8 MolDX: APC and MUTYH Gene Testing L37224 MolDX-024 05/01/2018

CPT code 81401 has been added to this policy:

81401 MOLECULAR PATHOLOGY PROCEDURE, LEVEL 2 (EG, 2-10 SNPS, 1 METHYLATED VARIANT, OR 1 SOMATIC VARIANT [TYPICALLY USING NONSEQUENCING TARGET VARIANT ANALYSIS], OR DETECTION OF A DYNAMIC MUTATION DISORDER/TRIPLET REPEAT
This information has been added to the policy: WPS GHA recognizes that evidence for clinical utility for ConfirmMDx in males with previous negative prostate biopsy who are being considered for repeat biopsy is promising with evidence of some clinical utility at the current time. WPS GHA believes the clinical studies planned will generate sufficient additional data to demonstrate the utility of ConfirmMDx in males with previous negative prostate biopsy who are being considered for repeat biopsy. Continued coverage of ConfirmMDx for males with previous negative prostate biopsy who are being considered for repeat biopsy will be dependent on semi-annual review of interim data, and/or peer-reviewed publications and/or presentations of clinical utility data demonstrating ConfirmMDx for males with previous negative prostate biopsy directs patient management as measured using clinical endpoints in one or more studies.

The following paragraph has been updated to read:
The performance of this assay in large, blinded clinical validation studies demonstrated a NPV of 90% for all prostate cancer and 96% for high-grade disease, which is considerably higher than that afforded by standard histopathology review. A mathematically-based budget impact model using the assay in urologic practices to decide upon the need for repeat biopsies reported significant cost and medical resource savings by avoiding unnecessary, invasive biopsies over current standard of care methods. Further logistic regression models using all pertinent risk factors for prostate cancer detection (patient age, serum PSA level, digital rectal exam, histopathological findings on the previous cancer-negative biopsy and the assay) from the clinical validation trial were analyzed to compare various metrics separately and in combination. Assay results and prior histopathology were the strongest predictors of missed cancers and these two measures combined had a higher performance than either alone. Further analysis demonstrated that the assay test results combined with traditional clinical risk factors improved patient risk stratification and significantly outperformed current risk prediction models such as the Prostate Cancer Prevention Trial Risk Calculator (PCPTRC 2.0) and PSA.

CDD has been removed from the title of this LCD. All of the information related to the Certification and Training Registry program, PASCUAL clinical trial and data collection has also been removed.

J5/J8 MolDX: Immunohistochemistry (IHC)
Indications for Breast Pathology
Added MolDX to the title of this article.

J5/J8 MolDX: Prolaris™ Prostate Cancer Genomic Assay
CDD has been removed from the title of this LCD. CPT code 81479 has been replaced with CPT code 81541.

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<td>J5/J8</td>
<td>MolDX: Immunohistochemistry (IHC) Indications for Breast Pathology</td>
<td>A55136</td>
<td>NA</td>
<td>05/01/2018</td>
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<tr>
<td>J5/J8</td>
<td>MolDX: Prolaris™ Prostate Cancer Genomic Assay</td>
<td>L36787</td>
<td>MolDX-008</td>
<td>01/01/2018</td>
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<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>81541</td>
<td>ONCOLOGY (PROSTATE), MRNA GENE EXPRESSION PROFILING BY REAL-TIME RT-PCR OF 46 GENES (31 CONTENT AND 15 HOUSEKEEPING), UTILIZING FORMALIN-FIXED PARAFFIN-</td>
</tr>
</tbody>
</table>
Embeddable Tissue, Algorithm Reported as a Disease-Specific Mortality Risk Score.

**J5/J8 MolDX: ProMark Risk Score**

<table>
<thead>
<tr>
<th>Intermediate</th>
<th>High</th>
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</thead>
<tbody>
<tr>
<td>T2b-T2c OR</td>
<td>T3a OR</td>
</tr>
<tr>
<td>Gleason score 3+4=7/Gleason grade group 2 OR</td>
<td>Gleason Score 8/Gleason grade group 4 OR</td>
</tr>
<tr>
<td>Gleason score 4+3=7/Gleason grade group 3 OR</td>
<td>Gleason score 9-10/Gleason grade group 5 OR</td>
</tr>
<tr>
<td>PSA 10-20 ng/mL</td>
<td>PSA &gt; 20 ng/mL</td>
</tr>
</tbody>
</table>

CDD has been removed from the title of this LCD. “OR” has been added back in between the Gleason score and PSA values in the table under the Intermediate and High-Risk sections.

**J5/J8 Self-Administered Drug Exclusion List (SAD List)**

Code update: added C9015 for Injection C1 Esterase Inhibitor, Human (Haegarda®), 10 units to the CPT/HCPCS Coding table.

**April 2018 Allergy Testing**

For clarification, added the following bullet point "d. Vaccines" to Intracutaneous/Intradermal Tests. Usable codes for vaccines are already listed in Group 1 for intracutaneous/intradermal allergy testing.

2. Intracutaneous/Intradermal Tests are usually performed when increased sensitivity is the main goal such as when percutaneous tests are negative and there is a strong suspicion of allergen sensitivity. Intradermal tests are injections of small amounts of antigen into the superficial layers of the skin. The usual testing program may include 2 concentrations of an extract: a weaker concentration and a stronger concentration. It would not be expected that 3 or more concentrations of one extract would be medically necessary. Medicare covers intradermal (intracutaneous) testing when IgE-mediated reactions occur to any of the following:

a. Inhalants.
b. Hymenoptera (stinging insects).
c. Specific drugs (penicillins and macromolecular agents).
d. Vaccines.

Bisphosphonate Drug Therapy

Added the following statement to the Group 2 Paragraph for J3489 Zoledronic acid: For codes in the table below that require a 7th character, letter A initial encounter for fracture, D subsequent encounter for fracture with routine healing, G subsequent encounter for fracture with delayed healing, K for subsequent encounter for fracture with nonunion, P for subsequent encounter for fracture with malunion, or S sequela may be used.

Added the following diagnosis codes to the Group 2 table of codes for J3489 Zoledronic acid:
- M80.011A Age-related osteoporosis with current pathological fracture, right shoulder, initial encounter for fracture
- M80.012A Age-related osteoporosis with current pathological fracture, left shoulder, initial encounter for fracture
- M80.021A Age-related osteoporosis with current pathological fracture, right humerus, initial encounter for fracture
- M80.022A Age-related osteoporosis with current pathological fracture, left humerus, initial encounter for fracture
- M80.031A Age-related osteoporosis with current pathological fracture, right forearm, initial encounter for fracture
- M80.032A Age-related osteoporosis with current pathological fracture, left forearm, initial encounter for fracture
- M80.041A Age-related osteoporosis with current pathological fracture, right hand, initial encounter for fracture
- M80.042A Age-related osteoporosis with current pathological fracture, left hand, initial encounter for fracture
- M80.051A Age-related osteoporosis with current pathological fracture, right femur, initial encounter for fracture
- M80.052A Age-related osteoporosis with current pathological fracture, left femur, initial encounter for fracture
- M80.061A Age-related osteoporosis with current pathological fracture, right lower leg, initial encounter for fracture
- M80.062A Age-related osteoporosis with current pathological fracture, left lower leg, initial encounter for fracture
- M80.071A Age-related osteoporosis with current pathological fracture, right ankle and foot, initial encounter for fracture
- M80.072A Age-related osteoporosis with current pathological fracture, left ankle and foot, initial encounter for fracture
- M80.08XA Age-related osteoporosis with current pathological fracture, vertebra(e), initial encounter for fracture
- M80.811A Other osteoporosis with current pathological fracture, right shoulder, initial encounter for fracture
- M80.812A Other osteoporosis with current pathological fracture, left shoulder, initial encounter for fracture
- M80.821A Other osteoporosis with current pathological fracture, right humerus, initial encounter for fracture
<table>
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<th>WPS Policy #</th>
<th>Effective Date</th>
</tr>
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<tbody>
<tr>
<td>J5/J8</td>
<td>Drugs and Biologics (Non-chemotherapy)</td>
<td>L34741</td>
<td>INJ-041</td>
<td>04/01/2018</td>
</tr>
</tbody>
</table>


Removed Q5102 Injection, Infliximab, Biosimilar, 10 mg and corresponding verbiage from Group 1 Paragraph.
Removed Q5102 Injection, Infliximab, Biosimilar, 10 mg from Group 1 Codes.

Added Q5103 Injection, Infliximab-DYYB, Biosimilar (Inflectra), 10mg and
Added Q5104 Injection, Infliximab-ABDA, Biosimilar (Renflexis), 10 mg to Group 1 Paragraph.

Removed Q5102 Injection, Infliximab, Biosimilar, 10 mg and corresponding verbiage from Group 11 Paragraph.

Added Q5103 Injection, Infliximab-DYYB, Biosimilar (Inflectra), 10 mg and
Added Q5104 Injection, Infliximab-ABDA, Biosimilar (Renflexis), 10 mg to Group 11 Paragraph.

J5/J8    | Human Granulocyte/Macrophage Colony Stimulating Factor | L34699 | INJ-019 | 04/01/2018 |

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<th>WPS Policy #</th>
<th>Effective Date</th>
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<tr>
<td></td>
<td>Revision to descriptor for HCPCS code Q5101: Injection, filgrastim-sndz, biosimilar, (zarxio), 1 microgram. Removed modifier ZA explanation and added &quot;modifiers with HCPCS codes for biosimilars no longer required&quot; to: G. Indications for Filgrastim-sndz (zarxio), Group 1 Paragraph, and Group 7 Paragraph. Utilization Guidelines: Removed Change Request 9284 modifier ZA explanation and added Change Request 10454 explanation: Effective for claims with dates of service on or after April 1, 2018 modifiers that describe the manufacturer of a biosimilar product (for example, ZA, ZB, and ZC) will no longer be required on Medicare claims.</td>
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<tr>
<td>J5/J8</td>
<td>J5/J8 MolDX: GeneSight® Assay for Refractory Depression</td>
<td>L36799</td>
<td>MolDX-015</td>
<td>05/15/2018</td>
</tr>
<tr>
<td></td>
<td>The following information has been added to this policy: Provider may have primary boards in internal medicine or neurology and also have boards in psychiatry or neuropsychiatry and the provider has a designated specialty in PECOS as IM/neurology. WPS GHA is allowing the GeneSight test to be ordered, when medically necessary, by these providers and they will affix a KX modifier attesting that they have psychiatry or neuropsychiatry boards. Assurex will maintain the certification and make it available upon request.</td>
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<tr>
<td>J5/J8</td>
<td>J5/J8 MolDX: Molecular Diagnostic Tests (MDT)</td>
<td>L36807</td>
<td>MolDX-004</td>
<td>05/15/2018</td>
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<td>The following CPT codes have been added to this policy (Effective 05/15/2018): 81105 GENE ANALYSIS (HUMAN PLATELET ANTIGEN 1) FOR COMMON VARIANT 81106 GENE ANALYSIS (HUMAN PLATELET ANTIGEN 2) FOR COMMON VARIANT 81107 GENE ANALYSIS (HUMAN PLATELET ANTIGEN 3) FOR COMMON VARIANT 81108 GENE ANALYSIS (HUMAN PLATELET ANTIGEN 4) FOR COMMON VARIANT 81109 GENE ANALYSIS (HUMAN PLATELET ANTIGEN 5) FOR COMMON VARIANT 81110 GENE ANALYSIS (HUMAN PLATELET ANTIGEN 6) FOR COMMON VARIANT 81111 GENE ANALYSIS (HUMAN PLATELET ANTIGEN 9) FOR COMMON VARIANT 81112 GENE ANALYSIS (HUMAN PLATELET ANTIGEN 15) FOR COMMON VARIANT 81120 GENE ANALYSIS (ISOCITRATE DEHYDROGENASE 1 [NADP+], SOLUBLE) FOR COMMON VARIANTS 81121 GENE ANALYSIS (ISOCITRATE DEHYDROGENASE 2 [NADP+], MITOCHONDRIAL) FOR COMMON VARIANTS</td>
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<td>ONC PRST8 CA MRNA 12 GEN ALG</td>
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<td>The following CPT codes have been removed from this policy (Effective 01/01/2018):</td>
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<tr>
<td></td>
<td>88271 MOLECULAR CYTOGENETICS; DNA PROBE, EACH (EG, FISH)</td>
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<tr>
<td></td>
<td>88272 MOLECULAR CYTOGENETICS; CHROMOSOMAL IN SITU HYBRIDIZATION, ANALYZE 3-5 CELLS</td>
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<tr>
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<td>88273 MOLECULAR CYTOGENETICS; CHROMOSOMAL IN SITU HYBRIDIZATION, ANALYZE 10-30 CELLS</td>
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<tr>
<td></td>
<td>88274 MOLECULAR CYTOGENETICS; INTERPHASE IN SITU HYBRIDIZATION, ANALYZE 25-99 CELLS</td>
<td></td>
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<tr>
<td></td>
<td>88275 MOLECULAR CYTOGENETICS; INTERPHASE IN SITU HYBRIDIZATION, ANALYZE 100-300 CELLS</td>
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<td></td>
<td>0008M ONC BREAST RISK SCORE</td>
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<td></td>
<td>0004U TEST FOR DETECTING GENES ASSOCIATED WITH ANTIBIOTIC RESISTANCE IN BACTERIAL CULTURE</td>
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<td></td>
<td>0015U TEST FOR DETECTING GENES ASSOCIATED WITH DRUG METABOLISM IN BLOOD OR CHEEK SWAB</td>
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<tr>
<td></td>
<td>The following CPT codes have been removed from this policy (Effective 03/01/2018):</td>
<td></td>
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<tr>
<td></td>
<td>87505 NFCT AGENT DETECTION GI</td>
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<tr>
<td></td>
<td>87506 IADNA-DNA/RNA PROBE TQ 6-11</td>
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<td>87507 IADNA-DNA/RNA PROBE TQ 12-25</td>
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<td></td>
<td>87631-87633 DETECTION TEST FOR MULTIPLE TYPES OF RESPIRATORY VIRUS</td>
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<td></td>
<td>87149 IDENTIFICATION OF ORGANISMS BY GENETIC ANALYSIS</td>
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<tr>
<td></td>
<td>87150 IDENTIFICATION OF ORGANISMS BY GENETIC ANALYSIS</td>
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<tr>
<td>J5/J8</td>
<td>MolDX: PreDx® Coding and Billing Guidelines</td>
<td>A55201</td>
<td>NA</td>
<td>05/15/2018</td>
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<tr>
<td></td>
<td>CPT 84999-Unlisted Chemistry code has been replaced with CPT code 81506.</td>
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<tr>
<td></td>
<td>81506 - endocrinology (type 2 diabetes), biochemical assays of seven analytes (glucose, hba1c, insulin, hs-crp, adiponectin, ferritin, interleukin 2-receptor alpha), utilizing serum or plasma, algorithm reporting a risk score</td>
<td></td>
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Electronic Data Interchange (EDI)

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

MLN Matters Number: MM10566  Related Change Request (CR) Number: 10566
Related CR Release Date: May 18, 2018  Effective Date: October 1, 2018
Related CR Transmittal Number: R4054CP  Implementation Date: October 1, 2018

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 (DME/MACs) for services to Medicare beneficiaries.

PROVIDER ACTION NEEDED

Change Request (CR) 10566 informs MACs to update their systems based on the CORE 360 Uniform use of Claims Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC) and Claim Adjustment Group Code (CAGC) rule publication. These system updates are based on the Committee on Operating Rules for Information Exchange (CORE) Code Combination List to be published on or about June 4, 2018. CR10566 applies to the Medicare Claims Processing Manual, Chapter 22, Section 80.2. Make sure that your billing staffs are aware of these changes.

BACKGROUND

The Department of Health and Human Services (DHHS) adopted the Phase III Council for Affordable Quality Healthcare (CAQH) CORE, Electronic Funds Transfer (EFT) and Electronic
Remittance Advice (ERA) Operating Rule Set that was implemented on January 1, 2014, under the Affordable Care Act. The Health Insurance Portability and Accountability Act (HIPAA) amended the Act by adding Part C—Administrative Simplification—to Title XI of the Social Security Act, requiring the Secretary of DHHS (the Secretary) 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 Affordable Care Act, 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.

CR10566 deals with the regular update in CAQH CORE defined code combinations per Operating Rule 360 - Uniform Use of CARC and RARC (835) Rule.

CAQH CORE will publish the next version of the Code Combination List on or about June 4, 2018. This update is based on the CARC and RARC updates as posted at the Washington Publishing Company (WPC) website on or about March 1, 2018. This will also include updates based on market based review that CAQH CORE conducts once a year to accommodate code combinations that are currently being used by health plans including Medicare, as the industry needs them.


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

**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/.
DOCUHENT HISTORY

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Modifications to the Implementation of the Paperwork (PWK) Segment of the Electronic Submission of Medical Documentation (esMD) System

MLN Matters Number: MM10397 Revised
Related CR Release Date: April 3, 2018
Related CR Transmittal Number: R2050OTN

Related Change Request (CR) Number: 10397
Effective Date: July 1, 2018
Implementation Date: July 2, 2018

Note: This article was revised on April 4, 2018, to reflect a revised CR issued on April 3. In the article, the CR release date, transmittal number, and the Web address of the CR are revised. All other information is the same.

PROVIDER TYPE AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 10397 updates the business requirements to enable MACs to receive unsolicited documentation (also known as paperwork (PWK)) via the Electronic Submission of Medical Documentation (esMD) system. CR10397 is for esMD purposes only. Please make sure your billing staffs are aware of these updates.

BACKGROUND

CR10397 also contains attachments that include cover sheets that must be used for electronic, fax, or mail submissions of documentation. There are three cover sheets, one each for Part A and Part B providers, as well as one for durable medical equipment (DME) suppliers. In addition, there are two companion guides attached to CR10397, one for institutional claims and one for professional claims. A link to CR10397 is available in the Additional Information section of this article.

With CR10397, MACs will modify PWK, also known as unsolicited documentation procedures to include electronic submission(s) via esMD. Also, Medicare systems will accept PWK 02 values “EL” and “FT” for those MACs in a CMS-approved esMD system. This mechanism will suppress
initial auto letter generation, if applicable, when PWK 02 is “EL” or “FT,” and is present at any level of the claim or line.

Providers will receive communication from MACs via companion documents for 5010 X12 837 to include:

- The value “EL” (electronic) in PWK 02 to represent an esMD submission for sending the documentation using X12 Standards (6020 X12 275)
- The value “FT” (file transfer) in PWK 02 to represent an esMD submission for sending the documentation in PDF format using XDR specifications.

MACs will allow 7 calendar “waiting days” (from the date of receipt) for additional information to be submitted when the PWK 02 value is “EL” or “FT.”

MACs will use RC Client to reject the PWK data submissions as administrative error(s) when the received cover sheet (via esMD) is incomplete or incorrectly filled out as applicable to current edits. Providers can expect to see new generic reason statements introduced to convey these errors as follows (Codes for these statements will be finalized and sent along with the RC implementation guide):

- The date(s) of service on the cover sheet received is missing or invalid.
- The NPI on the cover sheet received is missing or invalid.
- The state where services were provided is missing or invalid on the cover sheet received.
- The Medicare ID on the cover sheet received is missing or invalid.
- The billed amount on the cover sheet received is missing or invalid.
- The contact phone number on the cover sheet received is missing or invalid.
- The beneficiary name on the cover sheet received is missing or invalid.
- The claim number on the cover sheet received is missing or invalid.
- The Attachment Control Number (CAN) on the cover sheet is missing or invalid.

Once again, examples of the cover sheet are included as an attachment to CR10397.

**ADDITIONAL INFORMATION**


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

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<td>April 3, 2018</td>
<td>The article was revised to reflect a revised CR. In the article, the CR release date, transmittal number, and the Web address of the CR are revised. All other information is the same.</td>
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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: MM10489  Related Change Request (CR) Number: 10489
Related CR Release Date: February 16, 2018  Effective Date: July 1, 2018
Related CR Transmittal Number: R3980CP  Implementation Date: July 2, 2018

PROVIDER TYPES AFFECTED

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

WHAT YOU NEED TO KNOW

Change Request (CR) 10489 updates the Remittance Advice Remark Codes (RARC) and Claims Adjustment Reason Code (CARC) lists and instructs Medicare Shared System Maintainers (SSMs) to update Medicare Remit Easy Print (MREP) and PC Print. Be sure your staff are aware of these changes and obtain the updated MREP and PC Print software if they use that software.

Background

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

The Centers for Medicare & Medicaid Services (CMS) instructs MACs to conduct updates based on the code update schedule that results in publication three times per year – around March 1, July 1, and November 1. This Recurring Update Notification applies to Chapter 22, Sections 40.5, 60.1, and 60.2 of the “Medicare Claims Processing Manual.”

The 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 Washington Publishing Company (WPC) website. If any new or modified code has an effective date past the implementation date specified in CR 10489, MACs must implement on the date specified on the WPC website, available 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 this recurring CR, the MACs and the SSMs must get the complete list for both CARC and RARC from the WPC website to obtain the comprehensive lists for both code sets and determine the changes that are included on the code list since the last code update, CR 10270 (see MLN Matters article [MM10270](#)).

### ADDITIONAL INFORMATION


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General Information

Comprehensive ESRD Care (CEC) Model Telehealth - Implementation

MLN Matters Number: MM10314
Related Change Request (CR) Number: 10314
Related CR Release Date: April 27, 2018
Effective Date: October 1, 2018
Related CR Transmittal Number: R196DEMO
Implementation Date: October 1, 2018

PROVIDER TYPES AFFECTED

This MLN Matters Article is intended for physicians, providers, and suppliers billing Medicare Administrative Contractors (MACs) and participating in the Comprehensive ESRD Care (CEC) Model for telehealth services provided to Medicare End-Stage Renal Disease (ESRD) beneficiaries associated with the CEC Model.

PROVIDER ACTION NEEDED

Change Request (CR) 10314 details the CEC Model telehealth program and how it will be implemented. Make sure your billing staffs are aware of this initiative.

BACKGROUND

Section 1115A) of the Social Security Act (the Act) (added by Section 3021 of the Affordable Care Act (ACA) (42 USC 1315a) authorizes the Center for Medicare and Medicaid Innovation (CMMI) to test innovative health care payment and service-delivery models that have the potential to lower Medicare, Medicaid, and the Child Health Insurance Program (CHIP) spending while maintaining or improving the quality of beneficiaries’ care.

The CEC Model is designed to identify, test, and evaluate new ways to improve care for Medicare beneficiaries with ESRD. Through the CEC Model, the Centers for Medicare & Medicaid Services (CMS) will partner with health care providers and suppliers to test the effectiveness of a new payment and service delivery model in providing beneficiaries with person-centered, high-quality care. The Model builds on Accountable Care Organization (ACO) experience from the Pioneer ACO Model, Next Generation ACO Model, and the Medicare Shared Savings Program to test Accountable Care Organizations for ESRD beneficiaries.

More than 600,000 Americans have ESRD and require life-sustaining dialysis treatments several times per week. Many beneficiaries with ESRD suffer from poorer health outcomes,
often the result of underlying disease complications and multiple co-morbidities. These can lead to high rates of hospital admission and readmissions, as well as a mortality rate that is higher than that of the general Medicare population.

According to United States Renal Data System, in 2014, ESRD beneficiaries comprised less than 1 percent of the Medicare population, but accounted for an estimated 7.2 percent of total Medicare Fee-For-Service (FFS) spending, totaling more than $32.8 billion.

Because of their complex health needs, beneficiaries often require visits to multiple providers and follow multiple care plans, all of which can be challenging for beneficiaries if care is not coordinated. The CEC Model seeks to create incentives to enhance care coordination and to create a person-centered, coordinated care experience, and to ultimately improve health outcomes for this population.

In the CEC Model, dialysis clinics, nephrologists and other providers collaborate to create an ESRD Seamless Care Organization (ESCO) to coordinate care for matched beneficiaries. ESCOs are accountable for clinical quality outcomes and financial outcomes measured by Medicare Part A and B spending, including all spending on dialysis services for their aligned ESRD beneficiaries. This model encourages dialysis providers to think beyond their traditional roles in care delivery and supports them as they provide patient-centered care that will address beneficiaries' health needs, both in and outside of the dialysis clinic.

The CEC Model includes separate financial arrangements for larger and smaller dialysis organizations. Large Dialysis Organizations (LDOs), defined as having 200 or more dialysis facilities, will be eligible to receive shared savings payments. These LDOs will also be liable for shared losses and will have higher overall levels of risk compared with their smaller counterparts.

Non-Large Dialysis Organizations (Non-LDOs) include chains with fewer than 200 dialysis facilities, independent dialysis facilities, and hospital-based dialysis facilities. Non-LDOs will have the option of participating in a one-sided track where they will be able to receive shared savings payments, but will not be liable for payment of shared losses, or participating in a track with higher risk and the potential for shared losses. The one-sided track is offered in recognition of the Non-LDOs more limited resources.

The CEC Model began on October 1, 2015, and will run until December 31, 2020. The CEC Model conducted a solicitation in 2016 to add more ESCOs for Performance Year 2 of the model, beginning on January 1, 2017. The CEC Model has no current plans for another round of solicitations.

The CEC Model LDO payment track and Non-LDO two-sided payment track are considered Advance Payment Models (APMs) regarding the Quality Payment Program.

The CEC Model will implement design elements with implications for the FFS system for its third performance year that includes benefit enhancements to give ACOs the tools to direct care and engage beneficiaries in their own care. The model also offers increased monitoring to account for different financial incentives and the provision of enhanced benefits. The model’s quality
requirements are similar to Shared Savings Program (SSP) and Pioneer, modified as needed to take into account unique aspects of dialysis care, in keeping with the agencies initiatives to unify and streamline quality measurement and requirements.

**Telehealth Waiver**

In order to emphasize high-value services and support the ability of ESCOs to manage the care of beneficiaries, CMS plans to design policies and use the authority under Section 1115A of the Social Security Act (Section 3021 of the Affordable Care Act) to conditionally waive certain Medicare payment requirements as part of the CEC Model.

CMS will make available to qualified ESCOs a waiver of the originating site requirement for services provided via telehealth. This benefit enhancement will allow beneficiaries to receive qualified telehealth services in non-rural locations and locations that are not specified by statute, such as homes and dialysis facilities. The waiver will apply only to eligible aligned beneficiaries receiving services from ESCO providers.

An aligned beneficiary will be eligible to receive telehealth services through this waiver if the services are otherwise qualified with respect to:

1. The service provided, as designated by Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes, and
2. The remote site.

MACs will apply claims processing edit logic, audit, medical review, Medicare Secondary Payor, and fraud and abuse activities, appeals and overpayment processes for CEC claims in the same manner as normal FFS claims.

Notwithstanding these waivers, all telehealth services must be furnished in accordance with all other Medicare coverage and payment criteria, and no additional reimbursement will be made to cover set-up costs, technology purchases, training and education, or other related costs. In particular, the services allowed through telehealth are limited to those described under Section 1834(m)(4)(F) of the Act, and subsequent additional services specified through regulation with the exception that claims **will not** be allowed for the following telehealth services rendered to aligned beneficiaries located at their residence:

- Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or Skilled Nursing Facilities (SNFs) - HCPCS codes G0406-G0408.
- Subsequent hospital care services, with the limitation of 1 telehealth visit every 3 days - CPT codes 99231-99233.
- Subsequent nursing facility care services, with the limitation of 1 telehealth visit every 30 days - CPT codes 99307-99310.
- Telehealth consultations, emergency department or initial inpatient - HCPCS codes G0425-G0427.
- Telehealth Consultation, Critical Care, initial - HCPCS code G0508.
- Telehealth Consultation, Critical Care, subsequent - HCPCS code G0509.
• Prolonged service in the inpatient or observation setting requiring unit/floor time beyond the usual service - CPT codes 99356-99357.

MACs will be ready to process Part B CEC claims for dates of service on or after October 1, 2018. MACs will process CEC telehealth claims (Place of Service (POS) 02) when providers are ESCO providers and beneficiaries are aligned to the same ESCO for the Date of Service (DOS) on the claims and contains the demo code 85 and one of the following CPT or HCPCS codes:

90785, 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90846, 90847, 90951, 90952, 90954, 90955, 90957, 90958, 90960, 90961, 90963, 90964, 90965, 90966, 90967, 90968, 90969, 90970, 96116, 96150, 96151, 96152, 96153, 96154, 96160, 96161, 97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99354, 99355, 99406, 99407, 99495, 99496, 99497, 99498, 99508, G0109, G0270, G0396, G0397, G0420, G0421, G0438, G0439, G0442, G0443, G0444, G0445, G0446, G0447, G0459, G0506, G9481, G9482, G9483, G9484, G9485, G9486, G9487, G9488, G9489

For Part A CEC claims when providers are ESCO providers and beneficiaries are aligned to the same ESCO for the Date of Service (DOS) on the claims submitted on Type of Bill (TOB) 12X, 13X, 22X, 23X, 71X, 72X, 76X, 77X, or 85X and contains the demo code 85 and one of the following CPT or HCPCS codes:

90785, 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90846, 90847, 90951, 90952, 90954, 90955, 90957, 90958, 90960, 90961, 90963, 90964, 90965, 90966, 90967, 90968, 90969, 90970, 96116, 96150, 96151, 96152, 96153, 96154, 96160, 96161, 97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99354, 99355, 99406, 99407, 99495, 99496, 99497, 99498, G0108, G0109, G0270, G0396, G0397, G0420, G0421, G0438, G0439, G0442, G0443, G0444, G0445, G0446, G0447, G0459, G0506, G9481, G9482, G9483, G9484, G9485, G9486, G9487, G9488, G9489

MACs will not process as CEC telehealth claims that contain the following codes. Claims that contain these codes these codes can be processed following existing claims processing logic:

• HCPCS codes G0406 – G0408.
• CPT codes 99231 – 99233.
• CPT codes 99307 – 99310.
• HCPCS codes G0425-G0427
• HCPCS code G0508
• HCPCS code G0509
• CPT codes 99356-99357

MACs will treat CEC payments the same as Medicare patients for cost reporting purposes.
Providers submitting electronic 837 claims should enter DEMO 85 in the REF segment 2300 Loop Demonstration Project Identifiers and providers will include Qualifier P4. Providers submitting a paper claim should enter demo 85 in the treatment authorization field.

Providers should be aware that MACs will return claims if you append demo code 85, and:

- You are not on the CEC participant provider list with a telehealth record type; or
- DOS “from date” is prior to your telehealth effective date, or
- DOS “from date” is after your telehealth termination date, or
- The DOS “from date” is prior to the beneficiary’s effective date; or
- The DOS “from date” is after the beneficiary’s termination date, or
- The beneficiary was not aligned to the same ESCO with which you are participating, as identified by ESCO ID; or
- The claim is for Part A and the TOB is other than 12X, 13X, 22X, 23X, 71X, 72X, 76X, 77X, and 85X,
- Other, non-telehealth services are billed on the same claim. In these cases, none of the services on the claim are processed.

In returning Part B claims, your MAC will use the following messaging:

- Claims Adjustment Reason Code (CARC) 16: (Claim/service lacks information or has submission/billing error(s) which is needed for adjudication) and
- Remittance Advice Remark Code (RARC) N763 (The demonstration code is not appropriate for this claim; resubmit without a demonstration code.)
- Group Code: CO (Contractual Obligation)

For Part A claims, your MAC will just return the claim to the provider (RTP).

**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 Updates to Pub. 100-01, 100-02 and 100-04 to Correct Errors and Omissions (SNF) (2018)

MLN Matters Number: MM10512
Related Change Request (CR) Number: CR10512
Related CR Release Date: March 16, 2018
Effective Date: June 19, 2018
Related CR Transmittal Number: R114GI, R242BP, and R4001CP
Implementation Date: June 19, 2018

PROVIDER TYPE AFFECTED

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

PROVIDER ACTION NEEDED

STOP – Impact to you:

This article is based on Change Request (CR) 10512 which informs MACs about an update to the Medicare manuals to correct various minor technical errors and omissions. Those changes are intended only to clarify the existing content and no policy, processing, or system changes are anticipated.

GO – What you need to do:

Make sure that your billing staff are aware of these changes. See the Background and Additional Information Sections of this article for further details regarding these changes.

BACKGROUND

CR10512 updates the Medicare manuals with regard to SNF policy to clarify the existing content. These changes are being made to correct various omissions and minor technical errors. No policy, processing or system changes are anticipated.
CR10512 Changes

*Medicare General Information, Eligibility and Entitlement Manual,*

**Chapter 4: Physician Certification and Recertification of Services**

**Pub 100-01, Chapter 4, §40.1**
This section is revised by adding an appropriate cross-reference.

**Pub 100-01, Chapter 4, §40.2**
This section is revised by clarifying the discussion of the initial certification’s required content, and by adding an appropriate cross-reference.

**Chapter 5: Medicare General Information, Eligibility, and Entitlement**

**Pub 100-01, Chapter 5, §30.2**
This section is revised by updating the existing citation to the regulations at 42 CFR 483.75(n), in order to reflect their redesignation at 42 CFR 483.70(j) in the long-term care facility requirements reform final rule (81 FR 68831, October 4, 2016).

**Pub 100-01, Chapter 5, §30.3**
This section is revised by updating the existing citation to the regulations at 42 CFR 482.66, in order to reflect their redesignation at 42 CFR 482.58 in a final rule that was published on May 12, 2014 (79 FR 27155), and by adding an appropriate cross-reference.

*Medicare Benefit Policy Manual*

**Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance**

**Pub 100-02, Chapter 8, §20.2.3**
This section is revised by modifying the language that describes the starting point of the applicable 30-day period, so that it more accurately tracks that of the corresponding statutory authority in §1861(i) of the Social Security Act and the implementing regulations at 42 CFR 409.36.

**Pub 100-02, Chapter 8, §30.1**
This section is revised by modifying the language so that it no longer pertains to only one particular type of case-mix model, and by adding a reference to the posting of the CMS-designated case-mix classifiers on the SNF PPS web site. These changes reflect similar revisions made in the corresponding regulations at 42 CFR 409.30 and 413.345 by the FY 2018 SNF PPS final rule (82 FR 35644-45, August 4, 2017).

**Pub 100-02, Chapter 8, §40.1**
This section is revised by updating the existing citation to the regulations at 42 CFR 483.40(e), in order to reflect their redesignation at 42 CFR 483.30(e) in the long-term care facility requirements reform final rule (81 FR 68829, October 4, 2016).
Pub 100-02, Chapter 8, §50.3

This section is revised to correct some cross-references, and to clarify the language describing the nonparticipating portion of the same institution that also includes a participating distinct part.

Pub 100-02, Chapter 8, §50.8.2

This section is revised to correct a cross-reference.

Pub 100-02, Chapter 8, §70.4

The first paragraph of this section is revised to clarify the scope of services for which SNFs can make arrangements with outside sources, and also by adding an appropriate cross-reference.

Medicare Claims Processing Manual

Chapter 1 - General Billing Requirements

Pub 100-04, Chapter 1, §30.1.1.1

This section is revised by updating the existing citation to the regulations at 42 CFR 483.10(b)(5)-(6), in order to reflect their revision and redesignation at 42 CFR 483.10(g)(17)-(18) in the long-term care facility requirements reform final rule (81 FR 68825, 68854, October 4, 2016).

Chapter 6 - SNF Inpatient Part A Billing and SNF Consolidated Billing

Pub 100-04, Chapter 6, §10.1

This section is revised to expand and clarify the discussion of a beneficiary’s status as a SNF “resident” for consolidated billing purposes to conform more closely with the corresponding regulations at 42 CFR 411.15(p)(3), as well as by adding some appropriate cross-references, and by updating the existing citation to the regulations at 42 CFR 483.12(a)(2)(i)-(vi), in order to reflect their redesignation at 42 CFR 483.15(c)(1)(i)(A)-(F) in the long-term care facility requirements reform final rule (81 FR 68826, October 4, 2016).

Pub 100-04, Chapter 6, §10.4

This section is revised by updating the existing citation to the regulations at 42 CFR 483.75(h), in order to reflect their redesignation at 42 CFR 483.70(g) in the long-term care facility requirements reform final rule (81 FR 68830, October 4, 2016).

Pub 100-04, Chapter 6, §20.1.2

This section is revised to restore a minor edit that was agreed to during the internal review of CR 9748 but was then inadvertently omitted from the published version.

Pub 100-04, Chapter 6, §20.2.1

The final paragraph of this section is revised to reflect the statutory addition of acute dialysis to the scope of the Part B dialysis benefit and, by extension, to the scope of the dialysis exclusion from SNF consolidated billing as well.
Pub 100-04, Chapter 6, §20.3
This section is revised to clarify the language in a parenthetical phrase.

Pub 100-04, Chapter 6, §20.3.1
This section is revised to clarify that the exclusion of dialysis-related ambulance transports from SNF consolidated billing applies to the entire ambulance roundtrip from the SNF, and to clarify the discussion of a beneficiary’s status as a SNF “resident” for consolidated billing purposes. In addition, the existing citation to the regulations at 42 CFR 483.10(b)(6) is updated in order to reflect their revision and redesignation at 42 CFR 483.10(g)(18) in the long-term care facility requirements reform final rule (81 FR 68825, 68854, October 4, 2016).

Pub 100-04, Chapter 6, §40.3.3
This section is revised to clarify the language on counting inpatient days.

Pub 100-04, Chapter 6, §40.3.4
This section is revised to clarify the language on counting inpatient days and the discussion of a beneficiary’s status as a SNF “resident” for consolidated billing purposes.

Pub 100-04, Chapter 6, §40.3.5
This section is revised to clarify the language on counting inpatient days and the language that describes the nonparticipating portion of the same institution that also includes a participating distinct part.

Pub 100-04, Chapter 6, §40.3.5.2
This section is revised to clarify the language that describes the nonparticipating portion of the same institution that also includes a participating distinct part.

Chapter 20 - Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

Pub 100-04, Chapter 20, §10.2
In column A (“Conditions”), a cross-reference in item 2 is corrected, and in column B (“Review Action”), the next-to-last paragraph in item 2 is revised to clarify the language describing the nonparticipating portion of the same institution that also includes a participating distinct part.

Chapter 30 - Financial Liability Protections

Pub 100-04, Chapter 30, §130.3
Paragraphs A and B of this section are revised to clarify the language describing the nonparticipating portion of the same institution that also includes a participating distinct part.

Pub 100-04, Chapter 30, §130.4
Paragraph A of this section is revised to clarify the language describing the nonparticipating portion of the same institution that also includes a participating distinct part.
ADDITIONAL INFORMATION

The official instruction, CR10512, issued to your MAC regarding this change consists of the following three transmittals:


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 Cost Report E-Filing (MCRReF)

MLN Matters Number: MM10611
Related CR Release Date: April 30, 2018
Related CR Transmittal Number: R2075OTN
Related Change Request (CR) Number: 10611
Effective Date: June 12, 2018
Implementation Date: June 12, 2018

PROVIDER TYPES AFFECTED

This MLN Matters Article is intended for cost report staff submitting annual Medicare Cost Reports (MCRs) to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

Change Request (CR) 10611 informs MACs and providers of the new MCR e-filing (MCRReF) system available for electronic transmission of cost reports. Medicare Part A providers file an annual MCR with the Centers for Medicare & Medicaid Services (CMS). The reports are filed with a MAC assigned to each provider. The MCR is used to determine the providers’ Medicare reimbursable costs. MACs may suspend payments to providers that fail to file their MCR on the due date. Make sure your cost report staffs are aware of the new MCRReF System.

BACKGROUND

In accordance with Chapter 1, Section 104 of the Provider Reimbursement Manual, Part II (PRM-II), providers that continue to participate in the Medicare Program are required to submit a cost report within 5 months of their cost reporting fiscal year end. For cost reports ending on a day other than the last day of the month, cost reports are due 150 days after the last day of the cost reporting period. Exceptions to this due date for “no Medicare utilization” cost reports are addressed in PRM-II, Section110.A. MACs are required to suspend payments to providers that fail to file their MCR by the due date.

Current Medicare Cost Report (MCR) Filing and Receipt Process:

Generally, each provider must perform the following steps to properly submit an MCR to their MAC:

- Generate an MCR consisting of a machine-readable file (ECR) and a human-readable file (PDF or equivalent, also referred to as the Print Image), using CMS-approved MCR vendor software.
• Submit the Worksheet S (Certification Page) signed by an officer or administrator of the provider. A “wet” signature is required for cost reports ending before December 31, 2017; an electronic signature is allowed for cost reports ending on or after December 31, 2017.
• Provide supporting cost report documentation including, but not limited to, the working trial balance, financial statements, Medicare Bad Debt Listing, Interns and Residents Information System data, and so on.
• Submit the MCR package to their MAC via mail (or hand delivery), which account for 91 percent of all MCR submissions, or a hybrid of mail and electronic submissions which account for 9 percent of total submissions. The signed worksheet S must be mailed to the MAC.

Streamlined the MCR Filing Process:

To streamline the MCR filing process, the 2018 Inpatient Prospective Payment System (IPPS) Final Rule allows for an electronic signature on the MCR Worksheet S (Certification Page) for cost reports ending on or after December 31, 2017. Additionally, beginning May 1, 2018, CMS will make the MCRE F system available to Part A providers for electronic transmission (e-Filing) of an MCR package directly to a MAC. A CMS Enterprise Identity Management (EIDM) account is required to use MCRE F, which is the same account providers use to order copies of their Provider Statistical and Reimbursement Reports (PS&R).

Upon login, providers will be able to select the Fiscal Year End for which they are filing, upload all corresponding MCR materials as attachments, and submit the documents directly to their MAC. The system will perform a basic review of the attached materials to determine if the MCR is “receivable” (See Attachment A of CR10611. The Web address of CR10611 is in the Additional Information section of this article.). If issues are identified, the provider will immediately receive an error/warning message. If no issues are identified, the provider will receive a confirmation number, as well as an electronic postmark date, which can be used in correspondence regarding the submission. Once the cost report is deemed “receivable,” the MAC will perform the acceptability review within 30 days. The MAC will issue a rejection letter if the cost report is rejected.

Medicare Cost Report e-Filing (MCRE F) System Access:

MCRE F will be hosted at the following URL: https://mcref.cms.gov. System access to MCRE F will be controlled by the EIDM system, as previously noted. Part A Provider Security Officials (SOs) and their backups (BSOs), already registered in EIDM for access to CMS PS&R, will inherit access to MCRE F by default through their existing account.

Providers that are not registered in EIDM, but wish to gain access to MCRE F, must register in EIDM and assign an SO for their organization. New user registration is available at https://portal.cms.gov/wps/portal/unauthportal/eidm/newuserregistration.

Note: It is important for providers to keep their EIDM credentials in good standing to avoid problems using MCRE F to e-file cost reports and obtaining PS&R. This includes password updates per CMS policy and the timely replacement of SOs due to staffing changes. Issues with maintaining EIDM credentials will not constitute a valid reason for filing a cost report past its due date.
Starting July 2, 2018, providers that wish to e-file their MCR must use MCreF. MAC portals will no longer be an acceptable means of submission. Providers that wish to mail or hand deliver MCRs to MACs, may continue to do so.

Benefits of Streamlined MCR Processes:

- Increases CMS access to MCR data as submitted by providers to assist with responding to inquiries and remove additional administrative burdens on MACs and CMS.
- Eliminates MAC processes for populating the CMS Healthcare Cost Reporting Information System (HCoris) – including the submission of 100,000 cost reports to HCRIS and subsequent resubmission.
- Eliminates the need for MACs to enter MCR Postmarked Date, Received Date, and HCRIS Sent Date.
- Enables direct receipt/promotion of IRIS data to its required end-state in STAR (eliminates manually upload IRIS data).
- Large provider chain organizations will electronically submit MCRs to one system instead of transmitting their MCRs to their assigned MAC jurisdiction’s portals or physical mailing addresses.
- An MCR submitted through MCreF will be directed automatically to the correct MAC eliminating the risk of submitting the MCR to an incorrect MAC.
- Providers will receive immediate feedback on whether the MCR is received.
- Providers will save time compiling the paperwork (files) needed to create electronic media and mail the MCR package;
- Providers will have until 11:59 p.m. eastern time on the due date to submit the MCR through MCreF.
- MCreF has a simple, straightforward user interface with just one screen.
- Reduces provider confusion due to conflicting MAC “receivability” rules.

ADDITIONAL INFORMATION

The official instruction, CR10611, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R2075OTN.pdf. A detailed MCreF System Overview is attached to the CR. CMS encourages cost report staff to review this overview.


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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New Physician Specialty Code for Medical Genetics and Genomics

MLN Matters Number: MM10457
Related CR Release Date: April 27, 2018
Related CR Transmittal Number: R304FM
Related Change Request (CR) Number: 10457
Effective Date: October 1, 2018
Implementation Date: October 1, 2018

PROVIDER TYPE AFFECTED

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

PROVIDER ACTION NEEDED

This article is based on Change Request (CR) 10457 which informs MACs that CMS has established a new physician specialty code for Medical Genetics and Genomics (D3). Make sure that your billing staffs are aware of these changes.

BACKGROUND

Physicians self-designate their Medicare physician specialty on the Medicare enrollment application (CMS-855I or CMS-855O) or Internet-based Provider Enrollment, Chain and Ownership System (PECOS) when they enroll in the Medicare program. Medicare physician specialty codes describe the specific/unique types of medicine that physicians (and certain other suppliers) practice. The Centers for Medicare & Medicaid Services (CMS) uses specialty codes for programmatic and claims processing purposes. CMS has established a new physician specialty code for Medical Genetics and Genomics. The new code is D3. MACs will accept and recognize the new code of D3.

ADDITIONAL INFORMATION


The official instruction, CR10457, issued to your MAC regarding this change via two

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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Processing Instructions to Update the Identification Code Qualifier Being Used in the NM108 Data Element at the 2100 Loop, NM1- Patient Name Segment in the 835 Guide

MLN Matters Number: MM10565
Related CR Release Date: April 27, 2018
Related CR Transmittal Number: R2063OTN
Related Change Request (CR) Number: 10565
Effective Date: October 1, 2018 – Not based on Date of Service
Implementation Date: October 1, 2018

PROVIDER TYPE AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 10565 provides instructions to the MACs to update the Identification Code Qualifier in Data Element NM108 currently being used in the 2100 Loop, NM1- Patient Name Segment of the 835 guide. This will synchronize the usage of the same qualifier as used/submitted on the claim. Make sure your billing staffs are aware of these instructions.

BACKGROUND

With the removal of the Social Security Number (SSN)-based Health Insurance Claim Number (HICN) from Medicare cards and in an effort to synchronize the usage of the same Identification Code Qualifier in the Health Care Claim Payment/Advice (835) and the Professional and Institutional (837) Health Care Claim as required by the 835 guide, CR10565 modifies the Identification Code Qualifier being used in the 835 Electronic Remit from HN to MI.

ADDITIONAL INFORMATION

The official instruction, CR10565, issued to your MAC regarding this change is available at

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

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Updates to Publication 100-04, Chapters 1 and 27, to Replace Remittance Advice Remark Code (RARC) MA61 with N382

MLN Matters Number: MM10619  Related Change Request (CR) Number: 10619
Related CR Release Date: May 11, 2018  Effective Date: August 13, 2018
Related CR Transmittal Number: R4047CP  Implementation Date: August 13, 2018

PROVIDER TYPES AFFECTED

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

WHAT YOU NEED TO KNOW

Change Request (CR) 10619 initiates both Medicare manual changes and operational changes related to the New Medicare Card. Medicare will replace the use of Remittance Advice Remark Code (RARC) MA61, referenced in the Medicare Claims Processing Manual, Chapters 1 and 27, with RARC N382 - missing/incomplete/invalid patient identifier (HICN or MBI). Effective for claims processed on or after the effective date of CR10619, MACs will use N382 in place of MA61 to communicate reject/denials for patient identifiers (HICN or MBI) in all remittance advices and 835 transactions. However, MACs will continue to use RARC MA61 only when/if communicating rejections/denials related to a missing/incomplete/invalid social security number. Make sure your billing staffs are aware of these updates.

BACKGROUND

With the implementation of the Medicare Beneficiary Identifier (MBI), references to the Health Insurance Claim Number (HICN) will be replaced with a more generic reference (Patient Identifier), CR 16019 initiates the manual changes and operational changes to accomplish this task.

ADDITIONAL INFORMATION

The official instruction, CR 10619, issued to your MAC regarding this change, is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4047CP.pdf. If you have any questions, please contact your MAC at their toll-free number. That number is

**DOCUMENT HISTORY**

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<th>Description</th>
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</thead>
<tbody>
<tr>
<td>May 14, 2018</td>
<td>Initial article released.</td>
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WPS GHA Learning Center

WPS GHA Provider Outreach & Education (POE) has numerous educational opportunities in our Learning Center (https://wpsgha.litmos.com). We offer on-demand learning allowing you to access the education at your convenience. We also offer live events via seminar, teleconference, and webinar on many subjects that you may browse through and register in the Learning Center. Our education offers Certificates of Achievement identifying the time length of the education. You may use these certificates (without an index number) to receive Continuing Education Units (CEUs) from your accrediting organization. First time users, you will need to create a profile by completing our registration form (https://wpsghalearningcenter.com/).

We provide all educational materials in an electronic format. Participants are responsible for accessing/printing the materials. To locate, choose the Additional References tab within the individual course in our Learning Center.

Here are some of the events currently available.

Teleconferences

07/11/2018 The Physician’s Certification — What you need to know before writing one!

A physician’s certification is an opportunity for the physician to indicate why a service is medically necessary; however, certifying non-medically necessary services may cause issues for the patient. The training covers the rules for various physician's certifications that are causing confusion and errors.

08/21/2018 Costly Mistakes — Ambulance and Understanding Medical Necessity

During this program WPS GHA staff will review the basic ambulance benefit and define how this relates to medical necessity specifically. We will discuss examples to support what medical necessity is as it relates to ambulance services; followed by a question and answer period.

Webinars

06/27/2018 Home Health Billing and Documentation Requirements

WPS GHA, other A/B Medicare Administrative Contractors (MACs), and the Home Health MACs, are collaborating to provide education on the physician documentation required to allow payment of Home Health care services ordered for your patients. We will review home health coverage, billing requirements, common documentation errors, and resources. The link will take you to Noridian Healthcare Solutions; the MAC handling registration.
07/12/2018 Understanding the Benefit Period

A benefit period is a period of consecutive days during which covered inpatient services may be available to a beneficiary. Within each benefit period, Medicare allows coverage for a certain number of inpatient days depending on the type of facility. Learn about full, coinsurance, and lifetime reserve days; how a benefits period begins and ends; and tools available to check benefit days.

Evaluation and Management Webinar Series

06/26/2018 Evaluation and Management — History Component

First in a series of five webinars on E/M Services. The patient’s history is the first step in documenting an E/M service. We will provide information on the components related to this portion of the E/M service. Please encourage your physicians and non-physician practitioners to attend along with your coders, billers, and compliance officers.

07/10/2018 Evaluation and Management Services — Exam Component

Second in a series of five webinars on E/M services. Information associated with the 1995 and 1997 documentation guidelines will be reviewed as it related to the objective documentation providers deliver. Please encourage your physicians and non-physician practitioners to attend along with your coders, billers, and compliance officers.

07/24/2018 Evaluation and Management Services — Medical Decision Making

Third in a series of five webinars on E/M services. We will discuss the three separate components of MDM: diagnosis and/or management options, amount and/or complexity of date to be reviewed, and risk for the patient. Documentation supports medical necessity for the service, the procedure code chosen, and the level of care.

Understanding Medicare Secondary Payer (MSP) Denials Teleconference Series

06/13/2018 Understanding Medicare Secondary Payer (MSP) Denials — Group Health Plans

The session examines MSP-related errors and ways to remedy them. This session focuses on the rules for end stage renal disease (ESRD), employer and large group health plans, a review of the most common MSP denials and exploring methods for correcting and preventing rejections.

06/20/2018 Understanding Medicare Secondary Payer (MSP) Denials — Workers’ Compensation

This session will examine MSP-related errors and ways to remedy them. We will focus on workers’ compensation and black lung coverage, an analysis of the most common MSP denials and exploring methods for correcting and preventing rejections.
06/27/2018 Understanding Medicare Secondary Payer (MSP) Denials — No-Fault and Liability

This session examines MSP-related errors and ways to remedy them. We will focus on the rules for no-fault and liability coverage, review analysis of the most common MSP denials and exploring methods for correcting and preventing rejections.

New to Medicare Teleconference Series

06/05/18 New to Medicare – Appeals Overview

Do you know the Medicare appeals process? Are you familiar with the different contractors involved in appeals? Are you confused over the best way to file an appeal? Do you know which forms to use when filing an appeal? All of this will be answered and more.

The agenda will include:
- Identifying appealable issues
- Knowing where to file the appeals
- Appeals timeframes
- And more

In Person Events

WPS GHA is hosting a full day educational event designed for providers and suppliers of all types. Multiple breakout sessions will allow providers to pick topics they are interested in. 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:
- Keynote address by a WPS GHA Contractor Medical Director (CMD)
- 18 breakout session subjects to choose from
- Question and answer session

Here are the remaining upcoming dates and locations;
07/17/2018 – Grand Island, NE
07/19/2018 – Olathe, KS
08/07/2018 – Ankeny, IA

View the brochure (https://wpsghalearningcenter.com/files/2018MDLBrochure.pdf) for this event to see a description of all session topics.

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

MEDICARE LEARNING NETWORK (MLN)

We encourage you to visit the Medicare Learning Network the place for official CMS Medicare fee-for-service provider educational information. There you can find one of our most popular products, MLN Matters national provider education articles. These articles help you understand new or changed Medicare policy and how those changes affect you. 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](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](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](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](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 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](https://public.govdelivery.com/accounts/USCMS/subscriber/new?topic_id=USCMS_460).
Reimbursement

UNSOLICITED/VOLUNTARY REFUNDS

The acceptance of a voluntary refund as repayment for the claims specified in no way affects or limits the rights of the Federal Government, or any of its agencies or agents, to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims.

April 2018 Integrated Outpatient Code Editor (I/OCE) Specifications Version 19.1

MLN Matters Number: MM10514 Revised Related Change Request (CR) Number: 10514
Related CR Release Date: March 21, 2018 Effective Date: April 1, 2018
Related CR Transmittal Number: R4006CP Implementation Date: April 2, 2018

Note: This article was revised on March 22, 2018, to reflect an updated Change request (CR) that updated the status indicator for the drug code J0606 from SI=G to SI=K in the CR attachments. 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), including the Home Health and Hospice MACs, for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

CR 10514 provides the Integrated Outpatient Code Editor (I/OCE) instructions and specifications for the I/OCE that will be used in the Outpatient Prospective Payment System (OPPS) and non-OPPS for hospital inpatient departments, Community Mental Health Centers (CMHCs), all non-OPPS providers, and for limited services when provided in a home health agency not under the Home Health Prospective Payment System (HH PPS) or to a hospice patient for the treatment of a non-terminal illness. Make sure your billing staffs are aware of these updates.

BACKGROUND

CR10514 informs the MACs, including the Home Health and Hospice (HH&H MAC) and the Fiscal Intermediary Shared System (FISS), that the I/OCE is being updated for April 1, 2018. The I/OCE routes all institutional outpatient claims (which includes non-OPPS hospital claims) through a single integrated OCE. The I/OCE specifications are available at http://www.cms.gov/OutpatientCodeEdit/.

The following table summarizes the modifications of the I/OCE for the April 2018 V19.1 update. Readers should also read through the entire CR10514 and note the highlighted sections, which also indicate changes from the prior release of the software. Some I/OCE modifications in the
update may be retroactively added to prior releases. If so, the retroactive date appears in the 'Effective Date' column.

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Edits Affected</th>
<th>Modifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/1/2018</td>
<td></td>
<td>Update the program to remove the logic that assigns HCPCS level modifier V3 to the line level output for OPPS claims submitted with drug HCPCS lines with Status Indicator (SI) = K that are reported with modifier JG.</td>
</tr>
<tr>
<td>4/1/2018</td>
<td>72</td>
<td>Implement program logic to bypass edit 72 when a HCPCS is present from a specified list for Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) claims (see quarterly data files for HCPCS subject to edit 72 bypass).</td>
</tr>
<tr>
<td>4/1/2018</td>
<td>104</td>
<td>Implement new edit 104: Service not eligible for all-inclusive rate (LIR). Edit criteria: RHC claim with bill type 71x contains a line reported with modifier CG that is not eligible for the RHC all-inclusive rate.</td>
</tr>
<tr>
<td>7/1/2017</td>
<td>105</td>
<td>Implement new edit 105: Claim reported with pass-through device prior to FDA approval for procedure (LID). Edit criteria: A procedure is reported with a pass-through device prior to the FDA approval date for the procedure paired with the device. The line item denial is returned on the device line.</td>
</tr>
<tr>
<td>4/1/2018</td>
<td>106</td>
<td>Implement new edit 106: Add-on code reported without required primary procedure code (LID). Edit criteria: A Type I add-on code is reported on a non-OPPS claim without any of its defined primary codes. The disposition is set to line item denial and is applied to the line with the add-on code.</td>
</tr>
<tr>
<td>4/1/2018</td>
<td>107</td>
<td>Implement new edit 107: Add-on code reported without required contractor-defined primary procedure code (LID). Edit criteria: A Type II add-on code is reported on a non-OPPS claim without any primary code from the contractor-defined list. The disposition is set to line item denial and is applied to the line with the add-on code.</td>
</tr>
<tr>
<td>Effective Date</td>
<td>Edits Affected</td>
<td>Modifications</td>
</tr>
<tr>
<td>----------------</td>
<td>---------------</td>
<td>---------------</td>
</tr>
<tr>
<td>4/1/2018</td>
<td>108</td>
<td>Implement new edit 108: Add-on code reported without required primary procedure or without required contractor-defined primary procedure code (LID). Edit criteria: A Type III add-on code is reported on a non-OPPS without any of its defined primary codes, or without any of the primary codes from the contractor-defined list. The disposition is set to line item denial and is applied to the line with the add-on code.</td>
</tr>
</tbody>
</table>
| 4/1/2018       | 22            | Add the following new modifiers to the valid modifier list:  
  - VM: Mdpp virtual make-up session  
  - QA: Avg sta day/night o2 < 1 lpm  
  - QB: Avg day/nite o2 > 4 lpm/port  
  - QR: Avg sta day/night o2 > 4 lpm |
<p>| 4/1/2018       | 94, 103       | Update the program logic to deactivate edits 94 and 103 associated with the reporting of biosimilar HCPCS codes with manufacturer modifier. Note: biosimilar manufacturer modifiers ZA, ZB and ZC are deleted. |
| 4/1/2018       |               | Update Section 6.1 of documentation (Medical Visit Processing) to include additional examples of conditions for claims containing multiple medical visits. Note: no change to logic. |
| 4/1/2018       |               | Update Section 6.12 of documentation (Special Processing for Drugs and Biologicals) by removing the paragraph regarding the assignment of the HCPCS level modifier, V3 for HCPCS with SI = K. |</p>
<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Edits Affected</th>
<th>Modifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>4/1/2018</td>
<td></td>
<td>Update the following lists for the release (see quarterly data files):</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• HCPCS modifier list</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Biosimilar HCPCS list</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Complexity-adjusted comprehensive Ambulatory Payment Classification (APC) code pairs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Skin substitute products (edit 87)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Device offset code pairs (Mid-Quarter effective date 8/25/2017)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Add on Type I (new code list for edit 106)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Add on Type II (new code list for edit 107)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Add on Type III (new code list for edit 108)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• FQHC/RHC bypass edit 72 (new code list)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• RHC CG modifier not payable list (new code list)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Services not recognized under OPPS (edit 62)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Services reportable to DMERC (edit 61)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Services not billable to the MAC (edit 72)</td>
</tr>
<tr>
<td>4/1/2018</td>
<td></td>
<td>Make all HCPCS/APC/SI changes as specified by CMS (quarterly data files)</td>
</tr>
<tr>
<td>4/1/2018</td>
<td>20, 40</td>
<td>Implement version 24.1 of the National Correct Coding Initiative (NCCI) (as modified for applicable outpatient institutional providers).</td>
</tr>
</tbody>
</table>

**ADDITIONAL INFORMATION**


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

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<th>Date of Change</th>
<th>Description</th>
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<tr>
<td>March 22, 2018</td>
<td>This article was revised to reflect an updated CR that updated the status indicator for the drug code J0606 from SI=G to SI=K in the attachments. All other information remains the same.</td>
</tr>
<tr>
<td>March 2, 2018</td>
<td>Initial article released.</td>
</tr>
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</table>

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April 2018 Update of the Hospital Outpatient Prospective Payment System (OPPS)

MLN Matters Number: MM10515 Revised  Related Change Request (CR) Number: CR10515
Related CR Release Date: March 20, 2018  Effective Date: April 1, 2018
Related CR Transmittal Number: R4005CP  Implementation Date: April 2, 2018

Note: This article was revised on March 22, 2018, to reflect an updated Change Request (CR) that updated the number of drugs and biologicals with OPPS pass-through status effective April 1, 2018, from twelve to eleven and to remove HCPCS code J0606, Injection, etelcalcetide, 0.1 mg, from Table 5, Attachment A in the CR (page 5 in this article) since its status indicator remains "K" for the April update. 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), including Home Health and Hospice (HH&H) MACs, for services provided to Medicare beneficiaries and paid under the Outpatient Prospective Payment System (OPPS).

PROVIDER ACTION NEEDED

CR 10515 describes changes to the OPPS to be implemented in the April 2018 update. Make sure your billing staffs are aware of these changes.

BACKGROUND

The April 2018 Integrated Outpatient Code Editor (I/OCE) will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, Status Indicator (SI), and Revenue Code additions, changes, and deletions identified in CR 10515. The April 2018 revisions to I/OCE data files, instructions, and specifications are provided in the forthcoming April 2018 I/OCE CR.


1. New Separately Payable Procedure Code
Effective April 1, 2018, HCPCS Code C9749 is added and is described in the following table.
New Separately Payable Procedure Code

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>OPPS SI</th>
<th>OPPS APC</th>
<th>OPPS Payment Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9749</td>
<td>Repair nasal stenosis w/imp</td>
<td>Repair of nasal vestibular lateral wall stenosis with implant(s)</td>
<td>J1</td>
<td>5164</td>
<td>$2,199.06</td>
</tr>
</tbody>
</table>

2. Multianalyte Assays with Algorithmic Analyses (MAAA) CPT Coding Change Effective January 1, 2018

The AMA CPT Editorial Panel established one new MAAA code, specifically, 0011M, effective January 1, 2018. Because the code was released on December 1, 2017, it was too late to include in the January 2018 OPPS Update. Instead, this code is being included in the April 2018 Update with an effective date of January 1, 2018. The following table lists the long descriptor and SI for CPT code 0011M.

**MAAA CPT Coding Change Effective January 1, 2018**

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Long Descriptor</th>
<th>OPPS SI</th>
<th>OPPS APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>0011M</td>
<td>Oncology, prostate cancer, mRNA expression assay of 12 genes (10 content and 2 housekeeping), RT-PCR test utilizing blood plasma and/or urine, algorithms to predict high-grade prostate cancer risk</td>
<td>A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

3. Proprietary Laboratory Analyses (PLA) CPT Coding Changes Effective January 1, 2018

The AMA CPT Editorial Panel established 11 new PLA CPT codes, specifically, CPT codes 0024U through 0034U and deleted two PLA codes, specifically, CPT codes 0004U and 0015U, effective January 1, 2018. Because the codes were released on December 1, 2017, it was too late to include them in the January 2018 OPPS Update. Instead, they are being included in the April 2018 Update with an effective date of January 1, 2018.

The following table lists the long descriptors and status indicators for CPT codes 0024U through 0034U. For more information on OPPS status indicators “A” and “Q4”, refer to OPPS Addendum D1 of the CY 2018 OPPS/ASC final rule. CPT codes 0024U through 0034U have been added to the April 2018 I/OCE with an effective date of January 1, 2018. These codes, along with their short descriptors and status indicators, are also listed in the April 2018 OPPS Addendum B, which is available at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html).
### Proprietary Laboratory Analyses (PLA) CPT Coding Changes
Effective January 1, 2018

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Long Descriptor</th>
<th>OPPS SI</th>
<th>OPPS APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>0004U</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>
<td>D</td>
<td>N/A</td>
</tr>
<tr>
<td>0015U</td>
<td>Drug metabolism (adverse drug reactions), DNA, 22 drug metabolism and transporter genes, real-time PCR, blood or buccal swab, genotype and metabolizer status for therapeutic decision support</td>
<td>D</td>
<td>N/A</td>
</tr>
<tr>
<td>0024U</td>
<td>Glycosylated acute phase proteins (GlycA), nuclear magnetic resonance spectroscopy, quantitative</td>
<td>Q4</td>
<td>N/A</td>
</tr>
<tr>
<td>0025U</td>
<td>Tenofovir, by liquid chromatography with tandem mass spectrometry (LC-MS/MS), urine, quantitative</td>
<td>Q4</td>
<td>N/A</td>
</tr>
<tr>
<td>0026U</td>
<td>Oncology (thyroid), DNA and mRNA of 112 genes, next-generation sequencing, fine needle aspirate of thyroid nodule, algorithmic analysis reported as a categorical result (&quot;Positive, high probability of malignancy&quot; or &quot;Negative, low probability of malignancy&quot;)</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>0027U</td>
<td>JAK2 (Janus kinase 2) (eg, myeloproliferative disorder) gene analysis, targeted sequence analysis exons 12-15</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>0028U</td>
<td>CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism) gene analysis, copy number variants, common variants with reflex to targeted sequence analysis</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>0029U</td>
<td>Drug metabolism (adverse drug reactions and drug response), targeted sequence analysis (ie, CYP1A2, CYP2C19, CYP2C9, CYP2D6, CYP3A4, CYP3A5, CYP4F2, SLCO1B1, VKORC1 and rs12777823)</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>0030U</td>
<td>Drug metabolism (warfarin drug response), targeted sequence analysis (ie, CYP2C9, CYP4F2, VKORC1, rs12777823)</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>0031U</td>
<td>CYP1A2 (cytochrome P450 family 1, subfamily A, member 2)(eg, drug metabolism) gene analysis, common variants (ie, *1F, *1K, *6, *7)</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>0032U</td>
<td>COMT (catechol-O-methyltransferase)(drug metabolism) gene analysis, c.472G&gt;A (rs4680) variant</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>CPT Code</td>
<td>Long Descriptor</td>
<td>OPPS SI</td>
<td>OPPS APC</td>
</tr>
<tr>
<td>----------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------</td>
<td>---------</td>
</tr>
<tr>
<td>0033U</td>
<td>HTR2A (5-hydroxytryptamine receptor 2A), HTR2C (5-hydroxytryptamine receptor 2C) (eg, citalopram metabolism) gene analysis, common variants (ie, HTR2A rs7997012 [c.614-2211T&gt;C], HTR2C rs3813929 [c.-759C&gt;T] and rs1414334 [c.551-3008C&gt;G])</td>
<td>A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

4. Reassignment of Skin Substitute Product from the Low Cost Group to the High Cost Group

One skin substitute product, HCPCS code Q4180, has been reassigned from the low cost skin substitute group to the high cost skin substitute group based on updated pricing information. The product is listed in the following table.

### Reassignment of Skin Substitute Product from the Low Cost Group to the High Cost Group Effective April 1, 2018

<table>
<thead>
<tr>
<th>CY 2018 HCPCS Code</th>
<th>CY 2018 Short Descriptor</th>
<th>CY 2018 SI</th>
<th>Low/High Cost Skin Substitute</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q4180</td>
<td>Revita, per sq cm</td>
<td>N</td>
<td>High</td>
</tr>
</tbody>
</table>

5. Drugs, Biologicals, and Radiopharmaceuticals

a. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective April 1, 2018

For CY 2018, payment for nonpass-through drugs, biologicals and therapeutic radiopharmaceuticals that were not acquired through the 340B Program is made at a single rate of ASP + 6 percent (or ASP - 22.5 percent if acquired under the 340B Program), which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical. In CY 2018, a single payment of ASP + 6 percent for pass-through drugs, biologicals and radiopharmaceuticals is made to provide payment for both the acquisition cost and pharmacy overhead 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 April 1, 2018 and drug price restatements can be found in the April 2018 update of the OPPS Addendum A and Addendum B at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html).
b. Drugs and Biologicals with OPPS Pass-Through Status Effective April 1, 2018

Eleven drugs and biologicals have been granted OPPS pass-through status effective April 1, 2018. These items, along with their descriptors and APC assignments, are identified in the following table.

### Drugs and Biologicals with OPPS Pass-Through Status Effective April 1, 2018

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
<th>APC</th>
<th>Status Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9462</td>
<td>Injection, delafloxacin, 1 mg</td>
<td>9462</td>
<td>G</td>
</tr>
<tr>
<td>C9463</td>
<td>Injection, aprepitant, 1 mg</td>
<td>9463</td>
<td>G</td>
</tr>
<tr>
<td>C9464</td>
<td>Injection, rolapitant, 0.5 mg</td>
<td>9464</td>
<td>G</td>
</tr>
<tr>
<td>C9465</td>
<td>Hyaluronan or derivative, Durolane, for intra-articular injection, per dose</td>
<td>9465</td>
<td>G</td>
</tr>
<tr>
<td>C9466</td>
<td>Injection, benralizumab, 1 mg</td>
<td>9466</td>
<td>G</td>
</tr>
<tr>
<td>C9467</td>
<td>Injection, rituximab and hyaluronidase, 10 mg</td>
<td>9467</td>
<td>G</td>
</tr>
<tr>
<td>C9468</td>
<td>Injection, factor ix (antihemophilic factor, recombinant), glycopegylated, Rebinyn, 1 i.u.</td>
<td>9468</td>
<td>G</td>
</tr>
<tr>
<td>C9469</td>
<td>Injection, triamcinolone acetonide, preservative-free, extended-release, microsphere formulation, 1 mg</td>
<td>9469</td>
<td>G</td>
</tr>
<tr>
<td>Q2040</td>
<td>Tisagenlecleucel, up to 250 million car-positive viable t cells, including leukapheresis and dose preparation procedures, per infusion</td>
<td>9081</td>
<td>G</td>
</tr>
<tr>
<td>Q2041</td>
<td>Axicabtagene Ciloieucel, up to 200 Million Autologous Anti-CD19 CAR T Cells, Including Leukapheresis And Dose Preparation Procedures, Per Infusion</td>
<td>9035</td>
<td>G</td>
</tr>
<tr>
<td>Q5104</td>
<td>Injection, infliximab-abda, biosimilar, (renflexis), 10 mg</td>
<td>9036</td>
<td>G</td>
</tr>
</tbody>
</table>

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

Some drugs and biologicals based on ASP methodology will have payment rates that are corrected retroactively. These retroactive corrections typically occur on a quarterly basis. The list of drugs and biologicals with corrected payments rates will be accessible on the first date of
the quarter at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/OPPS-Restated-Payment-Rates.html.

Providers may resubmit claims that were impacted by adjustments to the previous quarter’s payment files.

d. Changes to Biosimilar Biological Product HCPCS Codes and Modifiers

Effective April 1, 2018, CMS is revising the long and short descriptors for HCPCS code Q5101. The following table displays the revised descriptors.

Revised Descriptors for Q5101

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>APC</th>
<th>Status Indicator</th>
<th>Added Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5101</td>
<td>Injection, zarxio</td>
<td>Injection, filgrastim-sndz, biosimilar, (zarxio), 1 microgram</td>
<td>1822</td>
<td>G</td>
<td>07/01/2015</td>
</tr>
</tbody>
</table>

In addition, effective April 1, 2018, HCPCS codes Q5103, Injection, infliximab-dyyb, biosimilar, (inflectra), 10 mg, and Q5104, Injection, infliximab-abda, biosimilar, (renflexis), 10 mg will replace HCPCS code Q5102, Inj., infliximab biosimilar. The following table describes coding changes, status indicator, APC assignments, and effective dates for biosimilar biological product HCPCS codes.

Changes to Biosimilar Biological Product HCPCS Codes

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>APC</th>
<th>Status Indicator</th>
<th>Added Date</th>
<th>Termination Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5102</td>
<td>Inj., infliximab biosimilar</td>
<td>Injection, infliximab, biosimilar, 10 mg</td>
<td>1847</td>
<td>G</td>
<td>07/01/2016</td>
<td>03/31/2018</td>
</tr>
<tr>
<td>Q5103</td>
<td>Injection, inflectra</td>
<td>Injection, infliximab-dyyb, biosimilar, (inflectra), 10 mg</td>
<td>1847</td>
<td>G</td>
<td>04/01/2018</td>
<td></td>
</tr>
<tr>
<td>Q5104</td>
<td>Injection, renflexis</td>
<td>Injection, infliximab-abda, biosimilar, (renflexis), 10 mg</td>
<td>9036</td>
<td>G</td>
<td>04/01/2018</td>
<td></td>
</tr>
</tbody>
</table>

The new biosimilar payment policy also makes the use of modifiers that describe the manufacturer of a biosimilar product unnecessary. Therefore, modifiers ZA, ZB, and ZC will be discontinued for dates of service on or after April 1, 2018. However, please note that HCPCS code Q5102 and the requirement to use applicable biosimilar modifiers remain in effect for dates of service prior to April 1, 2018.
6. Use of Modifier "FY"

As stated in the CY 2018 OPPS/ASC final rule, section 502 of Division O, title V of the Consolidated Appropriations Act, 2016 (Pub. L. 114-113), which was enacted on December 18, 2015, contains provisions to incentivize the transition from traditional X-ray imaging to digital radiography. As permitted by section 1833(t)(16)(F)(iv) of the Social Security Act (the Act), CMS implemented modifier “FY” (X-ray taken using computed radiography technology/cassette-based imaging) to enable providers under the OPPS to appropriately report computed radiography services. Effective January 1, 2018, hospital outpatient facilities are required to use this modifier with the applicable HCPCS code(s) to describe an imaging service that is an X-ray taken using computed radiography technology.

In this same final rule, CMS also stated that section 1833(t)(16)(F)(ii) of the Act provides for a phased-in reduction in payment in the case of an imaging service that is an X-ray taken using computed radiography technology (as defined in section 1848(b)(9)(C) of the Act). Payment for such a service (including the X-ray component of a packaged service) furnished during CY 2018, 2019, 2020, 2021, or 2022, that would otherwise be determined under section 1833(t) of the Act (without application of subparagraph (F)(ii) and before application of any other adjustment), will be reduced by 7 percent, and if such a service is furnished during CY 2023 or a subsequent year, by 10 percent. For purposes of this reduction, computed radiography technology is defined in section 1848(b)(9)(C) of the Act as cassette-based imaging which utilizes an imaging plate to create the image involved.

CMS notes that section 1833(t)(16)(F)(ii) refers to an imaging service that is an X-ray taken using computed radiography technology. Where the imaging service is comprised of multiple images that include both X-rays taken using computed radiography technology and images taken using digital radiography, CMS does not believe the payment reduction would apply to that service. Instead, the payment adjustment applies to an imaging service that is an X-ray taken using computed radiography technology where the X-ray taken using computed radiography technology is not combined with digital radiography in the same imaging service.

7. Coverage Determinations

As a reminder, the fact that a drug, device, procedure or service is assigned a HCPCS code and a payment rate under the OPPS does not imply coverage by the Medicare program, but indicates only how the product, procedure, or service may be paid if covered by the program. 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

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 22, 2018</td>
<td>This article was revised to reflect an updated CR that updated the number of drugs and biologicals with OPPS pass-through status effective April 1, 2018, from twelve to eleven and to remove HCPCS code J0606, Injection, etelcalcetide, 0.1 mg, from Table 5, Attachment A in the CR (page 5 in this article) since its status indicator remains &quot;K&quot; for the April update.</td>
</tr>
<tr>
<td>March 6, 2018</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>

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April Quarterly Update for 2018 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule

MLN Matters Number: 10503
Related Change Request (CR) Number: CR10503
Related CR Release Date: March 21, 2018
Effective Date: April 1, 2018
Related CR Transmittal Number: R4004CP
Implementation Date: April 2, 2018

PROVIDER TYPE AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 10503 provides the April 2018 Medicare DMEPOS fee schedule quarterly update. It provides specific instructions to your DME MAC for implementing updated Oxygen Volume Adjustments.

When necessary, the DMEPOS fee schedule is updated quarterly, to implement fee schedule amounts for new codes, to correct any fee schedule amounts for existing codes (as applicable) and to apply changes in payment policies. It contains fee schedule amounts for both non-rural and rural areas. Additionally, the parenteral and enteral nutrition (PEN) fee schedule file includes state fee schedule amounts for enteral nutrition items and national fee schedule amounts for parental nutrition items.

There were no Quarter 2, 2018 Rural ZIP code changes, so an April 2018 DMEPOS Rural ZIP code file will not be furnished as part of this update; and there was no change to the PEN fee schedule file for Quarter 2, 2018 so a new PEN fee schedule file will not be furnished as part of this update.

BACKGROUND

Section 1834(a), (h), and (i) of the Social Security Act (the Act) require payment for Durable Medical Equipment (DME), prosthetic devices, orthotics, prosthetics and surgical dressings be completed on a fee schedule basis. Further, payment on a fee schedule basis is a regulatory requirement at 42 Code of Federal Regulations (CFR) §414.102s, for parenteral and enteral nutrition, splints, casts and Intraocular Lenses (IOLs) inserted in a physician’s office.
Additionally, Section 1834(a)(1)(F)(ii) of the Act mandates adjustments to the fee schedule amounts for certain items furnished on or after January 1, 2016, in areas that are not competitive bid areas, based on information from Competitive Bidding Programs (CBPs) for DME. Section 1842(s)(3)(B) of the Act provides authority for making adjustments to the fee schedule amount for enteral nutrients, equipment and supplies (enteral nutrition) based on information from CBPs.

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


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

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

**K0903**

As part of this update, CR 10503 is adding fee schedule amounts for HCPCS code K0903 (For Diabetics Only, Multiple Density Insert, Made By Direct Carving With CAM Technology From A Rectified CAD Model Created From A Digitized Scan Of The Patient, Total Contact With Patient's Foot, Including Arch, Base Layer Minimum Of 3/16 Inch Material Of Shore A 35 Durometer (Or Higher), Includes Arch Filler And Other Shaping Material, Custom Fabricated, Each), effective for claims with dates of service on or after April 1, 2018. The fees for code K0903 are set based on the fees for code A5513 because inserts carved from a digitized scan of the patient’s foot were determined to be comparable to inserts made over a positive model of the patient’s foot.

**Oxygen Volume Adjustments**

As part of the 2017 April Quarterly DMEPOS fee schedule update (Please refer to the
associated MLN Matters article at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9988.pdf, the ‘QF’ modifier (Prescribed amount of oxygen is greater than 4 Liter Per Minute (LPM) and portable oxygen is prescribed) was added to the DMEPOS fee schedule for use with both stationary and portable oxygen when the oxygen flow rate exceeds 4 liters per minute (LPM) and portable oxygen is prescribed.

Section 1834(a)(5)(C) and (D) of the Act requires that when an oxygen flow rate exceeds 4 LPM, the Medicare payment amount be the higher of

- 50 percent of the stationary payment amount (HCPCS codes E0424, E0439, E1390, or E1391); or
- The portable oxygen add-on amount (HCPCS codes E0431, E0433, E0434, E1392 or K0738); and
- Never both.

The stationary oxygen QF modifier fee schedule amounts represent 100 percent of the stationary oxygen fee schedule amount. The portable oxygen ‘QF’ fee schedule amounts represent the higher of 1) 50 percent of the monthly stationary oxygen payment amount; or 2) The fee schedule amount for the portable oxygen add-on amount. The ‘QF’ modifier is billed on both the stationary oxygen and portable oxygen code when the prescribed amount of oxygen is greater than 4 LPM, portable oxygen is prescribed, and there is no difference in the prescribed flow rate for nighttime and daytime use.

CR 10503 provides that effective April 1, 2018:

- The ‘QF’ modifier is revised to read as follows:
  - QF – (PRESCRIBED AMOUNT OF STATIONARY OXYGEN WHILE AT REST EXCEEDS 4 LITERS PER MINUTE (LPM) AND PORTABLE OXYGEN IS PRESCRIBED); and
- The following new oxygen volume adjustment modifier is added to the HCPCS file:
  - QB – (PRESCRIBED AMOUNTS OF STATIONARY OXYGEN FOR DAYTIME USE WHILE AT REST AND NIGHTTIME USE DIFFER AND THE AVERAGE OF THE TWO AMOUNTS EXCEEDS 4 LITERS PER MINUTE (LPM) AND PORTABLE OXYGEN IS PRESCRIBED).

Specifically (effective April 1, 2018), the modifier ‘QB’ should be used in conjunction with claims submitted for stationary oxygen (codes E0424, E0439, E1390, or E1391) and portable oxygen (codes E0431, E0433, E0434, E1392, or K0738) when the prescribed amount of oxygen for daytime and nighttime differ and the average of the two amounts is greater than 4 liters per minute (LPM) and portable oxygen is prescribed. For more information on April 1, 2018, changes to the pricing modifiers for oxygen flow rate, please refer to MLN Matters Article MM10158, titled ‘Revised and New Modifiers for Oxygen Flow Rate.”

Please note that the ‘QB’ modifier is used in billing to denote when: 1) The average prescribed amount of oxygen is greater than 4 LPM; 2) Portable oxygen is prescribed; and 3) There is a difference in the prescribed flow rates for nighttime and for daytime use. In these instances, regulations at 42 CFR 414.226(e)(3)(iii) require that an average of the varying nighttime and
daytime flow rates is to be used in determining the volume adjustment. Therefore, the ‘QB’ modifier is used when the average of the nighttime and daytime flow rates exceed 4 LPM and portable oxygen is prescribed.

In addition, please note that Section 1834(a)(5)(C) and (D) of the Act also applies to the ‘QB’ modifier. This section of the Act requires that, when the oxygen flow rate exceeds 4 LPM, the Medicare payment amount is to be: 1) The higher of 50 percent of the stationary payment amount (codes E0424, E0439, E1390, or E1391); or 2) The portable oxygen add-on amount (E0431, E0433, E0434, E1392 or K0738); and 3) Never both.

To facilitate this payment calculation, CR 10503 adds the ‘QB’ modifier (effective April 1, 2018) to the DMEPOS fee schedule file, for both stationary and portable oxygen.

The stationary oxygen ‘QB’ modifier fee schedule amounts represent 100 percent of the stationary oxygen fee schedule amount. The portable oxygen ‘OB’ fee schedule amounts represent the higher of 1) 50 percent of the monthly stationary oxygen payment amount or 2) the fee schedule amount for the portable oxygen add-on amount.

**ADDITIONAL INFORMATION**


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

**DOCUMENT HISTORY**

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 22, 2018</td>
<td>Initial article released</td>
</tr>
</tbody>
</table>

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Increased Ambulance Payment Reduction for Non-Emergency Basic Life Support (BLS) Transports to and from Renal Dialysis Facilities

MLN Matters Number: MM10549
Related Change Request (CR) Number: 10549
Related CR Release Date: April 6, 2018
Effective Date: October 1, 2018
Related CR Transmittal Number: R4017CP
Implementation Date: October 1, 2018

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 10549 provides instructions regarding Section 53108 of the Bipartisan Budget Act of 2018. This section reduces the ambulance payment by 23 percent for non-emergency Basic Life Support (BLS) transports of individuals with End-Stage Renal Disease (ESRD), to and from renal dialysis treatment (at both hospital-based and freestanding renal dialysis treatment facilities). Please make sure your billing staffs are aware of these changes.

BACKGROUND

Payment for ambulance transports (including items and services furnished in association with such transports) are based on the Ambulance Fee Schedule (AFS) and include a base rate payment plus a separate payment for mileage. This raised payment reduction for non-emergency BLS transports to and from renal dialysis treatment applies to both the base rate and the mileage reimbursement.

CR8269, issued May 10, 2013, implemented Section 637 of the American Taxpayer Relief Act of 2012, which, for transports occurring on and after October 1, 2013; required a 10-percent reduction in fee schedule payments for non-emergency (BLS transports of beneficiaries with ESRD); to and from both hospital-based and freestanding renal dialysis treatment facilities, for non-emergent dialysis services. The MLN Matters article associated with this CR is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8269.pdf.
CR10549 provides instructions regarding Section 53108 of the Bipartisan Budget Act of 2018, (signed into law on February 9, 2018), which requires that, effective October 1, 2018, the reduction of fee schedule payments for BLS transports to and from renal dialysis treatments be increased to 23 percent.

Non-emergency BLS ground transports are identified by Healthcare Common Procedure Coding System (HCPCS) code A0428 (Ambulance service, basic life support, non-emergency transport, (bls)). Ambulance transports to and from renal dialysis treatment are further identified by origin/destination modifier codes “G” (hospital-based ESRD) and “J” (freestanding ESRD facility), in either the origin or destination position of an ambulance modifier.

**Specific Details**

- Effective for claims with dates of service on and after October 1, 2018, payment for non-emergency BLS transports to and from renal dialysis treatment facilities will be reduced by 23 percent. The reduced rate will be calculated after the normal payment rate (including any applicable add-on payments) is calculated, and will be applied to the base rate for non-emergency BLS transports (identified by HCPCS code A0428 when billed with the indicated modifier codes) and the associated, separate mileage payment (identified by HCPCS code A0425).
- Payment for emergency transports and non-emergency BLS transports to other destinations (rural and urban) will remain unchanged. The AFS will also remain unchanged.
- For ambulance services, suppliers and hospital-based ambulance providers must report an accurate origin and destination modifier for each ambulance trip provided. Origin and destination modifiers used for ambulance services are created by combining two alpha characters. Each alpha character, with the exception of “X”, represents an origin code or a destination code. The pair of alpha codes creates a modifier. The first position alpha code equals origin; the second position alpha code equals destination.
- The reduction will be applied on claim lines containing HCPCS code A0428 with modifier code “G” or “J”, in either the first position (origin code) or second position (destination code) within the two-digit ambulance modifier code and HCPCS code A0425.
- MACs will keep in place all existing edits and logic (implemented previously via CMS CR 8269) that currently apply to the reduced AFS payment rates; however, effective for claims with dates of service on or after October 1, 2018, will increase the reduction from 10 percent to 23 percent. Additionally, they will continue to use the claim adjustment reason code, group code and Medicare Summary Notice messages that are currently used for the reduced AFS payment methodology.

**Note:** This 23-percent reduction applies to beneficiaries with ESRD that are receiving a non-emergency BLS transport to and from renal dialysis treatment. While it is possible that a beneficiary who is not diagnosed with ESRD will require routine transport to and from renal dialysis treatment, it is highly unlikely. However, MACs have the discretion to override or reverse the reduction on appeal if they deem it appropriate based on supporting documentation.
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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Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital (LTCH) PPS Extensions per the Advancing Chronic Care, Extenders, and Social Services (ACCESS) Act Included in the Bipartisan Budget Act of 2018

MLN Matters Number: MM10547 Related Change Request (CR) Number: 10547
Related CR Release Date: May 10, 2018 Effective Date: October 1, 2017
Related CR Transmittal Number: R4046CP Implementation Date: April 2, 2018

PROVIDER TYPE AFFECTED

This MLN Matters® Article is intended for hospitals that submit claims to Medicare Administrative Contractors (MACs) for inpatient hospital services provided to Medicare beneficiaries by short term acute care and Long-Term Care Hospitals (LTCHs).

PROVIDER ACTION NEEDED

Change Request (CR) 10547 provides information and implementation instructions for Sections 50204, 50205, and 51005 of the Advancing Chronic Care, Extenders, and Social Services (ACCESS) Act of 2018. Make sure that your billing staffs are aware of these changes.

BACKGROUND

On February 9, 2018, President Trump signed into law the Bipartisan Budget Act of 2018 (see https://www.gpo.gov/fdsys/pkg/BILLS-115hr1892enr/pdf/BILLS-115hr1892enr.pdf). The new law includes the extension of certain provisions that had expired October 1, 2017. Specifically, the following Medicare Inpatient Prospective Payment System (IPPS) and LTCH Prospective Payment System (PPS) fee-for-service policies have been extended.

Section 50204 – Extension of Increased Inpatient Hospital Payment Adjustment for Certain Low-Volume Hospitals
The Affordable Care Act and subsequent legislation provided for temporary changes to the low-volume hospital adjustment for Fiscal Years (FYs) 2011 through 2017. To qualify, the hospital must have less than 1,600 Medicare discharges and be located 15 miles or more from the nearest subsection (d) hospital. Section 50204 of the Bipartisan Budget Act of 2018 extends
these temporary changes through FY 2018 (and provides for modified temporary changes through FY 2022).

**Section 50205 – Extension of the Medicare-Dependent Hospital (MDH) Program**
The MDH program provides enhanced payment to support small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges. The Affordable Care Act and subsequent legislation had authorized the MDH program through September 30, 2017. Section 50205 of the Bipartisan Budget Act of 2018 extends the MDH program for discharges occurring on or after October 1, 2017, through FY 2022 (that is, for discharges occurring on or before September 30, 2022).

**Section 51005 – Adjustments to the LTCH Site Neutral Payment Rate**
Section 1206(a) of the Bipartisan Budget Act of 2013 established patient-level criteria for payments under the LTCH PPS for implementation beginning for cost reporting periods beginning on or after October 1, 2015. LTCH cases meeting specific clinical criteria are paid the LTCH PPS standard Federal rate payment and those cases not meeting specific clinical criteria are paid the site neutral rate payment. The Bipartisan Budget Act of 2013 provided for a transition period to the site neutral payment rate discharges occurring in cost reporting periods beginning in FY 2016 and FY 2017. Section 51005 of the Bipartisan Budget Act of 2018 extends the blended payment rate for LTCH site neutral payment rate discharges that occur in cost reporting periods beginning in FY 2018 and FY 2019, and adjusts the site neutral payment rate by reducing the IPPS comparable amount by 4.6 percent for FYs 2018 through 2026.

**Low-Volume Hospitals – Criteria and Payment Adjustments for FY 2018**

To implement the extension of the temporary change in the low-volume hospital payment policy for FY 2018, in accordance with the existing regulations at Section 412.101(b)(2)(ii) (see https://www.ecfr.gov/cgi-bin/text-idx?SID=4d2d4d21664431bde481aff4210219ec&mc=true&node=pt42.2.412&rgn=div5#se42.2.412.1101) and consistent with implementation of the those changes in FYs 2011 and 2017, the Centers for Medicare & Medicaid Services (CMS) intends to publish a notice in the Federal Register updating the discharge data source used to identify qualifying low-volume hospitals and calculate the payment adjustment (percentage increase) for FY 2018. Implementation of the extension of this temporary change in the low-volume hospital payment adjustment for FY 2018 provided by Section 50204 of the Bipartisan Budget Act of 2018 generally follows the established process that was used for FYs 2011 and 2017. (For additional information on the established process, refer to the FY 2017 IPPS/LTCH PPS final rule (81 FR 56941 through 56943))

Specifically, the number of Medicare discharges for purposes of the low-volume hospital adjustment for FY 2018 is determined in a manner consistent with how it was done for FY 2011 through FY 2017. During that time, the number of Medicare discharges used to establish the discharge criterion and the applicable low-volume percentage adjustment for qualifying hospitals were determined by Table 14, a list of IPPS hospitals with fewer than 1,600 Medicare discharges and their number of Medicare discharges according to the most recent available data published in the corresponding IPPS/LTCH PPS final rule. In the case of FY 2018, the
corresponding most recent available data at the time CMS developed the FY 2018 IPPS/LTCH final rule was the March 2017 update of the FY 2016 Medicare Provider Analysis and Review (MedPAR) file.

A file that lists the IPPS hospitals with fewer than 1,600 Medicare discharges based on the March 2017 update of the FY 2016 MedPAR files (MAC Implementation File 6) is available on the FY 2018 MAC Implementation Files webpage at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2018-IPPS-Final-Rule-Home-Page-Items/FY2018-IPPS-Final-Rule-MAC-Implementation.html. (CMS issued CMS-1677-N Table 1, a list of the IPPS hospitals with fewer than 1,600 Medicare discharges based on the March 2017 update of the FY 2016 MedPAR files in conjunction with the notice in the Federal Register published on April 26, 2018, In lieu of Table 14 of the FY 2018 IPPS/LTCH PPS Final Rule. CMS-1677-N Table 1 is available on the FY 2018 Final Rule Tables webpage at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2018-IPPS-Final-Rule-Home-Page-Items/FY2018-IPPS-Final-Rule-Tables.html.)

In order to facilitate administrative implementation, consistent with historical practice, the only source that CMS and the MACs will use to determine the number of Medicare discharges for purposes of the low-volume adjustment for FY 2018 is the data from the March 2017 update of the FY 2016 MedPAR file. CMS notes that CMS-1677-N Table 1 is a list of IPPS hospitals with fewer than 1,600 Medicare discharges and is not a listing of the hospitals that qualify for the low-volume adjustment for FY 2018, since it does not reflect whether or not the hospital meets the mileage criterion (that is, generally the hospital must also be located more than 15 road miles from any other subsection (d) hospital). In order to receive the applicable low-volume hospital payment adjustment (percentage increase) for FY 2018 discharges, a hospital must meet both the discharge and mileage criteria.

In order to receive a low-volume adjustment for FY 2018, consistent with the previously established process (described in the FY 2017 IPPS/LTCH PPS final rule (81 FR 56941 through 56943)), CMS is continuing to require a hospital to provide written notification to its MAC. Such notification must contain sufficient documentation to establish that the hospital meets the applicable mileage and discharge criteria so that the MAC can determine if the hospital qualifies as a low-volume hospital in accordance with existing requirements set forth in the regulations at Section 412.101(b)(2)(ii) (in conjunction with Section 412.101(e) as applicable). Under this procedure, a hospital receiving the low-volume hospital payment adjustment in FY 2017 may continue to receive a low-volume hospital payment adjustment in FY 2018 without reapplying if it continues to meet both the discharge criterion and the mileage criterion applicable for FY 2018. Such a hospital must send written verification stating that it continues to meet the applicable mileage criterion applicable for FY 2018.

A hospital’s written notification must be received by its MAC no later than May 29, 2018, as stated in the notice CMS-1677-N published in the Federal Register on April 26, 2018 that announced the discharge data source (as mentioned above). If a hospital’s request for low-volume hospital status for FY 2018 is received after this date, and if the MAC determines the hospital meets the criteria to qualify as a low-volume hospital, the MAC will apply the low-volume hospital payment adjustment to determine the payment for the hospital’s FY 2018
discharges, effective prospectively within 30 days of the date of the MAC’s low-volume hospital status determination.

For discharges occurring during FY 2018, if a hospital qualifies as a low-volume hospital, the low-volume hospital indicator field on the Provider Specific File (PSF) (position 74 – temporary relief indicator) must contain a value of ‘Y’ and the low-volume payment adjustment factor field on the PSF (positions 252-258) must contain a value greater than 0 and less than or equal to 0.250000. (For hospitals that meet both the discharge criterion and the mileage criterion applicable for FY 2018, the value for the low-volume payment adjustment factor field can be found in CMS-1677-N Table 1 as described above). To implement this, the Pricer will apply the applicable low-volume hospital payment adjustment factor from the PSF for hospitals that have a value of ‘Y’ in the low-volume hospital indicator field on the PSF. Any hospital that does not meet either the discharge or mileage criteria is not eligible to receive a low-volume payment adjustment for FY 2018, and the MAC must update the low-volume hospital indicator field on the PSF (position 74 – temporary relief indicator) to hold a value of “blank.”

The applicable low-volume hospital adjustment (percentage increase) is based on and in addition to all other IPPS per discharge payments, including capital, Disproportionate Share Hospital (DSH), uncompensated care, Indirect Medical Education (IME) and outliers. For Sole Community Hospitals (SCHs) and MDHs, the applicable low-volume percentage increase is based on and in addition to either payment based on the federal rate or the hospital-specific rate, whichever results in a greater operating IPPS payment.

**Extension of the MDH Program**

Under Section 3124 of the Affordable Care Act, the MDH program authorized by the Social Security Act (§1886(d)(5)(G)) was set to expire at the end of FY 2012. These amendments were extended through September 30, 2017, by subsequent legislation. Section 50205 of the Bipartisan Budget Act of 2018 extends the MDH program, through September 30, 2022. CMS implemented the extension of the MDH program provided by the Affordable Care Act and subsequent legislation in the regulations at §412.108 (see [https://www.ecfr.gov/cgi-bin/text-idx?SID=4d2d4d21664431bde481aff4210219ec&mc=true&node=pt42.2.412&rgn=div5#se42.2.412_1108](https://www.ecfr.gov/cgi-bin/text-idx?SID=4d2d4d21664431bde481aff4210219ec&mc=true&node=pt42.2.412&rgn=div5#se42.2.412_1108)). (For additional information, refer to the FY 2016 Extension of the Low-Volume Hospital Payment Adjustment and MDH Program Interim Final Rule with Comment (IFC) (August 17, 2015; 80 FR 49594 through 49597))

**MDH Classification in States with No Rural Area**

In addition to extending the MDH program, Section 50205 of the Bipartisan Budget Act of 2018 also provides for hospitals that are located in a state without a rural area (that is, an all-urban state) to be eligible to qualify for MDH status if it otherwise satisfies any of the statutory criteria to be reclassified as rural. Prior to the Bipartisan Budget Act of 2018, hospitals could only qualify for MDH status if they were geographically in a rural area or if they reclassified as rural under the statutory provision that is codified in the regulations at 42 CFR 412.103 (see [https://www.ecfr.gov/cgi-bin/text-idx?SID=4d2d4d21664431bde481aff4210219ec&mc=true&node=pt42.2.412&rgn=div5#se42.2](https://www.ecfr.gov/cgi-bin/text-idx?SID=4d2d4d21664431bde481aff4210219ec&mc=true&node=pt42.2.412&rgn=div5#se42.2).
Under current regulations, hospitals located in all-urban states cannot reclassify as rural because their states do not have rural areas into which they can reclassify. This precluded hospitals in all-urban states from being classified as MDHs. The newly added provision in the Bipartisan Budget Act of 2018 allows a hospital in an all-urban state to be eligible for MDH classification if, among the other criteria, it would have qualified for rural reclassification by meeting the criteria at § 412.103(a)(1) or (3) or the criteria at § 412.103(a)(2) as of January 1, 2018, notwithstanding its location in an all-urban state.

Hospitals in all-urban states looking to qualify for MDH classification should submit the following:

1. Apply to their Regional Office as per the application requirements outlined at 42 CFR 412.103(b) to determine if they meet the qualifications for rural reclassification other than being located in an all urban state.
2. Submit its request for MDH status to its MAC as per the classification procedures under 42 CFR 412.108(b) (the requirements of which are detail below).

A hospital in an all-urban state that qualifies as an MDH under the newly-added statutory provision will not be considered as having reclassified as rural but only as having satisfied one of the criteria at section 1886(d)(8)(E)(ii)(I), (II), or (III) (as of January 1, 2018 as applicable) for purposes of MDH classification.

**Reinstatement of MDH Status**

Consistent with implementation of previous extensions of the MDH program, generally, providers that were classified as MDHs as of the date of expiration of the MDH provision will be reinstated as MDHs effective October 1, 2017, with no need to reapply for MDH classification. There are two exceptions:

**a. MDHs that classified as SChs on or after October 1, 2017**

In anticipation of the expiration of the MDH provision, CMS allowed MDHs that applied for classification as an SCH by September 1, 2017, (that is, 30 days prior to the expiration of the MDH program), to be granted such status effective with the expiration of the MDH program. Hospitals that applied in this manner and were approved for SCH classification received SCH status as of October 1, 2017. Additionally, some hospitals that had MDH status as of the October 1, 2017, expiration of the MDH program may have missed the September 1, 2017, application deadline. These hospitals applied for SCH status in the usual manner instead and may have been approved for SCH status effective 30 days from the date of approval resulting in an effective date later than October 1, 2017.

**b. MDHs that requested a cancellation of their rural classification under §412.103(b)**

In order to meet the criteria to become an MDH, generally a hospital must be located in a rural area. To qualify for MDH status, some MDHs may have reclassified as rural under the regulations at §412.103. With the expiration of the MDH provision, some of these providers may have requested a cancellation of their rural classification.

Any provider that falls within either of the two exceptions listed above will not have its MDH status automatically reinstated retroactively to October 1, 2017. All other former MDHs will be
automatically reinstated as MDHs effective October 1, 2017. Providers that fall within either of the two exceptions will have to reapply for MDH classification in accordance with the regulations at 42 CFR 412.108(b) and meet the classification criteria at 42 CFR 412.108(a). Specifically, the regulations at Section 412.108(b) require that:

1. The hospital submit a written request along with qualifying documentation to its contractor to be considered for MDH status (§412.108(b)(2)).
2. The contractor make its determination and notify the hospital within 90 days from the date that it receives the request for MDH classification (§412.108(b)(3)).
3. The determination of MDH status be effective 30 days after the date of the contractor's written notification to the hospital (§412.108(b)(4)).

Cancellation of MDH Status
As required by the regulations at Section 412.108(b)(5), MACs must “evaluate on an ongoing basis” whether or not a hospital continues to qualify for MDH status. Therefore, as required by the regulations at §412.108(b)(5) and (6), the MACs will ensure that the hospital continues to meet the MDH criteria at §412.108(a) and will notify any MDH that no longer qualifies for MDH status. The cancellation of MDH status will become effective 30 days after the date the MAC provides written notification to the hospital.

It is important to note that despite the fact some providers might no longer meet the criteria necessary to be classified as MDHs, these providers could qualify for automatic reinstatement of MDH status retroactive to October 1, 2017, (unless they meet either of the two exceptions for automatic reinstatement as explained above) and would subsequently lose their MDH status prospectively.

Notification to Provider
Notification to providers is necessary only if there is a change that affects a provider's MDH status; that is, if the provider's MDH status is not reinstated seamlessly from October 1, 2017, because it falls within one of the two exceptions listed above or if the provider will lose its MDH status prospectively due to no longer meeting the criteria for MDH status, per the regulations at §412.108(b)(6).

Hospital Specific (HSP) Rate Update for MDHs
For the payment of FY 2018 discharges occurring on or after October 1, 2017, the Hospital Specific (HSP) amount for MDHs in the PSF will continue to be entered in FY 2012 dollars. The Pricer will apply the cumulative documentation and coding adjustment factor for FYs 2011 - 2013 of 0.9480 and apply all updates and other adjustment factors to the HSP amount for FY 2013 and beyond.

Changes to the LTCH Site Neutral Payment Rate

Section 51005(a) of the Bipartisan Budget Act of 2018 extends the blended payment rate for LTCH PPS site neutral payment rate cases provided by the Social Security Act (§1886(m)(6)(B)(i)) to discharges occurring in cost reporting periods beginning in FY 2018 and
FY 2019. Section 51005(b) of the Bipartisan Budget Act of 2018 reduces the “IPPS comparable amount” component of the site neutral payment rate at §1886(m)(6)(B)(ii)(I) of the Social Security Act by 4.6 percent for FYs 2018 through 2026.

**Extension of the Blended Payment Rate for LTCH Site Neutral Payment Rate Cases**

The blended payment rate for LTCH site neutral payment rate cases is determined by the LTCH PPS Pricer according to the Federal PPS Blend Indicator variable in the PSF (data element 18, file position 75) so that providers with a value of ‘6’ or ‘7’ are paid a blend of 50 percent of the LTCH standard Federal payment rate payment and 50 percent of the site neutral payment rate payment, while providers with a value of ‘8’ in the Federal PPS Blend Indicator variable in the PSF are paid 100 percent of the site neutral payment rate payment.

To implement the extension of the blended payment rate provided by Section 51005(a) of the Bipartisan Budget Act of 2018, CMS is revising the description of the Federal PPS Blend Indicator variable in the PSF for a value of ‘7’ to indicate 50 percent of the site neutral payment rate and 50 percent of the LTCH standard Federal payment rate effective for all LTCH providers with cost reporting periods beginning in FY 2017, FY 2018, or FY 2019 (that is, Blend Years 2 through 4).

In order to ensure site neutral payment rate for discharges in cost reporting periods beginning in FY 2018 (beginning on or after October 1, 2017, and before October 1, 2018), MACs will update the Federal PPS Blend Indicator variable as follows:

6 – Blend Year 1 (represents 50 percent site neutral payment and 50 percent standard payment effective for all LTCH providers with cost reporting periods beginning in FY 2016 (on or after 10/01/2015 through 09/30/16)

7 – Blend Years 2 through 4 (represents 50 percent site neutral payment and 50 percent standard payment effective for all LTCH providers with cost reporting periods beginning in FY 2017, FY 2018, or FY 2019

8 – Transition Blend no longer applies with cost reporting periods beginning in FY 2020 (on or after 10/01/2019)

Therefore, MACs will ensure that the Federal PPS Blend Indicator variable in the PSF is updated to a value of ‘7’ for any providers with a cost reporting period beginning on or after October 1, 2017, and as such currently have a value of ‘8’ in the Federal PPS Blend Indicator variable in the PSF with an effective date of the fiscal year begin date for the cost reporting period.

**Adjustment to the LTCH Site Neutral Payment Rate Cases**

As provided by the Social Security Act (§1886(m)(6)(B)), the site neutral payment rate is the lesser of 100 percent of the estimated cost of the case or the “IPPS comparable amount.” Section 51005 (b) of the Bipartisan Budget Act of 2018 adjusts the “IPPS comparable payment” component under the site neutral payment rate at §1886(m)(6)(B)(ii)(I) of the Social Security Act (described in Section 412.522(c)(1)(i)) (see [https://www.ecfr.gov/cgi-bin/text].
In order to implement this adjustment, Pricer logic has been updated to reflect this reduction to the "IPPS comparable amount" component of the site neutral payment rate for discharges occurring in FY 2018.

**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 for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment

MLN Matters Number: MM10445 Revised  Related Change Request (CR) Number: CR10445
Related CR Release Date: March 14, 2018  Effective Date: January 1, 2018, for new HCPCS codes, otherwise April 1, 2018
Related CR Transmittal Number: R3999CP  Implementation Date: April 2, 2018

Note: This article was revised on March 15, 2018, to reflect an updated Change Request (CR). That CR removed the list of new codes with a QW modifier that were effective as of April 1, 2018 from the policy section. All other information remains the same.

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

CR 10445 which informs the MACs about the changes in the April 2018 quarterly update to the Clinical Laboratory Fee Schedule (CLFS). Make sure that your billing staffs are aware of these changes.

BACKGROUND

Effective January 1, 2018, CLFS rates will be based on weighted median private payor rates as required by the Protecting Access to Medicare Act (PAMA) of 2014. For more details, visit PAMA Regulations, at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ ClinicalLabFeeSched/PAMA-Regulations.html.

Part B deductible and coinsurance do not apply for services paid under the CLFS.

Access to Data File

Internet access to the quarterly CLFS data file will be available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service- Payment/ClinicalLabFeeSched/index.html. Interested parties, such as the Medicaid State agencies, the Indian Health Service, the United Mine Workers, and the Railroad Retirement Board, should use the Internet to retrieve the quarterly clinical laboratory fee schedule. The file
will be available in multiple formats: Excel, text, and comma delimited.

**Pricing Information**

The CLFS includes separately payable fees for certain specimen collection methods (codes 36415, P9612, and P9615). The fees are established in accordance with Section 1833(h)(4)(B) of the Social Security Act.

**New Codes**

The following new codes will be MAC priced, until they are addressed at the annual Clinical Laboratory Public Meeting, which will take place in July, 2018. The following "U" codes shall have HCPCS Pricing Indicator Code - 22 = Price established by A/B MACs Part B (e.g., gap-fills, A/B MACs Part B established panels) instead of Pricing Indicator - 21 = Price Subject to National Limitation Amount. (Code, Long Descriptor, Short Descriptor, Effective Date, Type of Service (TOS))

- 0024U Glycosylated acute phase proteins (GlycA), nuclear magnetic resonance spectroscopy, quantitative GLYCA NUC MR SPECTRSC QUAN 1/1/2018 5
- 0025U Tenofovir, by liquid chromatography with tandem mass spectrometry (LC-MS/MS), urine, quantitative TENOFOVIR LIQ CHROM UR QUAN 1/1/2018 5
- 0026U Oncology (thyroid), DNA and mRNA of 112 genes, next-generation sequencing, fine needle aspirate of thyroid nodule, algorithmic analysis reported as a categorical result ("Positive, high probability of malignancy" or "Negative, low probability of malignancy") ONC THYR DNA&MRNA 112 GENES 1/1/18 5
- 0027U JAK2 (Janus kinase 2) (eg, myeloproliferative disorder) gene analysis, targeted sequence analysis exons 12-15 JAK2 GENE TRGT SEQ ALYS 1/1/18 5
- 0028U CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism) gene analysis, copy number variants, common variants with reflex to targeted sequence analysis CYP2D6 GENE CPY NMR CMN VRNT 1/1/18 5
- 0029U Drug metabolism (adverse drug reactions and drug response), targeted sequence analysis (ie, CYP1A2, CYP2C19, CYP2C9, CYP2D6, CYP3A4, CYP3A5, CYP4F2, SLCO1B1, VKORC1 and rs12777823) RX METAB ADVRS TRGT SEQ ALYS 1/1/18 5
- 0030U Drug metabolism (warfarin drug response), targeted sequence analysis (ie, CYP2C9, CYP4F2, VKORC1, rs12777823) RX METAB WARF TRGT SEQ ALYS 1/1/18 5
- 0031U CYP1A2 (cytochrome P450 family 1, subfamily A, member 2)(eg, drug metabolism) gene analysis, common variants (ie, *1F, *1K, *6, *7) CYP1A2 GENE 1/1/18 5
• 0032U COMT (catechol-O-methyltransferase)(drug metabolism) gene analysis, c.472G>A (rs4680) variant COMT GENES 1/1/18 5

• 0033U HTR2A (5-hydroxytryptamine receptor 2A), HTR2C (5-hydroxytryptamine receptor 2C) (e.g., citalopram metabolism) gene analysis, common variants (i.e., HTR2A rs7997012 [c.614-2211T>C], HTR2C rs3813929 [c.-759C>T] and rs1414334 [c.551-3008C>G]) HTR2A HTR2C GENES 1/1/18 5


**The following new code is effective January 1, 2018:**
New code 87634QW is priced at the same rate as code 87634.

**Deleted Codes**
The following codes are deleted effective January 1, 2018:
Existing code 0004U is to be deleted.
Existing code 0015U is to be deleted.
Existing code 81280 is to be deleted.
Existing code 81281 is to be deleted.
Existing code 81282 is to be deleted.

**Code Update**
Existing code 80410 had an incorrect crosswalk (multiplier of 1 instead of 3) in the annual CLFS file, and is corrected with this CR in the quarterly file, effective January 1, 2018.

**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>
</tr>
</thead>
<tbody>
<tr>
<td>March 15, 2018</td>
<td>The article was revised to reflect an updated CR. That CR removed the list of new codes with a QW modifier that were effective as of April 1, 2018 from the policy section.</td>
</tr>
<tr>
<td>February 9, 2018</td>
<td>Initial article released.</td>
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Quarterly Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment

MLN Matters Number: MM10642  Related Change Request (CR) Number: 10642
Related CR Release Date: May 11, 2018  Effective Date: July 1, 2018
Related CR Transmittal Number: R4045CP  Implementation Date: July 2, 2018

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) 10642 informs MACs about the changes in the July 2018 quarterly update to the Clinical Laboratory Fee Schedule (CLFS). Make sure that your billing staffs are aware of these changes.

BACKGROUND

Effective January 1, 2018, CLFS rates will be based on weighted median private payor rates as required by the Protecting Access to Medicare Act (PAMA) of 2014. For more details, visit PAMA Regulations, at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/PAMA-Regulations.html. Part B deductible and coinsurance do not apply for services paid under the clinical laboratory fee schedule.

Access to Data File

Under normal circumstances, CMS will make the updated CLFS data file available to MACs approximately 6 weeks prior to the beginning of each quarter. For example, the updated file will typically be made available for download and testing on or before approximately May 15 for the July 1 release. Internet access to the quarterly CLFS data file will be available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/index.html.

Other interested parties, such as the Medicaid State agencies, the Indian Health Service, the United Mine Workers, and the Railroad Retirement Board, should use the Internet to retrieve the
quarterly CLFS. It will be available in multiple formats: Excel®, text, and comma delimited.

**Pricing Information**

The CLFS includes separately payable fees for certain specimen collection methods (codes 36415, P9612, and P9615). The fees are established in accordance with Section 1833(h)(4)(B) of the Social Security Act.

**New Codes**

The following new codes will be contractor priced until they are addressed at the annual Clinical Laboratory Public Meeting, which will take place in July 2018. The following "U" codes will have HCPCS Pricing Indicator Code - 22 = Price established by A/B MACs Part B (e.g., gap-fills, A/B MACs Part B established panels) instead of Pricing Indicator - 21 = Price Subject to National Limitation Amount. (Code, Type of Service (TOS), Short Descriptor, Long Descriptor)

The following new codes are effective April 1, 2018:

- **0035U TOS 5; Short Descriptor—Neuro csf prion prtn qual; Long Descriptor—Neurology (prion disease), cerebrospinal fluid, detection of prion protein by quaking-induced conformational conversion, qualitative**

- **0036U TOS 5; Short Descriptor—Xome tum & nml spec seq alys; Long Descriptor—Exome (ie, somatic mutations), paired formalin-fixed paraffin-embedded tumor tissue and normal specimen, sequence analyses**

- **0037U TOS 5; Short Descriptor—Trgt gen seq dna 324 genes; Long Descriptor—Targeted genomic sequence analysis, solid organ neoplasm, DNA analysis of 324 genes, interrogation for sequence variants, gene copy number amplifications, gene rearrangements, microsatellite instability and tumor mutational burden**

- **0038U TOS 5; Short Descriptor—Vitamin d srn microsamp quan; Long Descriptor—Vitamin D, 25 hydroxy D2 and D3, by LC-MS/MS, serum microsample, quantitative**

- **0039U TOS 5; Short Descriptor—Dna antb 2strand hi avidity; Long Descriptor—Deoxyribonucleic acid (DNA) antibody, double stranded, high avidity**

- **0040U TOS 5; Short Descriptor—Bcr/abl1 gene major bp quan; Long Descriptor—BCR/ABL1 (t(9;22)) (eg, chronic myelogenous leukemia) translocation analysis, major breakpoint, quantitative**

- **0041U TOS 5; Short Descriptor—B brgdferi antb 5 prtn igm; Long Descriptor—Borrelia burgdorferi, antibody detection of 5 recombinant protein groups, by immunoblot, IgM**

- **0042U TOS 5; Short Descriptor—B brgdferi antb 12 prtn igg; Long Descriptor—Borrelia burgdorferi, antibody detection of 12 recombinant protein groups, by immunoblot, IgG**
0043U TOS 5; Short Descriptor—Tbrf b grp antb 4 prtn igm; Long Descriptor—Tick-borne relapsing fever Borrelia group, antibody detection to 4 recombinant protein groups, by immunoblot, IgM

0044U TOS 5; Short Descriptor—Tbrf b grp antb 4 prtn igg; Long Descriptor—Tick-borne relapsing fever Borrelia group, antibody detection to 4 recombinant protein groups, by immunoblot, IgG0024U Glycosylated acute phase proteins (GlycA), nuclear magnetic resonance spectroscopy, quantitative

0012M TOS 5; Short Descriptor—Onc mrna 5 gen rsk urthl ca; Long Descriptor—Oncology (urothelial), mRNA, gene expression profiling by real-time quantitative PCR of five genes (MDK, HOXA13, CDC2 [CDK1], IGFBP5, and XCR2), utilizing urine, algorithm reported as a risk score for having urothelial carcinoma

0013M TOS 5; Short Descriptor—Onc mrna 5 gen recr urthl ca; Long Descriptor—Oncology (urothelial), mRNA, gene expression profiling by real-time quantitative PCR of five genes (MDK, HOXA13, CDC2 [CDK1], IGFBP5, and CXCR2), utilizing urine, algorithm reported as a risk score for having recurrent urothelial carcinoma

The following new code is effective January 1, 2018:

0011M TOS 5; Short Descriptor—Onc prst8 ca mrna 12 gen alg; Long Descriptor—Oncology, prostate cancer, mRNA expression assay of 12 genes (10 content and 2 housekeeping), RT-PCR test utilizing blood plasma and/or urine, algorithms to predict high-grade prostate cancer risk

Notes:

- In instances where Medicare-covered CLFS procedure codes do not yet appear on the quarterly CLFS file or the quarterly Integrated Outpatient Code Editor (I/OCE) update, MACs will locally price the codes until they appear on the CLFS file and/or, for Part A claims, the I/OCE.
- 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/.
**DOCUMENT HISTORY**

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<tr>
<th>Date of Change</th>
<th>Description</th>
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<tbody>
<tr>
<td>May 14, 2018</td>
<td>Initial article released.</td>
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</table>

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Update to the Medicare Physician Fee Schedule Database (MPFSDB) - April 2018 Update

MLN Matters Number: MM10488  Related Change Request (CR) Number: 10488
Related CR Release Date: February 16, 2018  Effective Date: January 1, 2018
Related CR Transmittal Number: R3976CP  Implementation Date: April 2, 2018

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) 10488 amends payment files issued to MACs based upon the calendar year 2018 Medicare Physician Fee Schedule (MPFS) Final Rule. Make sure your billings staffs are aware of these changes.

BACKGROUND

Payment files were issued to contractors based upon the 2018 MPFS Final Rule, published in the Federal Register on November 15, 2017, to be effective for services furnished between January 1, 2018, and December 31, 2018. Section 1848(c)(4) of the Social Security Act authorizes the Secretary to establish ancillary policies necessary to implement relative values for physicians’ services.

CR 10488 presents a summary of the changes for the April update to the 2018 MPFSDB. Unless otherwise stated, these changes are effective for dates of service on and after January 1, 2018.

<table>
<thead>
<tr>
<th>CPT/HCPCS &amp; Mod</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0516</td>
<td>Change in short descriptor on 4-1-18 to “insert drug implant, &gt;=4”</td>
</tr>
<tr>
<td>45399</td>
<td>Global Days = YYY</td>
</tr>
<tr>
<td>G9976</td>
<td>Procedure Status =</td>
</tr>
</tbody>
</table>
### CPT/HCPCS & Mod | Action
---|---
G9977 | Procedure Status = |
83992 | Procedure Status = |

The following “Q” codes are effective for services performed on or after April 1, 2018 (see MLN Matters Article [MM10454](#) for additional information):

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Short Description</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q2041</td>
<td>Axicabtagene ciloleucel car+</td>
<td>Procedure Status = E; there are no RVUs</td>
</tr>
<tr>
<td>Q5101</td>
<td>Injection, zarxio</td>
<td>Change in short descriptor</td>
</tr>
<tr>
<td>Q5102</td>
<td>Inj., infliximab biosimilar</td>
<td>Procedure Status = I (invalid); code discontinued 4-1-18 &amp; after</td>
</tr>
<tr>
<td>Q5103</td>
<td>Injection, inflectra</td>
<td>Procedure Status = E; there are no RVUs</td>
</tr>
<tr>
<td>Q5104</td>
<td>Injection, renfleixs</td>
<td>Procedure Status = E; there are no RVUs</td>
</tr>
</tbody>
</table>

The HCPCS “G” codes listed below have been added to the MPFSDB effective for dates of service on and after April 1, 2018. All of these new codes were communicated through other instructions. Please consult those instructions for the description and other information. In addition, the descriptions are available also at [https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update.html](https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update.html).

<table>
<thead>
<tr>
<th>CPT/HCPCS &amp; Mod</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>G9873</td>
<td>Procedure Status = X; there are no RVUs; all policy indicators = concept does not apply</td>
</tr>
<tr>
<td>G9874</td>
<td>Procedure Status = X; there are no RVUs; all policy indicators = concept does not apply</td>
</tr>
<tr>
<td>G9875</td>
<td>Procedure Status = X; there are no RVUs; all policy indicators = concept does not apply</td>
</tr>
<tr>
<td>G9876</td>
<td>Procedure Status = X; there are no RVUs; all policy indicators = concept does not apply</td>
</tr>
<tr>
<td>G9877</td>
<td>Procedure Status = X; there are no RVUs; all policy indicators = concept does not apply</td>
</tr>
<tr>
<td>CPT/HCPCS &amp; Mod</td>
<td>Action</td>
</tr>
<tr>
<td>----------------</td>
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</tr>
<tr>
<td>G9878</td>
<td>Procedure Status = X; there are no RVUs; all policy indicators = concept does not apply</td>
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<tr>
<td>G9879</td>
<td>Procedure Status = X; there are no RVUs; all policy indicators = concept does not apply</td>
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<td>Procedure Status = X; there are no RVUs; all policy indicators = concept does not apply</td>
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<td>Procedure Status = X; there are no RVUs; all policy indicators = concept does not apply</td>
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<tr>
<td>G9890</td>
<td>Procedure Status = X; there are no RVUs; all policy indicators = concept does not apply</td>
</tr>
<tr>
<td>G9891</td>
<td>Procedure Status = X; there are no RVUs; all policy indicators = concept does not apply</td>
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</tbody>
</table>

Providers should be aware MACs do not need to search their files to either retract payment for claims already paid or to retroactively pay claims. However, MACs will 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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Update to the Federally Qualified Health Center (FQHC) Prospective Payment System (PPS) for Calendar Year (CY) 2018 - Recurring File Update

MLN Matters Number: MM10480 Revised
Related Change Request (CR) Number: 10480

Related CR Release Date: February 23, 2018
Effective Date: April 1, 2018

Related CR Transmittal Number: R3982CP
Implementation Date: April 2, 2018

**Note:** This article was revised on February 23, 2018, to reflect the revised CR10480 issued on February 23. The article was revised to include further information in the background section, regarding payment methodology for FQHCs under the PPS.

**PROVIDER TYPE AFFECTED**

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

**PROVIDER ACTION NEEDED**

Change Request (CR) 10480 updates the Federally Qualified Health Center Prospective Payment System (FQHC PPS) grandfathered tribal FQHC base payment rate and the Geographic Adjustment Factors (GAFs) for the FQHC Pricer. Make sure your billing staffs are aware of these changes.

**BACKGROUND**

Payment for FQHCs under the Prospective Payment System (PPS)

Section 10501(i)(3)(A) of the Affordable Care Act (Pub. L. 111–148 and Pub. L. 111–152) added section 1834(o) of the Social Security Act to establish a payment system for the costs of FQHC services under Medicare Part B based on prospectively set rates. In the PPS for FQHC Final Rule published in the May 2, 2014 Federal Register (79 FR 25436), the Centers for Medicare & Medicaid Services (CMS) implemented a methodology and payment rates for FQHCs under the PPS beginning on October 1, 2014. Note that:

- Under the FQHC PPS, Medicare pays FQHCs based on the lesser of their actual charges or the PPS rate for all FQHC services furnished to a beneficiary on the same
day when a medically necessary face-to-face FQHC visit is furnished to a Medicare beneficiary.

- Beginning in 2017, the FQHC PPS rate is updated annually by the FQHC market basket. Based on historical data through second quarter 2017, the FQHC market basket for Calendar Year (CY) 2018 is 1.9 percent.

- From January 1, 2018 through December 31, 2018, the FQHC PPS base payment rate is $166.60. The 2018 base payment rate reflects a 1.9 percent increase above the 2017 base payment rate of $163.49.

- In accordance with Section 1834(o)(1)(A) of the Act, The FQHC PPS base rate is adjusted for each FQHC by the FQHC Geographic Adjustment Factor (GAF), based on the Geographic Practice Cost Indices (GPCIs) used to adjust payment under the Physician Fee Schedule (PFS). The FQHC GAF is adapted from the work and practice expense GPCIs, and are updated when the work and practice expense GPCIs are updated for the PFS.

- The Bipartisan Budget Act of 2018 revised the CY 2018 Work GPCI floor. Therefore, the FQHC GAFs have been updated in order to be consistent with the statutory requirements.

**Payment for Grandfathered Tribal FQHCs that were Provider-Based Clinics on or Before April 7, 2000**

Effective for dates of service on or after January 1, 2016, Indian Health Service (IHS) and tribal facilities and organizations may seek to become certified as grandfathered tribal FQHCs, if they:

1. Met the conditions of 42 CFR Section 413.65(m), which is available at https://www.ecfr.gov/cgi-bin/text-idx?SID=19dd7fa703112dee60510c39b8c4c2ae&mc=true&node=pt42.2.413&rgn=div5#se4.2.413.165, on or before April 7, 2000, and
2. Have

   - A change in their status on or after April 7, 2000, from IHS to tribal operation, or vice versa, or

   - The realignment of a facility from one IHS or tribal hospital to another IHS or tribal hospital such that the organization no longer meets the Conditions of Participation (CoPs).

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

- From January 1, 2018, through December 31, 2018, the grandfathered tribal FQHC PPS rate is $383.
- FQHC claims (TOB 77X) for grandfathered tribal FQHCs submitted with dates of service on or after January 1, 2018, through March 31, 2018, paid at the Calendar Year (CY) 2017 rate of $349 must be adjusted and paid at the CY 2018 rate of $383. These adjustments will be completed 90 days after the implementation of CR10480.
- Grandfathered tribal FQHC claims with dates of service on or after January 1, 2019, through December 31, 2019, should be paid at the CY 2018 rate of $383 until the Centers for Medicare & Medicaid Services (CMS) provides an updated payment rate for CY 2019.

The grandfathered tribal FQHC PPS rate will not be adjusted by the FQHC GAFs or be eligible for the special payment adjustments under the FQHC PPS for new patients, patients receiving an Initial Preventive Physical Examination (IPPE) or an Annual Wellness Visit (AWV). The rate is also ineligible for exceptions to the single per diem payment that is available to FQHCs paid under the FQHC PPS. In addition, the FQHC market basket adjustment that is applied annually to the FQHC PPS base rate will not apply to the grandfathered tribal FQHC PPS rate.

**ADDITIONAL INFORMATION**


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

**DOCUMENT HISTORY**

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<tr>
<th>Date of Change</th>
<th>Description</th>
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<tr>
<td>February 23, 2018</td>
<td>The article was revised to reflect a revised CR10480, which added further background information on the FQHC PPS rate and FQHC GAFs.</td>
</tr>
<tr>
<td>February 9, 2018</td>
<td>Initial article released.</td>
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