ITEMS OF IMPORTANCE

All Providers Are Expected to Subscribe to WPS GHA Medicare eNews - Sign Up Today! ......................................................... 2

Fiscal Year (FY) 2014 and 2015 Worksheet S-10 Revisions: Further Extension for All Inpatient Prospective Payment System (IPPS) Hospitals (MM 10378) .................................................. 3

Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Medicare Benefit Policy Manual Chapter 13 Update (Revised MM 10350) ................................................................. 6

Summary of Policies in the Calendar Year (CY) 2018 Medicare Physician Fee Schedule (MPFS) Final Rule, Telehealth Originating Site Facility Fee Payment Amount and Telehealth Services List, and CT Modifier Reduction List (MM 10393) ...... 8

Update to Medicare Deductible, Coinsurance and Premium Rates for 2018 (MM 10405) .......................................................... 13

Update to the Medicare Benefit Policy Manual (Pub. 100-02, Chapter 11 - End Stage Renal Disease (ESRD), Section 100). 16

CLAIM SUBMISSION

2018 Annual Update to the Therapy Code List (MM 10303) ........ 18

Changes to the Laboratory National Coverage Determination (NCD) Edit Software for January 2018 (Revised MM 10309)... 21

Changes to the Laboratory National Coverage Determination (NCD) Edit Software for April 2018 (MM 10424) .................. 24

Diagnosis Code Assignment for Add-on Payments for Blood Clotting Factor Administered to Hemophilia Inpatients (MM 10474) ...... 26

Elimination of the GT Modifier for Telehealth Services (MM 10152) ....................................................................................... 28

E/M Service Documentation Provided By Students (Manual Update) (MM 10412)................................................................. 30

Implementation of the Transitional Drug Add-On Payment Adjustment (Revised MM 10065) .................................................. 32

January 2018 Integrated Outpatient Code Editor (I/OCE) Specifications Version 19.0 (MM 10385) .................................................. 39

January 2018 Update of the Hospital Outpatient Prospective Payment System (OPPS) (MM 10417) .................................................. 44

Next Generation Accountable Care Organization (NGACO) Year Three Benefit Enhancements (Revised MM 10044) ................. 64

Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes - April 2018 Update (MM 10454) ................................................................. 67

Quarterly Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement (MM 10374) .......................... 70

Reinstating the Qualified Medicare Beneficiary Indicator in the Medicare Fee-For-Service Claims Processing System from CR9911 (MM 10433) .................................................. 72

Replacement of Mammography HCPCS Codes, Waiver of Coinsurance and Deductible for Preventive and Other Services, and Addition of Anesthesia and Prolonged Preventive Services (Revised MM 10181) ................................................................. 76

COVERAGE – GENERAL

Hyperbaric Oxygen (HBO) Therapy (Section C, Topical Application of Oxygen) ................................................................. 80

ICD-10 and Other Coding Revisions to National Coverage Determinations (NCDs) (Revised MM 10318) .................................................. 82

Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) (MM 10295) ............................................... 86

COVERAGE – POLICIES

Information on Website .................................................................. 91

New Policies .............................................................................. 91

Retired Policies ........................................................................ 92

Revised Policies ........................................................................ 92

ELECTRONIC DATA INTERCHANGE (EDI)

Suppression of the Standard Paper Remittance Advice (SPR) in 45 days if also Receiving Electronic Remittance Advice (ERA) (Revised MM 10151) ................................................................. 103

PROVIDER EDUCATION

Education Schedule .................................................................. 106

Medicare Learning Network (MLN) ......................................... 107

Quarterly Provider Update ....................................................... 108

REIMBURSEMENT

April 2018 Quarterly ASP Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files (MM 10447) ............... 109

Calendar Year (CY) 2018 Annual Update for Clinical Laboratory Fee Schedule (CLFS) and Laboratory Services Subject to Reasonable Charge Payment (MM 10409) ................. 112

Calendar Year (CY) 2018 Update for DMEPOS Fee Schedule (MM 10395) ................................................................. 123

Clinical Laboratory Fee Schedule – Medicare Travel Allowance Fees for Collection of Specimens (MM 10448) .......................... 131

Correction to Prevent Payment on Inpatient Information Only Claims for Beneficiaries Enrolled in Medicare Advantage Plans (Revised MM 10238) .................................................. 133

Global Surgical Days for Critical Access Hospital (CAH) Method II (MM 10425) ................................................................. 136

Off-Cycle Update to the SNF PPS Fiscal Year (FY) 2018 Pricer (MM 10377) ................................................................. 139

Quarterly Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment (MM 10445) ................................................................. 141

Update to the Federally Qualified Health Center (FQHC) Prospective Payment System (PPS) for Calendar Year (CY) 2018 - Recurring File Update (MM 10334) ........................................ 146

Update to the Federally Qualified Health Center (FQHC) Prospective Payment System (PPS) for Calendar Year (CY) 2018 - Recurring File Update (MM 10480) ........................................ 148

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

Current Procedural Terminology (CPT) is copyright 2017 American Medical Association. All Rights Reserved. No fee schedules, basic units, relative values, or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use.

Current Dental Terminology copyright © 2002, 2005 American Dental Association. All rights reserved.
ALL PROVIDERS ARE EXPECTED TO SUBSCRIBE TO WPS GHA MEDICARE ENEWS - SIGN UP TODAY!

WPS GHA is pleased to offer the convenient services of our WPS GHA Medicare eNews to all providers in our jurisdiction. WPS GHA Medicare eNews is an electronic newsletter sent to you via email. When you subscribe, WPS GHA Medicare eNews will bring the latest Medicare news directly to your email box, free of charge! You may unsubscribe at any time, and, as with all aspects of the WPS GHA publications, we value your privacy and will never disclose, give, sell or transfer any personally identifiable information to third parties.

WPS GHA Medicare eNews announces the posting of the following:
- Time-sensitive national and local Medicare news
- Medicare program changes
- Policy updates, including new, retired, and revised policies
- Training events (including seminars, teleconferences, webinars, and on demand trainings!)
- Communiqué newsletters
- Specialty- and service-specific educational articles
- Much, much more!

It is important to note that the Centers for Medicare & Medicaid Services (CMS) requires Medicare contractors (including WPS GHA) to increase provider subscribership to their eNews every year. In addition, CMS has instructed that every Medicare provider (including physicians, nurses, and billing staff) should be subscribed to eNews. It is a common misconception that only one provider in an office can be subscribed to WPS GHA Medicare eNews; CMS and WPS GHA encourage and expect all Medicare providers to subscribe to eNews.

Sign up today! Visit our website at https://corp-ws.wpsic.com/apps/commercial/unauth/medicareListservUserWelcomeLoadAction.do to subscribe (it only takes a minute). And if you know a co-worker or another Medicare provider who isn't receiving WPS GHA Medicare eNews, let them know that they're missing out on a very informative educational resource and direct them to https://corp-ws.wpsic.com/apps/commercial/unauth/medicareListservUserWelcomeLoadAction.do to sign up as well!
Fiscal Year (FY) 2014 and 2015 Worksheet S-10 Revisions: Further Extension for All Inpatient Prospective Payment System (IPPS) Hospitals

MLN Matters Number: MM10378
Related Change Request (CR) Number: CR 10378
Related CR Release Date: December 1, 2017
Effective Date: January 2, 2018
Related CR Transmittal Number: R1981OTN
Implementation Date: January 2, 2018

PROVIDER TYPE AFFECTED

This MLN Matters Article is intended for Inpatient Prospective Payment System (IPPS) hospitals billing Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

Change Request (CR) 10378 clarifies deadlines for uploading revised or initial Worksheet S-10 submissions to the Health Care Provider Cost Report Information System (HCRIS) for Fiscal Year (FY) 2014 or FY 2015 cost reports that have not been final settled. Make sure your cost report staffs are aware of these changes.

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) has extended the deadline to resubmit certain Worksheet S-10 data from October 31, 2017, until January 2, 2018, for all IPPS hospitals. For revisions to be considered CMS modified the deadline such that amended Fiscal Year (FY) 2014 and FY 2015 cost reports, due to revised or initial submissions of Worksheet S-10, must be received by MACs on or before January 2, 2018.

If an IPPS hospital whose FY 2014 or FY 2015 cost report has been final settled requests to revise Worksheet S-10 for that FY 2014 or FY 2015 cost report and the request was received on or before December 1, 2017, MACs will:

- Issue a Notice of Reopening (NOR) in order to reopen the cost report for revisions to Worksheet S-10
• Create and input Worksheet S-10 adjustments to the most recently final settled cost report
• Issue a Revised Notice of Program Reimbursement (RNPR)
• Upload the FY 2014 or FY 2015 revised cost report to the Health Care Provider Cost Report Information System (HCRIS) on or before December 31, 2017.

If an IPPS hospital whose FY 2014 or FY 2015 cost report has been final settled requests to revise Worksheet S-10 for that FY 2014 or FY 2015 cost report and the request is received between December 2, 2017, and January 2, 2018 (inclusive of those dates), MACs will:

• Issue an NOR in order to reopen the cost report for revisions to Worksheet S-10
• Create and input Worksheet S-10 adjustments to the most recently final settled cost report
• Issue an RNPR
• Upload the FY 2014 or FY 2015 revised cost report to HCRIS on or before January 31, 2018.

If an IPPS hospital whose FY 2014 or FY 2015 cost report has not been final settled requests to revise Worksheet S-10 for that FY 2014 or FY 2015 cost report, providers shall submit an amended cost report with Worksheet S-10 revisions only. MACs will review, accept, and upload the amended cost reports in accordance with the deadlines outlined in CR10378.

Cost reports amended to revise only Worksheet S-10 will not require a tentative settlement.

Change Request (CR) 10378 supersedes the previous deadline in CR10026 (issued June 30, 2017), with respect to the dates by which MACs will issue an NOR in order to accept a revised or newly submitted Worksheet S-10, issue an RNPR, and upload the FY 2014 or FY 2015 revised cost report to HCRIS. (A related MLN Matters article is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10026.pdf.)

MACs will continue to use the information contained in CR10026 or other previous instructions with respect to FY 2014 and FY 2015 Worksheet S-10 revisions for any matters not addressed in CR10378.

**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>December 4, 2017</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>

**Disclaimer:** This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2016 American Medical Association. All rights reserved.

Copyright © 2017, the American Hospital Association, Chicago, Illinois. Reproduced with permission. No portion of the AHA copyrighted materials contained within this publication may be copied without the express written consent of the AHA. AHA copyrighted materials including the UB-04 codes and descriptions may not be removed, copied, or utilized within any software, product, service, solution or derivative work without the written consent of the AHA. If an entity wishes to utilize any AHA materials, please contact the AHA at 312-893-6816. Making copies or utilizing the content of the UB-04 Manual, including the codes and/or descriptions, for internal purposes, resale and/or to be used in any product or publication; creating any modified or derivative work of the UB-04 Manual and/or codes and descriptions; and/or making any commercial use of UB-04 Manual or any portion thereof, including the codes and/or descriptions, is only authorized with an express license from the American Hospital Association. To license the electronic data file of UB-04 Data Specifications, contact Tim Carlson at (312) 893-6816 or Laryssa Marshall at (312) 893-6814. You may also contact us at ub04@healthforum.com

The American Hospital Association (the “AHA”) has not reviewed, and is not responsible for, the completeness or accuracy of any information contained in this material, nor was the AHA or any of its affiliates, involved in the preparation of this material, or the analysis of information provided in the material. The views and/or positions presented in the material do not necessarily represent the views of the AHA. CMS and its products and services are not endorsed by the AHA or any of its affiliates.
Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Medicare Benefit Policy Manual
Chapter 13 Update

MLN Matters Number: MM10350 Revised
Related Change Request (CR) Number: 10350
Related CR Release Date: January 9, 2018
Effective Date: January 22, 2018
Related CR Transmittal Number: R239BP
Implementation Date: January 22, 2018

Note: This article was revised on January 10, 2018, to reflect a revised CR10350 issued on January 9. In the article, the effective and implementation dates are revised. Also, 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 Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) billing Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

Change Request (CR) 10350 notifies RHCs and FQHCs of updates to Chapter 13 of the Medicare Benefit Policy Manual (Pub. 100-02). These updates clarify payment and other policy information. Make sure your billing staffs are aware of these updates.

BACKGROUND

The 2018 update of Chapter 13 of the Medicare Benefit Policy Manual – Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services – provides information on requirements and payment policies for RHCs and FQHCs, as authorized by Section 1861(aa) of the Social Security Act. This chapter now includes payment policy for Care Management in RHCs and FQHCs as finalized in the Calendar Year (CY) 2018 Physician Fee Schedule Final Rule. All other revisions serve to clarify existing policy.

New Manual sections relevant to Care Management Services in RHCs and FQHCs include:

- Section 230 – Care Management Services
• Section 230.1 – Transitional Care Management Services
• Section 230.2 – General Care Management Services – Chronic Care Management and General Behavioral Health Integration Services
• Section 230.3 – Psychiatric Collaborative Care Model (CoCM) Services

The revised chapter is attached to CR 10350.

ADDITIONAL INFORMATION


DOCUMENT HISTORY

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 10, 2018</td>
<td>The article was revised to reflect a revised CR10350 issued on January 9. In the article, the effective and implementation dates are revised. Also, the CR release date, transmittal number and the Web address for accessing the CR are revised. All other information remains the same.</td>
</tr>
<tr>
<td>November 17, 2017</td>
<td>Initial article released</td>
</tr>
</tbody>
</table>

Disclaimer: This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only Copyright 2016 American Medical Association. All rights reserved.

Copyright © 2017, the American Hospital Association, Chicago, Illinois. Reproduced with permission. No portion of the AHA copyrighted materials contained within this publication may be copied without the express written consent of the AHA. AHA copyrighted materials including the UB-04 codes and descriptions may not be removed, copied, or utilized within any software, product, service, solution or derivative work without the written consent of the AHA. If an entity wishes to utilize any AHA materials, please contact the AHA at 312-893-6816. Making copies or utilizing the content of the UB-04 Manual, including the codes and/or descriptions, for internal purposes, resale and/or to be used in any product or publication; creating any modified or derivative work of the UB-04 Manual and/or codes and descriptions; and/or making any commercial use of UB-04 Manual or any portion thereof, including the codes and/or descriptions, is only authorized with an express license from the American Hospital Association. To license the electronic data file of UB-04 Data Specifications, contact Tim Carlson at (312) 893-6816 or Laryssa Marshall at (312) 893-6814. You may also contact us at ub04@healthforum.com

The American Hospital Association (the “AHA”) has not reviewed, and is not responsible for, the completeness or accuracy of any information contained in this material, nor was the AHA or any of its affiliates, involved in the preparation of this material, or the analysis of information provided in the material. The views and/or positions presented in the material do not necessarily represent the views of the AHA. CMS and its products and services are not endorsed by the AHA or any of its affiliates.
Summary of Policies in the Calendar Year (CY) 2018 Medicare Physician Fee Schedule (MPFS) Final Rule, Telehealth Originating Site Facility Fee Payment Amount and Telehealth Services List, and CT Modifier Reduction List

MLN Matters Number: MM10393
Related Change Request (CR) Number: 10393
Related CR Release Date: December 22, 2017
Effective Date: January 1, 2018
Related CR Transmittal Number: R3938CP
Implementation Date: January 2, 2018

PROVIDER TYPES AFFECTED

This MLN Matters® Article is intended for physicians and other providers who submit claims to Medicare Administrative Contractors (MACs) for services paid under the Medicare Physician Fee Schedule (MPFS) and provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

Change Request (CR) 10393 provides a summary of policies in the Calendar Year (CY) 2018 MPFS Final Rule and announces the Telehealth Originating Site Facility Fee payment amount and makes other policy changes related to Medicare Part B payment. These changes are applicable to services furnished in CY 2018. Make sure your billing staffs are aware of these updates.

BACKGROUND

Section 1848(b)(1) of the Social Security Act (the Act) requires the Secretary of Health and Human Services to establish by regulation a fee schedule of payment amounts for physicians' services for the subsequent year. The Centers for Medicare & Medicaid Services (CMS) issued a final rule on November 2, 2017, that updates payment policies and Medicare payment rates for services furnished by physicians and Non-Physician Practitioners (NPPs) that are paid under the MPFS in CY 2018.

The final rule, CMS-1676-F, also addresses public comments on Medicare payment policies proposed earlier this year. The final rule, "Revisions to Payment Policies under the Physician

...
Fee Schedule and Other Revisions to Part B for CY 2018,” was published in the Federal Register on November 2, 2017. The key changes are as follows:

**Overall Payment Update and Misvalued Code Target**

The overall update to payments under the MPFS based on the finalized CY 2018 rates will be +0.41 percent. This update reflects the +0.50 percent update established under the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, reduced by 0.09 percent, due to the misvalued code target recapture amount, required under the Achieving a Better Life Experience (ABLE) Act of 2014.

After applying these adjustments and the budget neutrality adjustment to account for changes in Relative Resource Units (RVUs), all required by law, the final 2018 Physician Fee Schedule (PFS) conversion factor is $35.99, an increase to the 2017 PFS conversion factor of $35.89.

**Payment Rates for Non-excepted Off-Campus Provider-Based Hospital Departments Paid Under the MPFS**

Section 603 of the Bipartisan Budget Act of 2015 requires that certain items and services furnished by certain off-campus hospital outpatient provider-based departments are no longer paid under the Outpatient Prospective Payment System (OPPS) beginning January 1, 2017. For CY 2017, CMS finalized the MPFS as the applicable payment system for most of these items and services.

For CY 2018, CMS is finalizing a reduction to the current MPFS payment rates for these items and services by 20 percent. CMS currently pays for these services under the MPFS based on a percentage of the OPPS payment rate. Specifically, the final policy will change the MPFS payment rates for these services from 50 percent of the OPPS payment rate to 40 percent of the OPPS rate. CMS believes that this adjustment will provide a more level playing field for competition between hospitals and physician practices by promoting greater payment alignment.

**Telehealth originating site facility fee payment amount update**

Section 1834(m)(2)(B) of the Act establishes the payment amount for the Medicare telehealth originating site facility fee for telehealth services provided from October 1, 2001, through December 31, 2002, at $20. For telehealth services provided on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee is increased by the percentage increase in the Medicare Economic Index (MEI) as defined in Section 1842(i)(3) of the Act. The MEI increase for 2017 is 1.2 percent. Therefore, for CY 2018, the payment amount for Healthcare Common Procedure Coding System (HCPCS) code Q3014 (Telehealth originating site facility fee) is 80 percent of the lesser of the actual charge, or $25.76. (The beneficiary is responsible for any unmet deductible amount and Medicare coinsurance.)

**Medicare Telehealth Services**

For CY 2018, CMS is finalizing the addition of several codes to the list of telehealth services, including:
HCPCS code G0296 (visit to determine Low Dose Computed Tomography (LDCT) eligibility)
CPT code 90785 (Interactive Complexity)
CPT codes 96160 and 96161 (Health Risk Assessment)
HCPCS code G0506 (Care Planning for Chronic Care Management)
CPT codes 90839 and 90840 (Psychotherapy for Crisis)

Additionally, CMS is finalizing its proposal to eliminate the required reporting of the telehealth modifier GT for professional claims in an effort to reduce administrative burden for practitioners. CMS is also finalizing separate payment for CPT code 99091, which describes certain remote patient monitoring, for CY 2018. This code is payable in both non-facility and facility settings.

In addition, CMS stated the following in the CY 2018 MPFS Final Rule (82 FR 53014):

- CMS is adopting CPT prefatory guidance that this code should be billed no more than once every 30 days.
- CMS is allowing CPT code 99091 to be billed once per patient during the same service period as chronic care management (CCM) (CPT codes 99487, 99489, and 99490), Transitional Care Management (TCM) (CPT codes 99495 and 99496), and behavioral health integration (BHI) services (CPT codes 99492, 99493, 99494, and 99484).
- CMS is requiring that the practitioner obtain advance beneficiary consent for the service and document this in the patient’s medical record.
- For new patients or patients not seen by the billing practitioner within one year prior to billing CPT code 99091, CMS requires initiation of the service during a face-to-face visit with the billing practitioner, such as an Annual Wellness Visit or Initial Preventive Physical Exam, or other face-to-face visit with the billing practitioner.

Lastly, CMS will consider the stakeholder input received in response to the proposed rule’s comment solicitation on how CMS could expand access to telehealth services, within the current statutory authority.

**Care Management Services**

CMS is continuing efforts to improve payment within traditional fee-for-service Medicare for CCM and similar care management services to accommodate the changing needs of the Medicare patient population. CMS is finalizing its proposals to adopt CPT codes for CY 2018 for reporting several care management services currently reported using Medicare G-codes. Also, CMS is clarifying a few policies regarding CCM in this final rule.

**Improvement of Payment Rates for Office-based Behavioral Health Services**

CMS is finalizing an improvement in the way MPFS rates are set that will positively impact office-based behavioral health services with a patient. The final policy will increase payment for these important services by better recognizing overhead expenses for office-based face-to-face services with a patient.
Evaluation and Management Comment Solicitation

Most physicians and other practitioners bill patient visits to the MPFS under a relatively generic set of codes that distinguish level of complexity, site of care, and in some cases whether or not the patient is new or established. These codes are called Evaluation and Management (E/M) visit codes. Billing practitioners must maintain information in the medical record that documents that they have reported the appropriate level of E/M visit code. CMS maintains guidelines that specify the kind of information that is required to support Medicare payment for each level.

CMS agrees with continued feedback from stakeholders that these guidelines are potentially outdated and need to be revised. CMS thanks the public for the comments received in response to the proposed rule’s comment solicitation on the E/M guidelines and summarizes these comments in the final rule. Commenters suggested that CMS provide additional avenues for collaboration with stakeholders prior to implementing any changes. CMS will consider the best approaches for such collaboration and will take the public comments into account as it considers the issue in future rulemaking.

Prolonged Preventive Services

CMS is adding new codes for prolonged preventive services. Prolonged preventive services are add-on codes payable by Medicare when billed with an applicable preventive service that is both payable from the MPFS, and both deductible and coinsurance do not apply. For the complete list of codes that may be billed with prolonged preventive services visit https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Medicare-PFS-Preventive-Services.html.

Payments for Imaging Services that are X-rays Taken Using Computed Radiography

CMS is finalizing policy required by Section 1848(b)(9) of the Act, which requires payments for imaging services that are X-rays taken using computed radiography (including the technical component portion of a global service) furnished during CYs 2018-2022, that would otherwise be made under the MPFS (without application of subparagraph (B)(i) and before application of any other adjustment), be reduced by 7 percent.

Solicitations on Burden Reduction

CMS solicited comments on burden reduction on several issues including E/M, telehealth and remote patient monitoring. CMS appreciates the thoughtful input it received in response to these comment solicitations and will consider their input in future rulemaking.

Cognitive Therapy Services

CMS will retain the coding and valuation of cognitive therapy services through the creation of HCPCS code G0515 that will mirror CPT code 97532 deleted for CY 2018 instead of valuing CPT code 97127. CMS will assign status indicator “I” to CPT code 97127 to indicate that it is “Invalid” for Medicare purposes. HCPCS code G0515 has been added to the therapy code list,
see CR 10303 for more information. MLN Matters article MM10303 discusses CR10303 and it is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm10303.pdf.

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>December 26, 2017</td>
<td>Initial article released</td>
</tr>
</tbody>
</table>

Disclaimer: This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2016 American Medical Association. All rights reserved.

Copyright © 2017, the American Hospital Association, Chicago, Illinois. Reproduced with permission. No portion of the AHA copyrighted materials contained within this publication may be copied without the express written consent of the AHA. AHA copyrighted materials including the UB-04 codes and descriptions may not be removed, copied, or utilized within any software, product, service, solution or derivative work without the written consent of the AHA. If an entity wishes to utilize any AHA materials, please contact the AHA at 312-893-6816. Making copies or utilizing the content of the UB-04 Manual, including the codes and/or descriptions, for internal purposes, resale and/or to be used in any product or publication; creating any modified or derivative work of the UB-04 Manual and/or codes and descriptions; and/or making any commercial use of UB-04 Manual or any portion thereof, including the codes and/or descriptions, is only authorized with an express license from the American Hospital Association. To license the electronic data file of UB-04 Data Specifications, contact Tim Carlson at (312) 893-6816 or Laryssa Marshall at (312) 893-6814. You may also contact us at ub04@healthforum.com

The American Hospital Association (the “AHA”) has not reviewed, and is not responsible for, the completeness or accuracy of any information contained in this material, nor was the AHA or any of its affiliates, involved in the preparation of this material, or the analysis of information provided in the material. The views and/or positions presented in the material do not necessarily represent the views of the AHA. CMS and its products and services are not endorsed by the AHA or any of its affiliates.
Update to Medicare Deductible, Coinsurance and Premium Rates for 2018

MLN Matters Number: MM10405  Related Change Request (CR) Number: CR10405
Related CR Release Date: December 8, 2017  Effective Date: January 1, 2018
Related CR Transmittal Number: R111GI  Implementation Date: January 2, 2018

PROVIDER TYPE AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 10405 provides instruction for MACs to update the claims processing system with the new Calendar Year (CY) 2018 Medicare deductible, coinsurance, and premium rates. Make sure your billing staffs are aware of these changes.

BACKGROUND

Beneficiaries who use covered Part A services may be subject to deductible and coinsurance requirements. A beneficiary is responsible for an inpatient hospital deductible amount, which is deducted from the amount payable by the Medicare program to the hospital, for inpatient hospital services furnished in a spell of illness. When a beneficiary receives such services for more than 60 days during a spell of illness, he or she is responsible for a coinsurance amount equal to one-fourth of the inpatient hospital deductible per-day for the 61st - 90th day spent in the hospital. An individual has 60 lifetime reserve days of coverage, which they may elect to use after the 90th day in a spell of illness. The coinsurance amount for these days is equal to one-half of the inpatient hospital deductible. A beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible per day for the 21st through the 100th day of Skilled Nursing Facility (SNF) services furnished during a spell of illness.

Most individuals age 65 and older, and many disabled individuals under age 65, are insured for Health Insurance (HI) benefits without a premium payment. The Social Security Act provides that certain aged and disabled persons who are not insured may voluntarily enroll, but are subject to the payment of a monthly premium. Since 1994, voluntary enrollees may qualify for a
reduced premium if they have 30 - 39 quarters of covered employment. When voluntary enrollment takes place more than 12 months after a person’s initial enrollment period, a 10 percent penalty is assessed for 2 years for every year they could have enrolled and failed to enroll in Part A.

Under Part B of the Supplementary Medical Insurance (SMI) program, all enrollees are subject to a monthly premium. Most SMI services are subject to an annual deductible and coinsurance (percent of costs that the enrollee must pay), which are set by statute. When Part B enrollment takes place more than 12 months after a person’s initial enrollment period, there is a permanent 10 percent increase in the premium for each year the beneficiary could have enrolled and failed to enroll.

### 2018 PART A HOSPITAL INSURANCE (HI)

- **Deductible**: $1,340.00
- **Coinsurance**
  - $335.00 a day for 61st - 90th day
  - $670.00 a day for 91st - 150th day (lifetime reserve days)
  - $167.50 a day for 21st - 100th day (Skilled Nursing Facility coinsurance)
- **Base Premium (BP)**: $422.00 a month
  - BP with 10 percent surcharge: $464.20 a month
- **BP with 45 percent reduction**: $232.00 a month (for those who have 30-39 quarters of coverage)
- **BP with 45 percent reduction and 10 percent surcharge**: $255.20 a month

### 2018 PART B - SUPPLEMENTARY MEDICAL INSURANCE (SMI)

- **Standard Premium**: $134.00 a month
- **Deductible**: $183.00 a year
- **Pro Rata Data Amount**:
  - $126.88 1st month
  - $56.12 2nd month
- **Coinsurance**: 20 percent

### 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>December 8, 2017</td>
<td>Initial document released.</td>
</tr>
</tbody>
</table>

**Disclaimer:** This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2016 American Medical Association. All rights reserved.

Copyright © 2017, the American Hospital Association, Chicago, Illinois. Reproduced with permission. No portion of the AHA copyrighted materials contained within this publication may be copied without the express written consent of the AHA. AHA copyrighted materials including the UB-04 codes and descriptions may not be removed, copied, or utilized within any software, product, service, solution or derivative work without the written consent of the AHA. If an entity wishes to utilize any AHA materials, please contact the AHA at 312-893-6816. Making copies or utilizing the content of the UB-04 Manual, including the codes and/or descriptions, for internal purposes, resale and/or to be used in any product or publication; creating any modified or derivative work of the UB-04 Manual and/or codes and descriptions; and/or making any commercial use of UB-04 Manual or any portion thereof, including the codes and/or descriptions, is only authorized with an express license from the American Hospital Association. To license the electronic data file of UB-04 Data Specifications, contact Tim Carlson at (312) 893-6816 or Laryssa Marshall at (312) 893-6814. You may also contact us at [ub04@healthforum.com](mailto:ub04@healthforum.com)

The American Hospital Association (the “AHA”) has not reviewed, and is not responsible for, the completeness or accuracy of any information contained in this material, nor was the AHA or any of its affiliates, involved in the preparation of this material, or the analysis of information provided in the material. The views and/or positions presented in the material do not necessarily represent the views of the AHA. CMS and its products and services are not endorsed by the AHA or any of its affiliates.
Update to the Medicare Benefit Policy Manual (Pub. 100-02, Chapter 11 - End Stage Renal Disease (ESRD), Section 100)

MLN Matters Number: MM10366 Related Change Request (CR) Number: CR 10366
Related CR Release Date: January 19, 2018 Effective Date: January 1, 2017
Related CR Transmittal Number: R240BP Implementation Date: February 20, 2018

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 ESRD services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

Change Request (CR) 10366 updates the “Medicare Benefit Policy Manual” (Publication 100-02, Chapter 11 (End Stage Renal Disease (ESRD)), Section 100 (Payment for Renal Dialysis Services Furnished to Individuals with Acute Kidney Injury (AKI)). Note that CR10366 contains no policy changes. Make sure that your billing staffs are aware of these updates.

BACKGROUND

On June 29, 2015, the Trade Preferences Extension Act of 2015, available at https://www.gpo.gov/fdsys/pkg/PLAW-114publ27/pdf/PLAW-114publ27.pdf 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 the Social Security Act (Section 1881(b)(14)) to beneficiaries with acute kidney injury, effective January 1, 2017.

As previously stated, CR10366 presents no new policy. It only updates the “Medicare Benefit Policy Manual” to include information communicated previously in other CRs regarding Medicare coverage or renal dialysis furnished to individuals with AKI. The updated manual section is attached to CT10366.
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>January 19, 2018</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>

Disclaimer: This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2016 American Medical Association. All rights reserved.

Copyright © 2017, the American Hospital Association, Chicago, Illinois. Reproduced with permission. No portion of the AHA copyrighted materials contained within this publication may be copied without the express written consent of the AHA. AHA copyrighted materials including the UB-04 codes and descriptions may not be removed, copied, or utilized within any software, product, service, solution or derivative work without the written consent of the AHA. If an entity wishes to utilize any AHA materials, please contact the AHA at 312-893-6816. Making copies or utilizing the content of the UB-04 Manual, including the codes and/or descriptions, for internal purposes, resale and/or to be used in any product or publication; creating any modified or derivative work of the UB-04 Manual and/or codes and descriptions; and/or making any commercial use of UB-04 Manual or any portion thereof, including the codes and/or descriptions, is only authorized with an express license from the American Hospital Association. To license the electronic data file of UB-04 Data Specifications, contact Tim Carlson at (312) 893-6816 or Laryssa Marshall at (312) 893-6814. You may also contact us at ub04@healthforum.com.

The American Hospital Association (the “AHA”) has not reviewed, and is not responsible for, the completeness or accuracy of any information contained in this material, nor was the AHA or any of its affiliates, involved in the preparation of this material, or the analysis of information provided in the material. The views and/or positions presented in the material do not necessarily represent the views of the AHA. CMS and its products and services are not endorsed by the AHA or any of its affiliates.
2018 Annual Update to the Therapy Code List

MLN Matters Number: MM10303
Related Change Request (CR) Number: 10303
Related CR Release Date: November 16, 2017
Effective Date: January 1, 2018
Related CR Transmittal Number: R3924CP
Implementation Date: January 2, 2018

PROVIDER TYPES AFFECTED

This MLN Matters® Article is intended for physicians, therapists, and other providers, including Comprehensive Outpatient Rehabilitation Facilities (CORFs), submitting claims to Medicare Administrative Contractors (MACs), including Home Health & Hospice MACs, for outpatient therapy services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

Change Request (CR) 10303 updates the list of codes that sometimes or always describe therapy services and their associated policies. The additions, changes, and deletions to the therapy code list reflect those made in the Calendar Year (CY) 2018 Healthcare Common Procedure Coding System and Current Procedural Terminology, Fourth Edition (HCPCS/CPT-4). The therapy code listing is available at http://www.cms.gov/Medicare/Billing/TherapyServices/index.html. Make sure your billing staffs area aware of these updates.

BACKGROUND

The Social Security Act (Section 1834(k)(5)), available at https://www.ssa.gov/OP_Home/ssact/title18/1834.htm, requires that all claims for outpatient rehabilitation therapy services and all Comprehensive Outpatient Rehabilitation Facility (CORF) services be reported using a uniform coding system. The Calendar Year (CY) 2018 Healthcare Common Procedure Coding System and Current Procedural Terminology, Fourth Edition (HCPCS/CPT-4) is the coding system used for the reporting of these services.

The policies implemented in CR10303 were discussed in CY 2018 Medicare Physician Fee Schedule (MPFS) rulemaking. CR10303 updates the therapy code list and associated policies for CY 2018, as follows:

- The Current Procedural Terminology (CPT) Editorial Panel revised the set of codes physical and occupational therapists use to report orthotic and prosthetic management and training services by differentiating between initial and subsequent encounters through the: (a) addition of the term “initial encounter” to the code descriptors for CPT codes 97760 and 97761, (b) creation of CPT code 97763 to describe all subsequent
encounters for orthotics and/or prosthetics management and training services, and (c) deletion of CPT code 97762. The new long descriptors for CPT codes 97760 and 97761 – now intended only to be reported for the initial encounter with the patient – are:

- CPT code 97760 (Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes)
- CPT code 97761 (Prosthetic(s) training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes)

- The Centers for Medicare & Medicaid Services (CMS) will add CPT code 97763 to the therapy code list and CPT code 97762 will be deleted.
- The panel also created, for CY 2018, CPT code 97127 to replace/delete CPT code 97532. CMS will recognize HCPCS code G0515, instead of CPT code 97127, and add HCPCS code G0515 to the therapy code list. CPT code 97127 will be assigned a Medicare Physician Fee Schedule (MPFS) payment status indicator of “I” to indicate that it is “invalid” for Medicare purposes and that another code is used for reporting and payment for these services.
- Just as its predecessor code was, CPT code 97763 is designated as “always therapy” and must always be reported with the appropriate therapy modifier, GN, GO or GP, to indicate whether it’s under a Speech-language pathology (SLP), Occupational Therapy (OT) or Physical Therapy (PT) plan of care, respectively.
- HCPCS code G0515 is designated as a “sometimes therapy” code, which means that an appropriate therapy modifier – GN, GO or GP, to reflect it’s under an SLP, OT, or PT plan of care – is always required when this service is furnished by therapists; and, when it’s furnished by or incident to physicians and certain Nonphysician Practitioners (NPPs), that is, nurse practitioners, physician assistants, and clinical nurse specialists when the services are integral to an SLP, OT, or PT plan of care. Accordingly, HCPCS code G0515 is sometimes appropriately reported by physicians, NPPs, and psychologists without a therapy modifier when it is appropriately furnished outside an SLP, OT, or PT plan of care. When furnished by psychologists, the services of HCPCS code G0515 are never considered therapy services and may not be reported with a GN, GO, or GP therapy modifier.
- The therapy code list is updated with one new “always therapy” code and one new “sometimes therapy” code, using their HCPCS/CPT long descriptors, as follows:
  - CPT code 97763 – This “always therapy” code replaces/deletes CPT code 97762.
  - CPT code 97763: Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes
  - HCPCS code G0515 – This “sometimes therapy” code replaces/deletes CPT code 97532.
HCPCS code G0515: Development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct (one-on-one) patient contact, each 15 minutes

ADDITIONAL INFORMATION


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

DOCUMENT HISTORY

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>November 21, 2017</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>

Disclaimer: This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2016 American Medical Association. All rights reserved.

Copyright © 2017, the American Hospital Association, Chicago, Illinois. Reproduced with permission. No portion of the AHA copyrighted materials contained within this publication may be copied without the express written consent of the AHA. AHA copyrighted materials including the UB-04 codes and descriptions may not be removed, copied, or utilized within any software, product, service, solution or derivative work without the written consent of the AHA. If an entity wishes to utilize any AHA materials, please contact the AHA at 312-893-6816. Making copies or utilizing the content of the UB-04 Manual, including the codes and/or descriptions, for internal purposes, resale and/or to be used in any product or publication; creating any modified or derivative work of the UB-04 Manual and/or codes and descriptions; and/or making any commercial use of UB-04 Manual or any portion thereof, including the codes and/or descriptions, is only authorized with an express license from the American Hospital Association. To license the electronic data file of UB-04 Data Specifications, contact Tim Carlson at (312) 893-6816 or Laryssa Marshall at (312) 893-6814. You may also contact us at ub04@healthforum.com

The American Hospital Association (the “AHA”) has not reviewed, and is not responsible for, the completeness or accuracy of any information contained in this material, nor was the AHA or any of its affiliates involved in the preparation of this material, or the analysis of information provided in the material. The views and/or positions presented in the material do not necessarily represent the views of the AHA. CMS and its products and services are not endorsed by the AHA or any of its affiliates.
Changes to the Laboratory National Coverage Determination (NCD) Edit Software for January 2018

MLN Matters Number: MM10309 Revised
Related Change Request (CR) Number: CR10309
Related CR Release Date: November 21, 2017
Effective Date: October 1, 2017
Related CR Transmittal Number: R3925CP
Implementation Date: January 2, 2018

Note: The article was revised on November 21, 2017, to reflect a revised CR10309 issued on November 21. In the article, the CR release date, transmittal number, and the Web address of the CR are revised. All other information remains the same.

PROVIDER TYPE AFFECTED

This MLN Matters® Article is intended for physicians, providers, and suppliers submitting claims to Medicare contractors (Regional Home Health Intermediaries (RHHIs) and A/B Medicare Administrative Contractors (A/B MACs)) for services to Medicare beneficiaries.

WHAT YOU NEED TO KNOW

This article is based on Change Request (CR) 10309 which informs MACs about the changes that will be included in the January 2018 quarterly release of the edit module for clinical diagnostic laboratory services. CR10309 applies to Chapter 16, Section 120.2, Publication 100-04. Make sure that your billing staffs are aware of these changes.

See the Background and Additional Information Sections of this article for further details regarding these changes.

BACKGROUND

CR10309 announces the changes that will be included in the January 2018 quarterly release of the edit module for clinical diagnostic laboratory services. NCDs for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee, and the final rule was published on November 23, 2001. Nationally uniform software was developed and incorporated in the Medicare shared systems so that laboratory claims subject to one of the 23 NCDs (Publication 100-03, Sections 190.12 - 190.34) were processed uniformly throughout the nation effective April 1, 2003.
In accordance with Chapter 16, Section 120.2, Publication 100-04, the laboratory edit module is updated quarterly as necessary to reflect ministerial coding updates and substantive changes to the NCDs developed through the NCD process. The changes are a result of coding analysis decisions developed under the procedures for maintenance of codes in the negotiated NCDs and biannual updates of the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes. CR 10309 communicates requirements to Shared System Maintainers (SSMs) and contractors, notifying them of changes to the laboratory edit module to update it for changes in laboratory NCD code lists for January 2018. Please access the link below for the NCD spreadsheets included with CR10309: https://www.cms.gov/Medicare/Coverage/DeterminationProcess/downloads/CR207300-January2018.zip.

MACs will adjust claims brought to their attention, but will not search their files to retract payment for claims already paid or retroactively pay claims.

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/Research-Statistics/PPDr.html.

DOCUMENT HISTORY

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>November 22, 2017</td>
<td>The article is revised to reflect a revised CR10309 issued on November 21. In the article, the CR release date, transmittal number, and the Web address of the CR are revised. All other information remains the same.</td>
</tr>
<tr>
<td>October 12, 2017</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>

Disclaimer: This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2016 American Medical Association. All rights reserved.

Copyright © 2017, the American Hospital Association, Chicago, Illinois. Reproduced with permission. No portion of the AHA copyrighted materials contained within this publication may be copied without the express written consent of the AHA. AHA copyrighted materials including the UB-04 codes and descriptions may not be removed, copied, or utilized within any software,
product, service, solution or derivative work without the written consent of the AHA. If an entity wishes to utilize any AHA materials, please contact the AHA at 312-893-6816. Making copies or utilizing the content of the UB-04 Manual, including the codes and/or descriptions, for internal purposes, resale and/or to be used in any product or publication; creating any modified or derivative work of the UB-04 Manual and/or codes and descriptions; and/or making any commercial use of UB-04 Manual or any portion thereof, including the codes and/or descriptions, is only authorized with an express license from the American Hospital Association. To license the electronic data file of UB-04 Data Specifications, contact Tim Carlson at (312) 893-6816 or Laryssa Marshall at (312) 893-6814. You may also contact us at ub04@healthforum.com

The American Hospital Association (the “AHA”) has not reviewed, and is not responsible for, the completeness or accuracy of any information contained in this material, nor was the AHA or any of its affiliates, involved in the preparation of this material, or the analysis of information provided in the material. The views and/or positions presented in the material do not necessarily represent the views of the AHA. CMS and its products and services are not endorsed by the AHA or any of its affiliates.
Changes to the Laboratory National Coverage Determination (NCD) Edit Software for April 2018

MLN Matters Number: MM10424 Related Change Request (CR) Number: CR10424
Related CR Release Date: December 22, 2017 Effective Date: October 1, 2017
Related CR Transmittal Number: R3937CP Implementation Date: April 2, 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 provided to Medicare beneficiaries.

WHAT YOU NEED TO KNOW

This article is based on Change Request (CR) 10424 which informs MACs about the changes that will be included in the April 2018 quarterly release of the edit module for clinical diagnostic laboratory services. Make sure that your billing staffs are aware of these changes.

BACKGROUND

CR 10424 announces the changes that will be included in the April 2018 quarterly release of the edit module for clinical diagnostic laboratory services. The National Coverage Determinations (NCDs) for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee, and the final rule was published on November 23, 2001. Nationally uniform software was developed and incorporated in the Medicare shared systems so that laboratory claims subject to one of the 23 NCDs (Publication 100-03, Sections 190.12 - 190.34) were processed uniformly throughout the nation effective April 1, 2003.

In accordance with the Medicare Claims Processing Manual, Chapter 16, Section 120.2, the laboratory edit module is updated quarterly as necessary to reflect ministerial coding updates and substantive changes to the NCDs developed through the NCD process. The changes are a result of coding analysis decisions developed under the procedures for maintenance of codes in the negotiated NCDs and biannual updates of the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes. CR10424 communicates requirements to MACs notifying them of changes to the laboratory edit module for laboratory NCD code lists for April 2018. Please access the following link for the NCD spreadsheets included with CR10424:
MACs will adjust claims brought to their attention, but will not search their files to retract payment for claims already paid or retroactively pay claims.

**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>January 3, 2018</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>

Disclaimer: This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2016 American Medical Association. All rights reserved.

Copyright © 2017, the American Hospital Association, Chicago, Illinois. Reproduced with permission. No portion of the AHA copyrighted materials contained within this publication may be copied without the express written consent of the AHA. AHA copyrighted materials including the UB-04 codes and descriptions may not be removed, copied, or utilized within any software, product, service, solution or derivative work without the written consent of the AHA. If an entity wishes to utilize any AHA materials, please contact the AHA at 312-893-6816. Making copies or utilizing the content of the UB-04 Manual, including the codes and/or descriptions, for internal purposes, resale and/or to be used in any product or publication; creating any modified or derivative work of the UB-04 Manual and/or codes and descriptions; and/or making any commercial use of UB-04 Manual or any portion thereof, including the codes and/or descriptions, is only authorized with an express license from the American Hospital Association. To license the electronic data file of UB-04 Data Specifications, contact Tim Carlson at (312) 893-6816 or Laryssa Marshall at (312) 893-6814. You may also contact us at [ub04@healthforum.com](mailto:ub04@healthforum.com)

The American Hospital Association (the “AHA”) has not reviewed, and is not responsible for, the completeness or accuracy of any information contained in this material, nor was the AHA or any of its affiliates, involved in the preparation of this material, or the analysis of information provided in the material. The views and/or positions presented in the material do not necessarily represent the views of the AHA. CMS and its products and services are not endorsed by the AHA or any of its affiliates.
Diagnosis Code Update for Add-on Payments for Blood Clotting Factor Administered to Hemophilia Inpatients

MLN Matters Number: MM10474  Related Change Request (CR) Number: 10474
Related CR Release Date: February 8, 2018  Effective Date: July 1, 2018
Related CR Transmittal Number: R3974CP  Implementation Date: July 2, 2018

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/.

DOCUMENT HISTORY

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>February 9, 2018</td>
<td>Initial article released</td>
</tr>
</tbody>
</table>

Disclaimer: This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2016 American Medical Association. All rights reserved.

Copyright © 2017, the American Hospital Association, Chicago, Illinois. Reproduced with permission. No portion of the AHA copyrighted materials contained within this publication may be copied without the express written consent of the AHA. AHA copyrighted materials including the UB-04 codes and descriptions may not be removed, copied, or utilized within any software, product, service, solution or derivative work without the written consent of the AHA. If an entity wishes to utilize any AHA materials, please contact the AHA at 312-893-6816. Making copies or utilizing the content of the UB-04 Manual, including the codes and/or descriptions, for internal purposes, resale and/or to be used in any product or publication; creating any modified or derivative work of the UB-04 Manual and/or codes and descriptions; and/or making any commercial use of UB-04 Manual or any portion thereof, including the codes and/or descriptions, is only authorized with an express license from the American Hospital Association. To license the electronic data file of UB-04 Data Specifications, contact Tim Carlson at (312) 893-6816 or Laryssa Marshall at (312) 893-6814. You may also contact us at ub04@healthforum.com

The American Hospital Association (the “AHA”) has not reviewed, and is not responsible for, the completeness or accuracy of any information contained in this material, nor was the AHA or any of its affiliates, involved in the preparation of this material, or the analysis of information provided in the material. The views and/or positions presented in the material do not necessarily represent the views of the AHA. CMS and its products and services are not endorsed by the AHA or any of its affiliates.
Elimination of the GT Modifier for Telehealth Services

MLN Matters Number: MM10152
Related Change Request (CR) Number: 10152
Related CR Release Date: November 29, 2017
Effective Date: January 1, 2018
Related CR Transmittal Number: R3929CP
Implementation Date: January 2, 2018

PROVIDER TYPES 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) 10152 eliminates the requirement to use the GT modifier (via interactive audio and video telecommunications systems) on professional claims for telehealth services. Use of the telehealth Place of Service (POS) Code 02 certifies that the service meets the telehealth requirements.

BACKGROUND

CR10152 revises the previous guidance that instructed practitioners to submit claims for telehealth services using the appropriate CPT or HCPCS code for the professional service along with the telehealth modifier GT (via interactive audio and video telecommunications systems). The GQ modifier is still required when applicable. As a result of the CY 2017 Physician Fee Schedule (PFS) final rule, CR9726 implemented payment policies regarding Medicare’s use of a new POS Code 02 to describe services furnished via telehealth. The new POS code became effective January 1, 2017. Use of the telehealth POS code certifies that the service meets the telehealth requirements.

Note that for distant site services billed under Critical Access Hospital (CAH) method II on institutional claims, the GT modifier will still be required.

MACs will apply the “one every three days” frequency edit logic for telehealth services when codes 99231, 99232, and 99233 are billed with POS 02 for claims with dates of service January 1, 2018, and after. This frequency editing also applies when these services are span-dated on the claim (that is, the “from” date and the “to” date of service are not equal, and the “units” field is greater than one).

MACs will apply the existing “one every 30 days” frequency edit logic for telehealth services when codes 99307, 99308, 99309, and 99310 are billed with POS 02 for claims with dates of
service January 1, 2018, and after. This frequency editing also applies when these services are span-dated on the claim (that is, the “from” date and the “to” date of service are not equal, and the “units” field is greater than one).

**ADDITIONAL INFORMATION**

The official instruction issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Transmittals/2017Downloads/R3929CP.pdf.

To review the MLN Matters® article 9726 related to this CR you may go to: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM9726.pdf

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

**DOCUMENT HISTORY**

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 4, 2017</td>
<td>Initial Article Released</td>
</tr>
</tbody>
</table>

Disclaimer This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2016 American Medical Association. All rights reserved.

Copyright © 2017, the American Hospital Association, Chicago, Illinois. Reproduced with permission. No portion of the AHA copyrighted materials contained within this publication may be copied without the express written consent of the AHA. AHA copyrighted materials including the UB-04 codes and descriptions may not be removed, copied, or utilized within any software, product, service, solution or derivative work without the written consent of the AHA. If an entity wishes to utilize any AHA materials, please contact the AHA at 312-893-6816. Making copies or utilizing the content of the UB-04 Manual, including the codes and/or descriptions, for internal purposes, resale and/or to be used in any product or publication; creating any modified or derivative work of the UB-04 Manual and/or codes and descriptions; and/or making any commercial use of UB-04 Manual or any portion thereof, including the codes and/or descriptions, is only authorized with an express license from the American Hospital Association. To license the electronic data file of UB-04 Data Specifications, contact Tim Carlson at (312) 893-6816 or Laryssa Marshall at (312) 893-6814. You may also contact us at ub04@healthforum.com.

The American Hospital Association (the “AHA”) has not reviewed, and is not responsible for, the completeness or accuracy of any information contained in this material, nor was the AHA or any of its affiliates, involved in the preparation of this material, or the analysis of information provided in the material. The views and/or positions presented in the material do not necessarily represent the views of the AHA. CMS and its products and services are not endorsed by the AHA or any of its affiliates.
E/M Service Documentation Provided By Students
(Manual Update)

MLN Matters Number: MM10412
Related Change Request (CR) Number: 10412
Related CR Release Date: February 2, 2018
Effective Date: January 1, 2018
Related CR Transmittal Number: R3971CP
Implementation Date: March 5, 2018

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 10412 revises the Medicare Claims Processing Manual to allow the teaching physician to verify in the medical record any student documentation of components of E/M services, rather than re-documenting the work. Make sure your billing staffs are aware of the changes.

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) is revising the Medicare Claims Processing Manual, Chapter 12, Section 100.1.1, to update policy on Evaluation and Management (E/M) documentation to allow the teaching physician to verify in the medical record any student documentation of components of E/M services, rather than re-documenting the work. Students may document services in the medical record. However, the teaching physician must verify in the medical record all student documentation or findings, including history, physical exam and/or medical decision making. The teaching physician must personally perform (or re-perform) the physical exam and medical decision making activities of the E/M service being billed, but may verify any student documentation of them in the medical record, rather than re-documenting this work.

ADDITIONAL INFORMATION


If you have any questions, please contact your MAC at their toll-free number. That number is

**DOCUMENT HISTORY**

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>February 5, 2018</td>
<td>Initial article released</td>
</tr>
</tbody>
</table>

Disclaimer: This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2016 American Medical Association. All rights reserved.

Copyright © 2017, the American Hospital Association, Chicago, Illinois. Reproduced with permission. No portion of the AHA copyrighted materials contained within this publication may be copied without the express written consent of the AHA. AHA copyrighted materials including the UB-04 codes and descriptions may not be removed, copied, or utilized within any software, product, service, solution or derivative work without the written consent of the AHA. If an entity wishes to utilize any AHA materials, please contact the AHA at 312-893-6816. Making copies or utilizing the content of the UB-04 Manual, including the codes and/or descriptions, for internal purposes, resale and/or to be used in any product or publication; creating any modified or derivative work of the UB-04 Manual and/or codes and descriptions; and/or making any commercial use of UB-04 Manual or any portion thereof, including the codes and/or descriptions, is only authorized with an express license from the American Hospital Association. To license the electronic data file of UB-04 Data Specifications, contact Tim Carlson at (312) 893-6816 or Laryssa Marshall at (312) 893-6814. You may also contact us at ub04@healthforum.com

The American Hospital Association (the “AHA”) has not reviewed, and is not responsible for, the completeness or accuracy of any information contained in this material, nor was the AHA or any of its affiliates, involved in the preparation of this material, or the analysis of information provided in the material. The views and/or positions presented in the material do not necessarily represent the views of the AHA. CMS and its products and services are not endorsed by the AHA or any of its affiliates.
Implementation of the Transitional Drug Add-On Payment Adjustment

MLN Matters Number: MM10065 Revised  Related Change Request (CR) Number: CR 10065
Related CR Release Date: January 10, 2018  Effective Date: January 1, 2018
Related CR Transmittal Number: R1999OTN  Implementation Date: January 2, 2018

Note: This article was revised on January 10, 2018 to reflect the revised CR10065 issued on that date. The CR was revised to provide more descriptive examples for Parsabiv and Sensipar. These examples were added to the article. In addition, the CR release date, transmittal number and the Web address for accessing the CR were revised. All other information remains the same.

PROVIDER TYPE AFFECTED

This MLN Matters Article is intended for End-Stage Renal Disease (ESRD) facilities submitting claims to Medicare Administrative Contractors (MACs) for certain ESRD drugs provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

This article informs you about Change Request (CR) 10065, which directs the MACS to implement the Transitional Drug Add-On Payment Adjustment (TDAPA). Please be sure your billing staffs are informed of this change.

BACKGROUND

In accordance with section 217(c) of the Protecting Access to Medicare Act, the Centers for Medicare & Medicaid Services (CMS) implemented a drug designation process for: (1) determining when a product is no longer an oral-only drug; and (2) including new injectable and intravenous products into the ESRD Prospective Payment System (PPS). Under the drug designation process, CMS provides payment using a TDAPA for new injectable or intravenous drugs and biologicals that qualify under 42 Code of Federal Regulations (CFR) 413.234(c)(1).

To be considered a new injectable or intravenous product, the product must be approved by the Food and Drug Administration (FDA), commercially available, assigned a Healthcare Common Procedure Coding System (HCPCS) code, and designated by CMS as a renal dialysis service. CMS considers the new injectable or intravenous product to be included in the ESRD PPS...
bundled payment (with no separate payment available) if used to treat or manage a condition for which there is an ESRD PPS functional category. CMS will pay for the drug or biological using a TDAPA, if the new injectable or intravenous product is used to treat or manage a condition for which there is not an existing ESRD PPS functional category. While calcimimetics are included in the bone and mineral metabolism ESRD PPS functional category, they are an exception to the drug designation process as discussed in the Calendar Year (CY) 2016 ESRD PPS final rule (80 FR 69025, 69027). CMS bases the TDAPA on payment methodologies under section 1847A of the Social Security Act which are discussed in the “Medicare Claims Processing Manual”, Chapter 17, Section 20. This payment is applicable for a period of 2 years. While the TDAPA applies to a new injectable or intravenous drug or biological, the drug or biological is not considered an outlier service.

The ESRD PPS includes consolidated billing (CB) requirements for limited Part B services included in the ESRD facility’s bundled payment. CMS periodically updates the lists of items and services that are subject to Part B consolidated billing and are therefore no longer separately payable when provided to ESRD beneficiaries by providers other than ESRD facilities.

**Transitional Drug Add-On Payment Adjustment**

Effective January 1, 2018, injectable, intravenous, and oral calcimimetics qualify for the TDAPA. ESRD facilities should report the AX modifier (Item furnished in conjunction with dialysis services) with the HCPCS for these drugs to receive payment for these drugs using the TDAPA. While these drugs are eligible for the TDAPA, they do not qualify toward outlier calculation. Currently, calcimimetics are the only drugs that qualify for payment using the TDAPA. **ESRD facilities should not use the AX modifier for any other drug until notified by CMS.**

Effective January 1, 2018, MACs will return to provider (RTP) ESRD claims (TOB 72X) when:

- HCPCS code J0604 or J0606 is present without modifier AX or
- Modifier AX is present without HCPCS code J0604 or J0606

J0604 and J0606 are drugs that are used for bone and mineral metabolism. Bone and mineral metabolism is an ESRD PPS functional category where drugs and biologicals that fall in this category are always considered to be used for the treatment of ESRD.

ESRD facilities will not receive separate payment for J0604 and J0606 with or without the AY modifier and the MACs will process the line item as covered with no separate payment under the ESRD PPS. The ESRD PPS CB requirements will be updated to include J0604 and J0606.

CR 10065 also implements the payer only value code Q8 – Total TDAPA Amount, to be used to capture the add-on payment adjustment. CR 10065 has an example of the calculation used in PRICER.

**Parsabiv Example:**

Patient is prescribed 5mg 3 times per week with a payment limit of $3.50 per 0.1 mg.

1/1/2018 HCPCS J0606, 50 units

1/1/2018 REV 821
1/3/2018 HCPCS J0606, 50 units
1/3/2018 REV 821
1/5/2018 HCPCS J0606, 50 units
1/5/2018 REV 821
1/8/2018 HCPCS J0606, 50 units
1/8/2018 REV 821
1/10/2018 HCPCS J0606, 50 units
1/10/2018 REV 821
1/12/2018 HCPCS J0606, 50 units
1/12/2018 REV 821
1/15/2018 HCPCS J0606, 50 units
1/15/2018 REV 821
1/17/2018 HCPCS J0606, 50 units
1/17/2018 REV 821
1/19/2018 HCPCS J0606, 50 units
1/19/2018 REV 821
1/22/2018 HCPCS J0606, 50 units
1/22/2018 REV 821
1/24/2018 HCPCS J0606, 50 units
1/24/2018 REV 821
1/26/2018 HCPCS J0606, 50 units
1/26/2018 REV 821
1/29/2018 HCPCS J0606, 50 units
1/29/2018 REV 821
1/31/2018 HCPCS J0606, 50 units
1/31/2018 REV 821
Q8 is assigned $2450 \((50 \times 3.50) \times 14 = 2450\)

Number of dialysis treatments for month = 14

Adjusted ESRD PPS base rate = $250.00

QIP reduction = 0.985

Cost of TDAPA drug/ number of dialysis treatments for the month = TDAPA payment per treatment

\[ \frac{2450}{14} = 175 \]

Final Payment Rate = \((\text{Adjusted ESRD PPS base rate} + \text{TDAPA payment per treatment}) \times \text{QIP reduction}\)

\[ \frac{418.63}{1} = (250.00 + 175) \times 0.985 \]

\[ \frac{418.63}{1} = 425 \times 0.985 \]

The final per treatment payment rate is $418.63

**Sensipar Example:**

Patient is prescribed 1-30mg tablet per day on January 10, 2018 with a payment limit of $1.00 per 1 mg.

1/1/2018 REV 821
1/3/2018 REV 821
1/5/2018 REV 821
1/8/2018 REV 821
1/10/2018 HCPCS J0604, 660 units
1/10/2018 REV 821
1/12/2018 REV 821
1/15/2018 REV 821
1/17/2018 REV 821
1/19/2018 REV 821
1/22/2018 REV 821
Q8 is assigned $660 \((660 \times 1) = $660\)

Number of dialysis treatments for month = 14

Adjusted ESRD PPS base rate = $250.00

QIP reduction = 0.985

Cost of TDAPA drug/ number of dialysis treatments for the month = TDAPA payment per treatment

$660/ 14 = $47.14

Final Payment Rate = \((\text{Adjusted ESRD PPS base rate} + \text{TDAPA payment per treatment}) \times \text{QIP reduction}\)

$292.68 = \((250.00 + 47.14) \times 0.985\)

$292.68 = 297.14 \times 0.985

The final per treatment payment rate is $292.68

**Oral or Other Forms of Injectable Drugs and Biologicals**

ESRD facilities are responsible for furnishing renal dialysis services either directly or under arrangement. The one exception to this policy is oral-only drugs and biologicals that are not paid under the ESRD PPS until January 1, 2025.

CMS recognizes that ESRD facilities may have unique circumstances with regard to furnishing oral and other forms of injectable drugs and biologicals when the medication cannot be administered in the ESRD facility. For example, a pharmacy may, under arrangement with the ESRD facility, dispense the medication and provide the patient with instructions on how to self-administer the drug. In this situation, the ESRD facility is responsible for developing contractual arrangements with pharmacies and ensuring that appropriate delivery and billing of the drug is completed in accordance with the beneficiary’s plan of care.

CMS Pub. 100-02, chapter 11, section 20.3.C provides the reporting guidance for oral or other forms of renal dialysis drugs that are filled at the pharmacy or furnished directly by an ESRD facility for home use. ESRD facilities are instructed to report one line item per prescription, but only for the quantity of the drug expected to be taken during the claim billing period, that is, calendar month. ESRD facilities should use the best information they have to determine the amount expected to be taken in a given calendar month, including prescription fill information.
from the pharmacy and the patient’s plan of care (80 FR 37838).

ESRD facility claims include only the items and services used during the calendar month. CMS does not expect facilities to physically administer the drug to the patient, however, CMS does expect facilities to be aware of the patient’s plan of care and know the medications the patient was instructed to take for the claim’s time period, and ensure the claim reflects that plan of care.

With the implementation of TDAPA, facilities are now responsible for reporting an oral calcimimetic (J0604) on the ESRD claim. The ESRD PPS is built and operationalized around the monthly reporting of items and services that are furnished. However, we recognize that continuity of therapy may be unpredictable. For example, beneficiaries can be hospitalized, switch facilities, or change dosages all within the same calendar month. CMS recognizes that these situations may be beyond the control of the ESRD facility and that they can impact payment. ESRD facilities will need to determine the most appropriate way to furnish drugs and biologicals that ensures patients receive their required medications, while mitigating the facilities’ risk for drug costs.

Again, with regard to reporting for the oral calcimimetic (J0604), CMS expects that ESRD facilities will report the quantity of the drug expected to be taken during the calendar month using the best information available as discussed above. CMS does not expect the date of the line on the claim for the oral calcimimetic to correspond to a treatment date or the specific day that the patient received the supply of medication, however, the facility’s recordkeeping (for example, the patient’s medical record) should be consistent with the claim.

CMS expects all providers and suppliers to supply and administer all patient drugs and biologicals in a clinically approved, efficient and economical manner. CMS will closely monitor the utilization of renal dialysis services and the use of TDAPA to analyze trends, behaviors and require appropriate corrective action when necessary.

**ADDITIONAL INFORMATION**


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

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 10, 2018</td>
<td>The article was revised to provide more descriptive examples in the Background section for Parsabiv and Sensipar. The CR release date, transmittal number and the Web address for accessing the CR were revised also. All other information remains the same.</td>
</tr>
<tr>
<td>December 29, 2017</td>
<td>The article was revised in order to add the section entitled “Oral or Other Forms of Injectable Drugs and Biologicals” starting on page 2.</td>
</tr>
<tr>
<td>August 9, 2017</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>

**Disclaimer** This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2016 American Medical Association. All rights reserved.

Copyright © 2017, the American Hospital Association, Chicago, Illinois. Reproduced with permission. No portion of the AHA copyrighted materials contained within this publication may be copied without the express written consent of the AHA. AHA copyrighted materials including the UB-04 codes and descriptions may not be removed, copied, or utilized within any software, product, service, solution or derivative work without the written consent of the AHA. If an entity wishes to utilize any AHA materials, please contact the AHA at 312-893-6816. Making copies or utilizing the content of the UB-04 Manual, including the codes and/or descriptions, for internal purposes, resale and/or to be used in any product or publication; creating any modified or derivative work of the UB-04 Manual and/or codes and descriptions; and/or making any commercial use of UB-04 Manual or any portion thereof, including the codes and/or descriptions, is only authorized with an express license from the American Hospital Association. To license the electronic data file of UB-04 Data Specifications, contact Tim Carlson at (312) 893-6816 or Laryssa Marshall at (312) 893-6814. You may also contact us at ub04@healthforum.com

The American Hospital Association (the “AHA”) has not reviewed, and is not responsible for, the completeness or accuracy of any information contained in this material, nor was the AHA or any of its affiliates, involved in the preparation of this material, or the analysis of information provided in the material. The views and/or positions presented in the material do not necessarily represent the views of the AHA. CMS and its products and services are not endorsed by the AHA or any of its affiliates.
January 2018 Integrated Outpatient Code Editor (I/OCE) Specifications Version 19.0

MLN Matters Number: MM10385  Related Change Request (CR) Number: 10385
Related CR Release Date: December 22, 2017  Effective Date: January 1, 2018
Related CR Transmittal Number: R3940CP  Implementation Date: January 2, 2018

PROVIDER TYPE 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

Change Request (CR) 10385 provides the Integrated Outpatient Code Editor (I/OCE) instructions and specifications for the Integrated OCE that Medicare uses under the Outpatient Perspective Payment (OPPS) and Non-OPPS for hospital outpatient departments, community mental health centers, all non-OPPS providers, and for limited services when provided in a Home Health Agency (HHA) not under the Home Health Prospective Payment System or to a hospice patient for the treatment of a non-terminal illness. Make sure your billing staffs are aware of these changes.

BACKGROUND

CR10385 informs MACs, as well as the Fiscal Intermediary Shared System (FISS) maintainer of the updates to the I/OCE for January 1, 2018. The I/OCE routes all institutional outpatient claims (which includes non-OPPS hospital claims) through a single integrated OCE. The Centers for Medicare & Medicaid Services (CMS) will post the I/OCE specifications at https://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/index.html. The following table summarizes the modifications of the I/OCE for the January 2018 V19.0. Readers should also read through the entire document attached to CR10385 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>Modification</th>
</tr>
</thead>
</table>
| 1/1/2018      | Updates to the following tables (additional details included in the tables listed in the attachment to CR10385):  
Table 1: IOCE Control Block  
- Add Value Codes and Value Code Amounts, up to 36  
- Increase the number of Condition Codes to 30  
- Increase the number of Occurrence Codes to 30  
- Remove the following fields: Ndxptr, Nsgptr, NCCptr, NOccptr, CodeTypePtr  
- Modify the Comments for the following fields: Dxeditptr, Proceditptr, Mdeditptr, Dteditptr, Rceditptr, APCptr, Claimptr  
Table 5: Claim Return Buffer  
- Add Payer Condition Code field  
Table 7: APC Return Buffer  
- Add HCPCS Modifier field |  |
<p>| 1/1/2016      | Update program logic for drug HCPCS lines with Status Indicator (SI) of G or K to return the Payment Ambulatory Payment Classification (APC) (see processing logic and Appendix E of the attachment to CR10385). |  |
| 1/1/2018      | Update Appendix K to note the deletion of composite APC 8001. |  |
| 1/1/2018      | Implement program logic for payment reduction of x-rays taken using computed radiography technology. HCPCS codes reporting modifier FY are assigned new payment adjustment flag value 22 (CAA Section 502b reduction on computed radiography) (see special processing section and Appendix G). Note: Currently the list of HCPCS codes affected by this logic is the same as that used with modifier FX. |  |
| 1/1/2018      | Implement program logic for OPPS claims to assign a HCPCS level modifier to the line level output when drug HCPCS with SI = K are reported with new modifier JG. The IOCE adds modifier V3 to the line in the new ‘HCPCS modifier’ field of the program output (see processing logic and Table 7). |  |
| 1/1/2017      | Implement new edit 102: Modifiers PO/PN not allowed on the same line (Return to Provider (RTP)). Edit criteria: A claim line has both modifiers PO and PN present (see processing logic, Tables 4 and 5, and Appendix F(a) – Edits by Bill Type). |  |
| 7/24/2017     | Implement new edit 103: Modifier reported prior to FDA approval date (Line Item Denial (LID)). Edit criteria: A modifier is reported prior to the mid-quarter activation date (see processing logic, Tables 4 and 5, and Appendix F(a) – Edits by Bill Type). |  |
| 1/1/2017      | Modify program logic for conditional packaging of laboratory services. Laboratory services with SI = Q4 have the SI changed to A if present with an OPPS procedure that has final SI = Q1 with a line item action flag of 2 or 3 applied (see processing logic). |  |
| 6/5/2017      | Implement mid-quarter NCD approval edit for procedure code 0421T. |  |</p>
<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Edits Affected</th>
<th>Modification</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/1/2018</td>
<td></td>
<td>Update program logic for Federally Qualified Health Center (FQHC) claims for new Chronic Care Management codes G0511, G0512. If either code is reported, assign Payment Indicator = 2 and bypass edits 88 and 89 if no FQHC payment code is reported (see Appendix M).</td>
</tr>
<tr>
<td>4/1/2011</td>
<td></td>
<td>Update program logic for services that may be subject to deductible or deductible/coinsurance waiver. If the services are packaged with SI = N and the line item charges = 0.00, do not assign payment adjustment flags 4, 9 or 10 (see processing logic where payment adjustment flags 4, 9 or 10 are applicable and Appendix G).</td>
</tr>
</tbody>
</table>
| 1/1/2018       | 22             | Add the following new modifiers to the valid modifier list:  
- FY: Computed radiography x-ray  
- JG: 340B Acquired Drug  
- TB: Tracking 340b acquired drug  
- X1: Continuous/broad services  
- X2: Continuous/focused services  
- X3: Episodic/broad services  
- X4: Episodic/focused services  
- X5: Svc req by another clinician  
- 96: Habilitative services  
- 97: Rehabilitative services |
| 1/1/2018       |                | Update Appendix D to reference HCPCS codes that have SI values different from its APC SI value and impact to discounting (see Appendix D). |
| 10/1/2017      |                | Update program logic for Partial Hospitalization Program (PHP) claims to return Payer-defined Condition Codes in the following instances:  
- Return condition code MP if the PHP claim represents the initial admit week claim  
- Return condition code MQ if the PHP claim represents the final discharge week claim  
Note: edit 95 is not returned on an initial admit week or a final discharge week of a PHP claim (see processing logic). |
<p>| 1/1/2018       |                | Update program logic for critical care ancillary services to discontinue the modifier 59 logic exception for code 36600; code no longer identified as critical care ancillary service (see processing logic). |
| 1/1/2018       |                | Add new payment adjustment flag value 22 (see Appendix G). |</p>
<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Edits Affected</th>
<th>Modification</th>
</tr>
</thead>
</table>
| 1/1/2018       | Update the following lists for the release (see quarterly data files): | - Comprehensive APC ranking  
- Complexity-adjusted comprehensive APC code pairs  
- Critical care ancillary services (conditional packaging)  
- Procedure and sex conflict (edit 8)  
- Bilateral procedure editing  
- Blood clotting factor and biologic response HCPCS (edit 99 excusions)  
- Blood products (edit 73, code updates)  
- Skin substitute lists (edit 87 – code updates, see Appendix O)  
- Coinsurance/Deductible N/A list (code updates, Appendix O, Preventive Services)  
- Device Offset Code Pairs (code pair updates for pass-through device offset logic)  
- Device-Procedure; terminated device-procedures for offset (edit 92, code updates)  
- Pass-through drugs and biological APC offset amounts  
- Pass-through skin substitute products (code updates)  
- Radiation HCPCS for Section 603 (code updates)  
- CT Scan HCPCS subject to NEMA (code updates)  
- X-ray list for modifiers FX/FY (code updates)  
- Non-covered services lists (SI = E1, for edits 9, 28, 50, code updates)  
- Separate payment not provided list (SI = E2, edit 13)  
- Non-reportable for OPPS list (SI = B, edit 62)  
- Services not billable to MAC list (SI = M, edit 72)  
- FQHC non-covered list (code updates for FQHC and RHC claims)  
- FQHC flu vaccine list (code updates for FQHC claims)  
- FQHC Chronic Care Management (new codes for new list) |
|                | Make all HCPCS/APC/SI changes as specified by CMS (quarterly data files). |   |
| 1/1/2018       | Implement version 24.0 of the NCCI (as modified for applicable outpatient institutional providers). |   |
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>December 22, 2017</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>

Disclaimer: This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2016 American Medical Association. All rights reserved.

Copyright © 2017, the American Hospital Association, Chicago, Illinois. Reproduced with permission. No portion of the AHA copyrighted materials contained within this publication may be copied without the express written consent of the AHA. AHA copyrighted materials including the UB-04 codes and descriptions may not be removed, copied, or utilized within any software, product, service, solution or derivative work without the written consent of the AHA. If an entity wishes to utilize any AHA materials, please contact the AHA at 312-893-6816. Making copies or utilizing the content of the UB-04 Manual, including the codes and/or descriptions, for internal purposes, resale and/or to be used in any product or publication; creating any modified or derivative work of the UB-04 Manual and/or codes and descriptions; and/or making any commercial use of UB-04 Manual or any portion thereof, including the codes and/or descriptions, is only authorized with an express license from the American Hospital Association. To license the electronic data file of UB-04 Data Specifications, contact Tim Carlson at (312) 893-6816 or Laryssa Marshall at (312) 893-6814. You may also contact us at ub04@healthforum.com

The American Hospital Association (the “AHA”) has not reviewed, and is not responsible for, the completeness or accuracy of any information contained in this material, nor was the AHA or any of its affiliates, involved in the preparation of this material, or the analysis of information provided in the material. The views and/or positions presented in the material do not necessarily represent the views of the AHA. CMS and its products and services are not endorsed by the AHA or any of its affiliates.
January 2018 Update of the Hospital Outpatient Prospective Payment System (OPPS)

MLN Matters Number: MM10417
Related Change Request (CR) Number: 10417
Related CR Release Date: December 22, 2017
Effective Date: January 1, 2018
Related CR Transmittal Number: R3941CP
Implementation Date: January 2, 2018

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

Change Request (CR) 10417 describes changes to the OPPS to be implemented in the January 2018 update. Make sure your billing staffs are aware of these changes.

BACKGROUND

CR10417 describes changes to and billing instructions for various payment policies implemented in the January 2018 OPPS update. The January 2018 Integrated Outpatient Code Editor (I/OCE) will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in this Change Request (CR).

The January 2018 revisions to I/OCE data files, instructions, and specifications are provided in the forthcoming January 2018 I/OCE CR10385. Once the I/OCE CR is issued, a related MLN Matters article will be available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10385.pdf.

Key changes to and billing instructions for various payment policies implemented in the January 2018 OPPS update are as follows:

New Device Pass-Through Categories

Section 1833(t)(6)(B) of the Social Security Act (the Act) requires that, under the OPPS,
categories of devices be eligible for transitional pass-through payments for at least two (2), but not more than three (3), years. Section 1833(t)(6)(B)(ii)(IV) of the Act requires that the Centers for Medicare & Medicaid Services (CMS) create additional categories for transitional pass-through payment of new medical devices not described by existing or previously existing categories of devices.

Effective January 1, 2018, there are no device categories eligible for pass-through payment. However, an existing device described by HCPCS code C2623 (Catheter, transluminal angioplasty, drug coated, non-laser) was approved on August 25, 2017, by the Food and Drug Administration (FDA) for a new indication, specifically the treatment of patients with dysfunctional Arteriovenous (AV) fistulae.

Accordingly, in this January 2018 update, devices described by HCPCS code C2623 are eligible for pass through status retroactive to August 25, 2017, when the device is billed with Current Procedural Terminology (CPT) code 36902 (Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report; with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty) or CPT code 36903 (Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report; with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis segment). This device pass through status will be applied retroactively from August 25, 2017, through December 31, 2017.

Refer to https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html for the most current device pass-through information.

**Transitional Pass-Through Payments for Designated Devices**

Certain designated new devices are assigned to Ambulatory Payment Classifications (APCs) and identified by the OCE as eligible for payment based on the reasonable cost of the new device reduced by the amount included in the APC for the procedure that reflects the packaged payment for device(s) used in the procedure. OCE will determine the proper payment amount for these APCs as well as the coinsurance and any applicable deductible. All related payment calculations will be returned on the same APC line and identified as a designated new device.

Refer to https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Annual-Policy-Files-Items/2018-Annual-Policy-Files.html for the most current OPPS HCPCS Offset File.
**Device Offset from Payment for Device Category**

Section 1833(t)(6)(D)(ii) of the Act requires CMS to deduct from pass-through payments for devices an amount that reflects the portion of the APC payment amount. With respect to device code C2623, CMS has previously determined that the costs associated with C2623 are not reflected in the APC payment amount. Therefore, CMS is not applying a device offset to the retroactive pass-through payments for C2623. Retroactive pass-through payments for August 25, 2017, through December 31, 2017, will only apply when HCPCS code C2623 is billed with CPT code 36902 or CPT code 36903. The device/procedure offset pair requirements for HCPCS code C2623 listed in Change Request 9553, Transmittal 3483 are no longer applicable effective January 1, 2018.

**New Separately Payable Procedure Code**

Effective January 1, 2018, new HCPCS code C9748 has been created, as described in Table 1.

<p>| Table 1. — New Separately Payable Procedure Code Effective January 1, 2018 |
|-----------------------------------------------|-----------------------------------------------|</p>
<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>January 2018 OPPS STATUS INDICATOR (SI)</th>
<th>January 2018 OPPS APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9748</td>
<td>Prostatic rf water vapor tx</td>
<td>Transurethral destruction of prostate tissue; by radiofrequency water vapor (steam) thermal therapy</td>
<td>J1</td>
<td>5373</td>
</tr>
</tbody>
</table>

**Argus Retinal Prosthesis Add-on Code (C1842)**

Effective January 1, 2017, CMS created HCPCS code C1842 (Retinal prosthesis, includes all internal and external components; add-on to C1841) and assigned it the Status Indicator (SI) of “N.” HCPCS code C1842 was created to resolve a claims processing issue for Ambulatory Surgical Centers (ASCs) and should not be reported on institutional claims by hospital outpatient department providers. HCPCS code C1842 is included in the Calendar Year (CY) 2018 Annual HCPCS file.

**Changes to New Technology APCs 1901 – 1908**

Effective January 1, 2018, two additional New Technology APCs (1907 and 1908) are created. In addition, the payment ranges for APCs 1901 – 1906 have been changed. All changes are documented in Table 2.
Table 2. — CY 2018 Additional New Technology APC Groups

<table>
<thead>
<tr>
<th>CY 2018 APC</th>
<th>CY 2018 APC Title</th>
<th>CY 2018 SI</th>
<th>Updated or New APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>1901</td>
<td>New Technology - Level 49 ($100,001-$115,000)</td>
<td>S</td>
<td>Updated</td>
</tr>
<tr>
<td>1902</td>
<td>New Technology - Level 49 ($100,001-$115,000)</td>
<td>T</td>
<td>Updated</td>
</tr>
<tr>
<td>1903</td>
<td>New Technology - Level 50 ($115,001-$130,000)</td>
<td>S</td>
<td>Updated</td>
</tr>
<tr>
<td>1904</td>
<td>New Technology - Level 50 ($115,001-$130,000)</td>
<td>T</td>
<td>Updated</td>
</tr>
<tr>
<td>1905</td>
<td>New Technology - Level 51 ($130,001-$145,000)</td>
<td>S</td>
<td>Updated</td>
</tr>
<tr>
<td>1906</td>
<td>New Technology - Level 51 ($130,001-$145,000)</td>
<td>T</td>
<td>Updated</td>
</tr>
<tr>
<td>1907</td>
<td>New Technology - Level 52 ($145,001-$160,000)</td>
<td>S</td>
<td>New</td>
</tr>
<tr>
<td>1908</td>
<td>New Technology - Level 52 ($145,001-$160,000)</td>
<td>T</td>
<td>New</td>
</tr>
</tbody>
</table>

Services Eligible for New Technology APC Assignment and Payments

Under OPPS, services eligible for payment through New Technology APCs are those codes that are assigned to the series of New Technology APCs published in Addendum A of the latest OPPS update. OPPS considers any HCPCS code assigned to the APCs below to be a “new technology procedure or service.” As of January 1, 2018, the range of New Technology APCs include:

- APCs 1491 through 1500
- APCs 1502 through 1537
- APCs 1539 through 1585,
- APCs 1589 through 1599
- APCs 1901 through 1908

The application for consideration as a New Technology procedure or service is available at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/passthrough_payment.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/passthrough_payment.html), At that website, under the “Downloads” section, refer to the document, entitled “For a New Technology Ambulatory Payment Classification (APC) Designation Under the Hospital Outpatient Prospective Payment System (OPPS)” for information on the requirements for submitting an application. The list of
HCPCS codes and payment rates assigned to New Technology APCs are in Addendum B of the latest OPPS update regulation each year at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html.

**Payment Changes for X-rays Taken Using Film and Computed Radiography Technology**

On December 18, 2015, the Consolidated Appropriations Act of 2016 was signed into law (Public Law 114-113). Section 502 of the Consolidated Appropriations Act requires that Medicare implement the following provisions under the hospital OPPS for the technical component of imaging services:

- Reduce payment by 20 percent for an X-ray taken using film, beginning January 1, 2017, and
- Reduce payment by 7 percent from January 1, 2018 through December 31, 2022, and
- Thereafter to 10 percent, beginning January 1, 2023,

For an imaging service that is an X-ray taken using computed radiography technology.

In response to these provisions, CMS established modifiers “FX,” effective January 1, 2017, and “FY,” effective January 1, 2018. Below is additional information related to these modifiers. CMS notes that Section 502(b) of Division O, Title V of the Consolidated Appropriations Act of 2016 amended Section 1833(t)(16) of the Act by adding new subparagraph (F).

**Payment Modifier for X-ray Taken Using Film, Effective January 1, 2017**

Consistent with the requirements set forth in Section 1833(t)(16)(F)(i) and in accordance with provisions allowed under Section 1833(t)(16)(F)(iv) of the Act, CMS established modifier “FX” (X-ray taken using film) to identify imaging services that are X-rays taken using film. As stated in the CY 2017 OPPS/ASC final rule with comment period (81 FR 79729 through 79730) and in the January 2017 Update of the OPPS (Change Request 9930, Transmittal 3685, dated December 22, 2016), hospitals are required to use this modifier to report imaging services that are x-rays taken using film, effective January 1, 2017.

The use of the FX modifier is applicable to all imaging services that are X-rays taken using film and results in a payment reduction of 20 percent, beginning January 1, 2017. All imaging services are listed in the OPPS Addendum B.

**Payment Modifier for X-ray Taken Using Computed Radiography Technology, Effective January 1, 2018**

Consistent with the requirements set forth in Section 1833(t)(16)(F)(ii) and in accordance with provisions allowed under Section 1833(t)(16)(F)(iv) of the Act, CMS established modifier “FY” (X-ray taken using computed radiography technology/cassette-based imaging) to identify an imaging service that is an X-ray taken using computed radiography technology. Effective January 1, 2018, hospitals are required to use this modifier to report imaging services that are X-rays taken using computed radiography technology.
The use of this modifier results in a payment reduction of 7 percent from January 1, 2018, through December 31, 2022, and thereafter to 10 percent beginning January 1, 2023, for imaging services that are X-rays taken using computed radiography technology/cassette-based imaging. All imaging services are listed in the OPPS Addendum B.

**Deletion of Modifier “CP”**

Modifier “CP” became effective in CY 2016 and was used to identify adjunctive services on a claim related to a procedure assigned to a Comprehensive Ambulatory Payment Classification (C-APC) procedure. The use of the modifier was required for CYs 2016 and 2017 and the data collection period for this modifier was set to conclude on December 31, 2017. Accordingly, for CY 2018, CMS is deleting modifier “CP” and discontinuing its required use.

Also, for CY 2018, for the C-APC for Stereotactic Radio Surgery (SRS), specifically, C-APC 5627 (Level 7 Radiation Therapy), CMS will continue to make separate payments for the 10 planning and preparation services adjacent to the delivery of the SRS treatment using either the Cobalt-60-based or LINAC-based technology when furnished to a beneficiary within 30 days of the SRS treatment. The 10 planning and preparation codes listed in Table 3 will be paid according to their assigned SI when furnished within 30 days of SRS treatment delivery.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>CY 2018 Short Descriptor</th>
<th>CY 2018 SI</th>
</tr>
</thead>
<tbody>
<tr>
<td>70551</td>
<td>MRI brain stem w/o dye</td>
<td>Q3</td>
</tr>
<tr>
<td>70552</td>
<td>MRI brain stem w/dye</td>
<td>Q3</td>
</tr>
<tr>
<td>70553</td>
<td>MRI brain stem w/o &amp; w/dye</td>
<td>Q3</td>
</tr>
<tr>
<td>77011</td>
<td>Ct scan for localization</td>
<td>N</td>
</tr>
<tr>
<td>77014</td>
<td>Ct scan for therapy guide</td>
<td>N</td>
</tr>
<tr>
<td>77280</td>
<td>Set radiation therapy field</td>
<td>S</td>
</tr>
<tr>
<td>77285</td>
<td>Set radiation therapy field</td>
<td>S</td>
</tr>
<tr>
<td>77290</td>
<td>Set radiation therapy field</td>
<td>S</td>
</tr>
<tr>
<td>77295</td>
<td>3-d radiotherapy plan</td>
<td>S</td>
</tr>
<tr>
<td>77336</td>
<td>Radiation physics consult</td>
<td>S</td>
</tr>
</tbody>
</table>

**Changes to the Inpatient-Only (IPO List)**

The Medicare Inpatient-Only (IPO) list includes procedures that are typically only provided in the inpatient setting and therefore are not paid under the OPPS. For CY 2018, CMS is removing Total Knee Arthroplasty (TKA) from the IPO list as well as five other procedures. CMS is also adding one procedure to the IPO list. The changes to the IPO list for CY 2018 are included in Table 4.
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>27447</td>
<td>Arthroplasty, knee, condyle and plateau; medical and lateral compartments with or without patella resurfacing (total knee arthroplasty)</td>
<td>Removed</td>
<td>5115</td>
<td>J1</td>
</tr>
<tr>
<td>43282</td>
<td>Laparoscopy, surgical, repair of para-esophageal hernia, includes fundoplasty, when performed; with implantation of mesh</td>
<td>Removed</td>
<td>5362</td>
<td>J1</td>
</tr>
<tr>
<td>43772</td>
<td>Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device component only</td>
<td>Removed</td>
<td>5303</td>
<td>J1</td>
</tr>
<tr>
<td>43773</td>
<td>Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric restrictive device component only</td>
<td>Removed</td>
<td>5361</td>
<td>J1</td>
</tr>
<tr>
<td>43774</td>
<td>Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device and subcutaneous port components</td>
<td>Removed</td>
<td>5303</td>
<td>J1</td>
</tr>
<tr>
<td>55866</td>
<td>Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing; includes robotic assistance, when performed</td>
<td>Removed</td>
<td>5362</td>
<td>J1</td>
</tr>
<tr>
<td>92941</td>
<td>Percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, coronary artery or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty, including aspiration thrombectomy when performed, single vessel</td>
<td>Added</td>
<td>N/A</td>
<td>C</td>
</tr>
</tbody>
</table>
Revisions to the Laboratory Date of Service (DOS) Policy

a. Laboratory Test/Service Performed by an Independent Laboratory

In the CY 2018 OPPS/ASC final rule (82 FR 52533-52540), CMS discussed an additional exception to current laboratory DOS regulations at 42 Code of Federal Regulations (CFR) 414.510. This new exception to the laboratory DOS policy permits independent laboratories to bill Medicare directly for molecular pathology tests and Advanced Diagnostic Laboratory Tests (ADLTs), which are excluded from the OPPS packaging policy, if the specimen was collected from a hospital outpatient during a hospital outpatient encounter and the test was performed following the patient’s discharge from the hospital outpatient department.

Consequently, Hospital Outpatient Departments (HOPDs) should no longer bill Medicare for molecular pathology tests and ADLTs performed by independent laboratories following the patient’s discharge from the HOPD, and independent laboratories will no longer have to seek payment from the HOPD for these tests, if all of the conditions are met.

Note there are no current codes designated as ADLTs; however, molecular pathology codes are currently assigned to OPPS SI “A” to indicate that they are not paid under the OPPS, but may be paid under a different Medicare payment system.

b. Laboratory Test/Service Performed by a Hospital Laboratory

For a molecular pathology test or ADLT test performed by a hospital laboratory, refer to the “Medicare Claims Processing Manual,” Chapter 16, Laboratory Services, Section 50.3, Hospitals.

OPPS Status Indicator Updates for Clinical Laboratory Fee Schedule (CLFS) Molecular Pathology Tests and Advanced Diagnostic Laboratory Tests (ADLTs)

Under the OPPS, Medicare conditionally packages laboratory tests and only pays separately for certain types of laboratory tests. Molecular pathology tests and ADLTs are paid separately at the CLFS rate rather than the OPPS. The current list of molecular pathology tests is available in the OPPS Addendum B (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html) and are identified with status indicator “A.”

However, for the January 2018 OPPS update, there are no laboratory tests currently designated by CMS as ADLTs under the CLFS. As stated in the CY 2017 OPPS/ASC final rule with comment period (81 FR 79594), CMS will assign SI “A” (Not paid under OPPS. Paid by Medicare Administrative Contractors (MACs) under a fee schedule or payment system other than OPPS) to ADLTs once a laboratory test has been granted ADLT status under the CLFS.

Prior to ADLT designation, applicants must submit an application to CMS requesting ADLT status for a laboratory test. Once a test is designated by CMS as an ADLT under paragraph (1) of the definition of advanced diagnostic laboratory test in 42 CFR 414.502, CMS will update the OPPS Addendum B on a quarterly basis to reflect the appropriate SI assignment.
Billing Instructions for 340B-Acquired Drugs

As finalized in the CY 2018 OPPS/ASC final rule with comment period, separately payable Part B drugs (assigned SI “K”), other than vaccines (assigned SI “L” or “M”) and drugs on pass-through payment status (assigned SI “G”) that are acquired through the 340B Program or through the 340B prime vendor program, will be paid at the Average Sales Price (ASP) minus 22.5 percent, when billed by a hospital paid under the OPPS that is not excepted from the payment adjustment.

Hospital types that are excepted from the 340B payment policy in CY 2018 include rural Sole Community Hospitals (SCHs), children’s hospitals, and Prospective Payment System (PPS)-exempt cancer hospitals. These excepted hospitals will continue to receive ASP + 6 percent payment for separately payable drugs.

Medicare will continue to pay separately payable drugs that were not acquired under the 340B Program at ASP + 6 percent.

In addition, effective January 1, 2018, hospitals paid under the OPPS that are not excepted from the 340B drug payment policy for CY 2018 are required to report modifier “JG” on the same claim line as the drug HCPCS code to identify a 340B-acquired drug. Since rural SCHs, children’s hospitals and PPS-exempt cancer hospitals are excepted from the 340B payment adjustment in CY 2018, these hospitals will report informational modifier “TB” for 340B-acquired drugs, and will continue to be paid at the ASP + 6 percent.

The 340B modifiers and their descriptors are listed in Table 5.

<table>
<thead>
<tr>
<th>2-Digit HCPCS Modifier</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>JG</td>
<td>340B acquired drug</td>
<td>Drug or biological acquired with 340B drug pricing program discount</td>
<td>01/01/2018</td>
</tr>
<tr>
<td>TB</td>
<td>Tracking 340B acquired drug</td>
<td>Drug or biological acquired with 340B drug pricing program discount, reported for informational purposes</td>
<td>01/01/2018</td>
</tr>
</tbody>
</table>

Drugs, Biologicals, and Radiopharmaceuticals

a. New CY 2018 HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Radiopharmaceuticals

For CY 2018, several new HCPCS codes have been created for reporting drugs and biologicals in the hospital outpatient setting, where there have not previously been specific codes available.
These new codes are listed in Table 6.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>C9014</td>
<td>Injection, cerliponase alfa, 1 mg</td>
<td>G</td>
<td>9014</td>
</tr>
<tr>
<td>C9015</td>
<td>Injection, c-1 esterase inhibitor (human), Haegarda, 10 units</td>
<td>G</td>
<td>9015</td>
</tr>
<tr>
<td>C9016</td>
<td>Injection, triptorelin extended release, 3.75 mg</td>
<td>G</td>
<td>9016</td>
</tr>
<tr>
<td>C9024</td>
<td>Injection, liposomal, 1 mg daunorubicin and 2.27 mg cytarabine</td>
<td>G</td>
<td>9302</td>
</tr>
<tr>
<td>C9028</td>
<td>Injection, inotuzumab ozogamicin, 0.1 mg</td>
<td>G</td>
<td>9028</td>
</tr>
<tr>
<td>C9029</td>
<td>Injection, guselkumab, 1 mg</td>
<td>G</td>
<td>9029</td>
</tr>
<tr>
<td>J0604</td>
<td>Cinacalcet, oral, 1 mg, (for ESRD on dialysis)</td>
<td>B</td>
<td>N/A</td>
</tr>
<tr>
<td>J0606</td>
<td>Injection, etelcalcetide, 0.1 mg</td>
<td>K</td>
<td>9031</td>
</tr>
<tr>
<td>J1555</td>
<td>Injection, immune globulin (cuvitru), 100 mg</td>
<td>K</td>
<td>9034</td>
</tr>
<tr>
<td>J7211</td>
<td>Injection, factor viii, (antihemophilic factor, recombinant), (kovaltry), 1 i.u.</td>
<td>K</td>
<td>9075</td>
</tr>
<tr>
<td>J7345</td>
<td>Aminolevulinic acid hcl for topical administration, 10% gel, 10 mg</td>
<td>G</td>
<td>9301</td>
</tr>
<tr>
<td>J9203</td>
<td>Injection, gemtuzumab ozogamicin, 0.1 mg</td>
<td>G</td>
<td>9495</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>K</td>
<td>9081</td>
</tr>
<tr>
<td>Q4176</td>
<td>Neopatch, per square centimeter</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>Q4177</td>
<td>Floweramnioflo, 0.1 cc</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>Q4178</td>
<td>Floweramniopatch, per square centimeter</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>Q4179</td>
<td>Flowerderm, per square centimeter</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>Q4180</td>
<td>Revita, per square centimeter</td>
<td>N</td>
<td>N/A</td>
</tr>
</tbody>
</table>
b. Other Changes to CY 2018 HCPCS and CPT Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals

Many HCPCS and CPT codes for drugs, biologicals, and radiopharmaceuticals have undergone changes in their HCPCS and CPT code descriptors that will be effective in CY 2018. In addition, several temporary HCPCS C-codes have been deleted, effective December 31, 2017, and replaced with permanent HCPCS codes effective CY 2018. Hospitals should pay close attention to accurate billing for units of service consistent with the dosages contained in the long descriptors of the active CY 2018 HCPCS and CPT codes.

Table 7 notes those drugs, biologicals, and radiopharmaceuticals that have undergone changes in their HCPCS/CPT code, their long descriptor, or both. Each product’s CY 2017 HCPCS/CPT code and long descriptor are noted in the two left-hand columns and the CY 2018 HCPCS/CPT code and long descriptor are noted in the adjacent right-hand columns.

Table 7 — Other CY 2018 HCPCS and CPT Code Changes for Certain Drugs, Biologicals, and Radiopharmaceuticals

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>C9490</td>
<td>Injection, bezlotoxumab, 10 mg</td>
<td>J0565</td>
<td>Injection, bezlotoxumab, 10 mg</td>
</tr>
<tr>
<td>C9484</td>
<td>Injection, eteplirsen, 10 mg</td>
<td>J1428</td>
<td>Injection, eteplirsen, 10 mg</td>
</tr>
<tr>
<td>C9486</td>
<td>Injection, granisetron extended release, 0.1 mg</td>
<td>J1627</td>
<td>Injection, granisetron extended release, 0.1 mg</td>
</tr>
<tr>
<td>Q9986</td>
<td>Injection, hydroxyprogesterone caproate (Makena), 10 mg</td>
<td>J1726</td>
<td>Injection, hydroxyprogesterone caproate (Makena), 10 mg</td>
</tr>
</tbody>
</table>
--- | --- | --- | ---
Q9985 | Injection, hydroxyprogesterone caproate, not otherwise specified, 10 mg | J1729 | Injection, hydroxyprogesterone caproate, not otherwise specified, 10 mg
C9489 | Injection, nusinersen, 0.1 mg | J2326 | Injection, nusinersen, 0.1 mg
C9494 | Injection, ocrelizumab, 1 mg | J2350 | Injection, ocrelizumab, 1 mg
Q9989 | Ustekinumab, for Intravenous Injection, 1 mg | J3358 | Ustekinumab, for Intravenous Injection, 1 mg
C9140 | Injection, Factor VIII (antihemophilic factor, recombinant) (Afstyla), 1 I.U. | J7210 | Injection, factor viii, (antihemophilic factor, recombinant), (Afstyla), 1 i.u.
Q9984 | Levonorgestrel-releasing intrauterine contraceptive system (Kyleena), 19.5 mg | J7296 | Levonorgestrel-releasing intrauterine contraceptive system (Kyleena), 19.5 mg
C9483 | Injection, atezolizumab, 10 mg | J9022 | Injection, atezolizumab, 10 mg
C9491 | Injection, avelumab, 10 mg | J9023 | Injection, avelumab, 10 mg
C9485 | Injection, olaratumab, 10 mg | J9285 | Injection, olaratumab, 10 mg

**c. Drugs and Biologicals with Payments Based on Average Sales Price (ASP), Effective January 1, 2018**

For CY 2018, payment for non-pass-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 minus 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.

Effective January 1, 2018, payment rates for many drugs and biologicals have changed from the values published in the CY 2018 OPPS/ASC final rule with comment period as a result of the
new ASP calculations based on sales price submissions from the third quarter of CY 2017. In cases where adjustments to payment rates are necessary, changes to the payment rates will be incorporated in the January 2018 Fiscal Intermediary Shared System (FISS) release.

CMS is not publishing the updated payment rates in CR10417 implementing the January 2018 update of the OPPS. However, the updated payment rates effective January 1, 2018, are in the January 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.

d. 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 CMS website 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.

e. Biosimilar Payment Policy

Effective January 1, 2018, the payment rate for biosimilars in the OPPS will generally continue to be the same as the payment rate in the physician office setting, calculated as the ASP of the biosimilar described by the HCPCS code + 6 percent of the ASP of the reference product. Biosimilars will also be eligible for transitional pass-through payment for which payment will be made at the ASP of the biosimilar described by the HCPCS code + 6 percent of the ASP of the reference product. A biosimilar that does not have pass-through status, but instead has SI of “K,” will be paid the ASP of the biosimilar minus 22.5 percent of the ASP of the reference product, effective January 1, 2018.

In addition, effective January 1, 2018, newly approved biosimilar biological products with a common reference product will no longer be grouped into the same billing code with other biosimilars. CMS will issue guidance on coding, including instructions for new codes for biosimilars that are currently grouped into a common payment code and the use of modifiers separate from CR10417. However, until such guidance is released, providers should continue to use applicable existing HCPCS codes and report a biosimilar modifier that identifies the manufacturer of the specific product. The modifier does not affect payment determination, but is used to distinguish between biosimilar products that appear in the same HCPCS code, but are made by different manufacturers. A list of the biosimilar biological product HCPCS codes and modifiers is available on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/Part-B-Biosimilar-Biological-Product-Payment.html.
**Skin Substitute Procedure Edits**

The payment for skin substitute products that do not qualify for pass-through status will be packaged into the payment for the associated skin substitute application procedure. The skin substitute products are divided into two groups:

1) high cost skin substitute products, and

2) low cost skin substitute products for packaging purposes.

Table 8 lists the skin substitute products and their assignment as either a high-cost or a low-cost skin substitute product, when applicable.

**Table 8 --- Skin Substitute Assignments to High-Cost and Low-Cost Groups for CY 2018**

<table>
<thead>
<tr>
<th>CY 2018 HCPCS Code</th>
<th>CY 2018 Short Descriptor</th>
<th>CY 2018 SI</th>
<th>CY 2018 High/Low Assignment</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9363</td>
<td>Integra Meshed Bil Wound Mat</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4100</td>
<td>Skin Substitute, NOS</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4101</td>
<td>Apligraf</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4102</td>
<td>Oasis Wound Matrix</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4103</td>
<td>Oasis Burn Matrix</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4104</td>
<td>Integra bmwd</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4105</td>
<td>Integra drt or omnigraft</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4106</td>
<td>Dermagraft</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4107</td>
<td>GraftJacket</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4108</td>
<td>Integra Matrix</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4110</td>
<td>Primatrix</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4111</td>
<td>Gammagraft</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4115</td>
<td>Alloskin</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4116</td>
<td>Alloderm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>CY 2018 HCPCS Code</td>
<td>CY 2018 Short Descriptor</td>
<td>CY 2018 SI</td>
<td>CY 2018 High/Low Assignment</td>
</tr>
<tr>
<td>-------------------</td>
<td>-------------------------</td>
<td>----------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>Q4117</td>
<td>Hyalomatrix</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4121</td>
<td>Theraskin</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4122</td>
<td>Dermacell</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4123</td>
<td>Alloskin</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4124</td>
<td>Oasis Tri-layer Wound Matrix</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4126</td>
<td>Memoderm/derma/tranz/integup</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4127</td>
<td>Talymed</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4128</td>
<td>Flexhd/Allopatchhd/Matrixhd</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4131</td>
<td>Epifix or epicord</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4132</td>
<td>Grafix core, grafixpl core</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4133</td>
<td>Grafix prime grafix pl prime</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4134</td>
<td>Hmatrix</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4135</td>
<td>Mediskin</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4136</td>
<td>Ezderm</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4137</td>
<td>Amnioexcel or Biodexcel, 1cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4138</td>
<td>Biodfence dryflex, 1cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4140</td>
<td>Biodfence 1cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4141</td>
<td>Alloskin ac, 1cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4143</td>
<td>Repriza, 1cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4146</td>
<td>Tensix, 1 cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4147</td>
<td>Architect ecm px fx 1 sq cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4148</td>
<td>Neox neox rt, or clarix cord</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4150</td>
<td>Allowrap ds or dry 1 sq cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>CY 2018 HCPCS Code</td>
<td>CY 2018 Short Descriptor</td>
<td>CY 2018 SI</td>
<td>CY 2018 High/Low Assignment</td>
</tr>
<tr>
<td>---------------------</td>
<td>------------------------------------------</td>
<td>------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>Q4151</td>
<td>Amnioband, guardian 1 sq cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4152</td>
<td>Dermapure 1 square cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4153</td>
<td>Dermavest, plurivest sq cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4154</td>
<td>Biovance 1 square cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4156</td>
<td>Neox 100 or clarix 100</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4157</td>
<td>Revitalon 1 square cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4158</td>
<td>Kericis omega3, per sq cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4159</td>
<td>Affinity 1 square cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4160</td>
<td>NuShield 1 square cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4161</td>
<td>Bio-Connekt per square cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4163</td>
<td>Woundex, bioskin, per sq cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4164</td>
<td>Helicoll, per square cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4165</td>
<td>Keramatrix, per square cm</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4166</td>
<td>Cytal, per square cm</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4167</td>
<td>Truskin, per square cm</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4169</td>
<td>Artacent wound, per square cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4170</td>
<td>Cygnus, per square cm</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4172*</td>
<td>Puraply or puraply am</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4173</td>
<td>Palingen or palingen xplus</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4175</td>
<td>Miroderm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4176*</td>
<td>Neopatch, per square centimeter</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4178*</td>
<td>Floweramniopatch, per sq cm</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4179*</td>
<td>Flowerderm, per square centimeter</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>CY 2018 HCPCS Code</td>
<td>CY 2018 Short Descriptor</td>
<td>CY 2018 SI</td>
<td>CY 2018 High/Low Assignment</td>
</tr>
<tr>
<td>-------------------</td>
<td>---------------------------------------------</td>
<td>------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>Q4180*</td>
<td>Revita, per sq cm</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4181*</td>
<td>Amnio wound, per square centimeter</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4182*</td>
<td>Transcyte, per square centimeter</td>
<td>N</td>
<td>Low</td>
</tr>
</tbody>
</table>

* HCPCS codes Q4176, Q4178, Q4179, Q4180, Q4181, and Q4182 were assigned to the low-cost group in CY 2018 OPPS/ASC final rule with comment period. Pass-through status for HCPCS code Q4172 ended on December 31, 2017.

**New HCPCS Codes for Pathogen Reduced Platelets and Pathogen Testing for Platelets**

For the January 2018 update, the HCPCS Workgroup deleted HCPCS codes Q9987 and Q9988 for Medicare reporting and replaced the codes with two new HCPCS codes effective January 1, 2018. Specifically, to report the service described by HCPCS code Q9988 based on the code descriptor in effect for July 1, 2017, through December 31, 2017, providers must instead report HCPCS code P9073 (Platelets, pathogen reduced, each unit) instead of HCPCS code Q9988 effective January 1, 2018. Providers reporting the service described by HCPCS code Q9987 based on the code descriptor in effect for July 1, 2017, through December 31, 2017 shall instead report HCPCS code P9100 (Pathogen(s) test for platelets) instead of HCPCS code Q9987 effective January 1, 2018. Note that HCPCS code P9100 should be reported to describe the test used for the detection of bacterial contamination in platelets as well as any other test that may be used to detect pathogen contamination. Table 9 describes blood platelet coding changes that are effective January 1, 2018. The coding changes associated with these codes were also published on the CMS HCPCS Quarterly Update website effective January 2018, at [https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update.html](https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update.html). The payment rates for HCPCS codes P9073 and P9100 can be found in the January 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).
Table 9. –Blood Platelet Coding Changes Effective January 1, 2018

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>January 2018 OPPS SI</th>
<th>January 2018 OPPS APCS</th>
</tr>
</thead>
<tbody>
<tr>
<td>P9073</td>
<td>Platelets, pathogen reduced</td>
<td>Platelets, pathogen reduced, each unit</td>
<td>R</td>
<td>9536</td>
</tr>
<tr>
<td>P9100</td>
<td>Pathogen test for platelets</td>
<td>Pathogen(s) test for platelets</td>
<td>S</td>
<td>1493</td>
</tr>
</tbody>
</table>

**Payment Adjustment for Certain Cancer Hospitals Beginning CY 2018**

For certain cancer hospitals that receive interim monthly payments associated with the cancer hospital adjustment at 42 CFR 419.43(i), Section 16002(b) of the 21st Century Cures Act which requires that, for CY 2018 and subsequent calendar years, the target Payment-to-Cost Ratio (PCR) that should be used in the calculation of the interim monthly payments and at final cost report settlement is reduced by 0.01. For CY 2018, the target PCR, after including the reduction required by Section 16002(b), is 0.88.

**Section 4011 of the 21st Century Cures Act**

Section 4011 of the 21st Century Cures Act created a new subsection (t) in Section 1834 of the Social Security Act that requires CMS to make available to the public a searchable Internet website that compares estimated payment and beneficiary liability for an appropriate number of items and services paid under the OPPS and the ASC Payment System. Consistent with this statute, CMS plans to first make this website available during CY 2018.

CMS believes that making available a comparison for all services that receive separate payment under both the OPPS and ASC payment system would be most useful to the public with regards to displaying the comparison for an “appropriate number of such items and services.” CMS believes that displaying the national unadjusted payments and copayment amounts will allow the user to make a meaningful comparison between the systems for items and services paid under both systems. CMS may consider providing payment and copayment comparisons at the locality or provider level for future years.

Along with the comparison information that CMS will make available to the public in accordance with the requirements of Section 4011, CMS also plans to include a disclaimer statement that notes some of the payment policy differences in each care setting and that notes the limitations of the comparison tool, to provide users with some context for why there might be potential differences. In the case of the OPPS copayments, CMS plans to include an additional indicator where the service is likely to be capped at the Part A inpatient deductible, based on the unadjusted copayments, under the OPPS coinsurance rules.
Changes to OPPS Pricer Logic

a. Rural SCHs and Essential Access Community Hospitals (EACHs) will continue to receive a 7.1 percent payment increase for most services in CY 2018. The rural SCH and EACH payment adjustment excludes drugs, biologicals, items and services paid at charges reduced to cost, and items paid under the pass-through payment policy in accordance with Section 1833(t)(13)(B) of the Act, as added by Section 411 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA).

b. New OPPS payment rates and copayment amounts will be effective January 1, 2018. All copayment amounts will be limited to a maximum of 40 percent of the APC payment rate. Copayment amounts for each service cannot exceed the CY 2018 inpatient deductible of $1,340. For most OPPS services, copayments are set at 20 percent of the APC payment rate.

c. For hospital outlier payments under OPPS, there will be no change in the multiple threshold of 1.75 for 2018. This threshold of 1.75 is multiplied by the total line-item APC payment to determine eligibility for outlier payments. This factor also is used to determine the outlier payment, which is 50 percent of the estimated cost less 1.75 times the APC payment amount. The payment formula is \((\text{cost} - (\text{APC payment} \times 1.75))/2\).

d. The fixed-dollar threshold for OPPS outlier payments increases in CY 2018 relative to CY 2017. The estimated cost of a service must be greater than the APC payment amount plus $4,150 in order to qualify for outlier payments.

e. For outliers for Community Mental Health Centers (bill type 76x), there will be no change in the multiple threshold of 3.4 for 2017. This threshold of 3.4 is multiplied by the total line-item APC payment for APC 5853 to determine eligibility for outlier payments. This multiple amount is also used to determine the outlier payment, which is 50 percent of estimated costs less 3.4 times the APC payment amount. The payment formula is \((\text{cost} - (\text{APC 5853 payment} \times 3.4))/2\).

f. Continuing Medicare’s established policy for CY 2018, the OPPS Pricer will apply a reduced update ratio of 0.980 to the payment and copayment for hospitals that fail to meet their hospital outpatient quality data reporting requirements or that fail to meet CMS validation edits. The reduced payment amount will be used to calculate outlier payments.

g. Effective January 1, 2018, CMS is adopting the FY 2018 IPPS post-reclassification wage index values with application of the CY 2018 out-commuting adjustment authorized by Section 505 of the MMA to non-IPPS hospitals as implemented through the Pricer logic.

h. Effective January 1, 2014, for claims with APCs, which require implantable devices and have significant device offsets (greater than 40%), a device offset cap will be applied based on the credit amount listed in the “FD” (Credit Received from the Manufacturer for a Replaced Medical Device) value code. The credit amount in value code “FD” which
reduces the APC payment for the applicable procedure, will be capped by the device offset amount for that APC. The offset amounts for the above referenced APCs are available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html.

**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>December 22, 2017</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>

**Disclaimer:** This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2016 American Medical Association. All rights reserved.

Copyright © 2017, the American Hospital Association, Chicago, Illinois. Reproduced with permission. No portion of the AHA copyrighted materials contained within this publication may be copied without the express written consent of the AHA. AHA copyrighted materials including the UB-04 codes and descriptions may not be removed, copied, or utilized within any software, product, service, solution or derivative work without the written consent of the AHA. If an entity wishes to utilize any AHA materials, please contact the AHA at 312-893-6816. Making copies or utilizing the content of the UB-04 Manual, including the codes and/or descriptions, for internal purposes, resale and/or to be used in any product or publication; creating any modified or derivative work of the UB-04 Manual and/or codes and descriptions; and/or making any commercial use of UB-04 Manual or any portion thereof, including the codes and/or descriptions, is only authorized with an express license from the American Hospital Association. To license the electronic data file of UB-04 Data Specifications, contact Tim Carlson at (312) 893-6816 or Laryssa Marshall at (312) 893-6814. You may also contact us at ub04@healthforum.com

The American Hospital Association (the “AHA”) has not reviewed, and is not responsible for, the completeness or accuracy of any information contained in this material, nor was the AHA or any of its affiliates, involved in the preparation of this material, or the analysis of information provided in the material. The views and/or positions presented in the material do not necessarily represent the views of the AHA. CMS and its products and services are not endorsed by the AHA or any of its affiliates.
Next Generation Accountable Care Organization (NGACO) Year Three Benefit Enhancements

MLN Matters Number: MM10044 Revised  Related Change Request (CR) Number: 10044
Related CR Release Date: November 22, 2017  Effective Date: January 1, 2018
Related CR Transmittal Number: R187DEMO  Implementation Date: January 2, 2018

Note: This article was revised on January 23, 2018, to reflect the revised CR10044 issued on November 22, 2017. In the article, the CR release date, transmittal number, and the Web address of the CR are revised. All other information remains the same.

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

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

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

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

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

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

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

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

- **Code 2**: G9869 – Receipt and analysis of remote, asynchronous images for dermatologic and/or ophthalmologic evaluation, for use under the Next Generation ACO model, 10-20 minutes.

- **Code 3**: G9870 – Receipt and analysis of remote, asynchronous images for dermatologic and/or ophthalmologic evaluation, for use under the Next Generation ACO model, 20 or more minutes.

ADDITIONAL INFORMATION


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


**DOCUMENT HISTORY**

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>August 4, 2017</td>
<td>Initial article issued.</td>
</tr>
<tr>
<td>January 23, 2018</td>
<td>The article was revised to reflect the revised CR10044 issued on November 22, 2017. 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>
</tr>
</tbody>
</table>

**Disclaimer**  This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2016 American Medical Association. All rights reserved.

Copyright © 2017, the American Hospital Association, Chicago, Illinois. Reproduced with permission. No portion of the AHA copyrighted materials contained within this publication may be copied without the express written consent of the AHA. AHA copyrighted materials including the UB-04 codes and descriptions may not be removed, copied, or utilized within any software, product, service, solution or derivative work without the written consent of the AHA. If an entity wishes to utilize any AHA materials, please contact the AHA at 312-893-6816. Making copies or utilizing the content of the UB-04 Manual, including the codes and/or descriptions, for internal purposes, resale and/or to be used in any product or publication; creating any modified or derivative work of the UB-04 Manual and/or codes and descriptions; and/or making any commercial use of UB-04 Manual or any portion thereof, including the codes and/or descriptions, is only authorized with an express license from the American Hospital Association. To license the electronic data file of UB-04 Data Specifications, contact Tim Carlson at (312) 893-6816 or Laryssa Marshall at (312) 893-6814. You may also contact us at ub04@healthforum.com.

The American Hospital Association (the "AHA") has not reviewed, and is not responsible for, the completeness or accuracy of any information contained in this material, nor was the AHA or any of its affiliates, involved in the preparation of this material, or the analysis of information provided in the material. The views and/or positions presented in the material do not necessarily represent the views of the AHA. CMS and its products and services are not endorsed by the AHA or any of its affiliates.
Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes - April 2018 Update

MLN Matters Number: MM10454  Related Change Request (CR) Number: 10454
Related CR Release Date: February 2, 2018  Effective Date: April 1, 2018
Related CR Transmittal Number: R3966CP  Implementation Date: April 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

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

• HCPCS Code: Q2041
  o Short Description: Axicabtagene ciloleucel car+
  o Long Description: Axicabtagene Ciloleucel, up to 200 million autologous Anti-CD19 CAR T Cells, Including leukapheresis and dose preparation procedures, per infusion
  o TOS Code: 1
  o 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**

The official instruction, CR 10454, issued to your MAC regarding this change is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/.

If you have any questions, please contact your MAC at their toll-free number. That number is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R3966CP.pdf.
MLN Matters MM10454

DOCUMENT HISTORY

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>February 2, 2018</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>

Disclaimer: This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2016 American Medical Association. All rights reserved.

Copyright © 2017, the American Hospital Association, Chicago, Illinois. Reproduced with permission. No portion of the AHA copyrighted materials contained within this publication may be copied without the express written consent of the AHA. AHA copyrighted materials including the UB-04 codes and descriptions may not be removed, copied, or utilized within any software, product, service, solution or derivative work without the written consent of the AHA. If an entity wishes to utilize any AHA materials, please contact the AHA at 312-893-6816. Making copies or utilizing the content of the UB-04 Manual, including the codes and/or descriptions, for internal purposes, resale and/or to be used in any product or publication; creating any modified or derivative work of the UB-04 Manual and/or codes and descriptions; and/or making any commercial use of UB-04 Manual or any portion thereof, including the codes and/or descriptions, is only authorized with an express license from the American Hospital Association. To license the electronic data file of UB-04 Data Specifications, contact Tim Carlson at (312) 893-6816 or Laryssa Marshall at (312) 893-6814. You may also contact us at ub04@healthforum.com

The American Hospital Association (the “AHA”) has not reviewed, and is not responsible for, the completeness or accuracy of any information contained in this material, nor was the AHA or any of its affiliates, involved in the preparation of this material, or the analysis of information provided in the material. The views and/or positions presented in the material do not necessarily represent the views of the AHA. CMS and its products and services are not endorsed by the AHA or any of its affiliates.
Quarterly Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement

MLN Matters Number: MM10374
Related Change Request (CR) Number: 10374
Related CR Release Date: November 17, 2017
Effective Date: April 1, 2018
Related CR Transmittal Number: R3923CP
Implementation Date: April 2, 2018

PROVIDER TYPES AFFECTED

This MLN Matters Article is intended for Home Health Agencies (HHAs) and other providers submitting claims to Medicare Administrative Contractors (MACs) for home health services provided to Medicare beneficiaries

PROVIDER ACTION NEEDED

This article is based on Change Request (CR) 10374, which provides the quarterly update of HCPCS codes used for HH consolidated billing effective April 1, 2018. Make sure that your billing staffs are aware of these changes.

BACKGROUND

Section 1842(b)(6) of the Social Security Act requires that payment for home health services provided under a home health plan of care is made to the home health agency. This requirement is in Medicare regulations at 42 CFR 409.100 and in Medicare instructions provided in Chapter 10, Section 20 of the Medicare Claims Processing Manual.

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of HCPCS codes that are subject to the consolidated billing provision of the Home Health Prospective Payment System (HH PPS). With the exception of therapies performed by physicians, supplies incidental to physician services and supplies used in institutional settings, services appearing on this list that are submitted on claims to your MAC will not be paid separately on dates when a beneficiary for whom such a service is being billed is in a home health episode (that is, under a home health plan of care administered by an HHA).

Medicare will only directly reimburse the primary HHAs that have opened such episodes during the episode periods. Therapies performed by physicians, supplies incidental to physician services, and supplies used in institutional settings are not subject to HH consolidated billing.

The HH consolidated billing code lists are updated annually to reflect changes to the HCPCS code set itself. Additional updates may occur as frequently as quarterly in order to reflect the creation of temporary HCPCS codes (for example, 'K' codes) throughout the calendar year. The
new coding identified in each update describes the same services that were used to determine the applicable HH PPS payment rates. No additional services will be added by these updates; that is, new updates are required by changes to the coding system, not because the services subject to HH consolidated billing are being redefined.

Effective April 1, 2018, the following HCPCS code is added to the HH consolidated billing non-routine supply code list as a result of CR10374:

- A4575 Topical hyperbaric oxygen chamber, disposable (Hyperbaric o2 chamber disp)

No HCPCS codes are added to the HH consolidated billing therapy code list in this update.

ADDITIONAL INFORMATION

The official instruction, CR 10374, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3923CP.pdf. If you have any questions, please contact your MAC at their toll-free number. That number is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/

DOCUMENT HISTORY

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>November 17, 2017</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>

Disclaimer: This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2016 American Medical Association. All rights reserved.

Copyright © 2017, the American Hospital Association, Chicago, Illinois. Reproduced with permission. No portion of the AHA copyrighted materials contained within this publication may be copied without the express written consent of the AHA. AHA copyrighted materials including the UB-04 codes and descriptions may not be removed, copied, or utilized within any software, product, service, solution or derivative work without the written consent of the AHA. If an entity wishes to utilize any AHA materials, please contact the AHA at 312-893-6816. Making copies or utilizing the content of the UB-04 Manual, including the codes and/or descriptions, for internal purposes, resale and/or to be used in any product or publication; creating any modified or derivative work of the UB-04 Manual and/or codes and descriptions; and/or making any commercial use of UB-04 Manual or any portion thereof, including the codes and/or descriptions, is only authorized with an express license from the American Hospital Association. To license the electronic data file of UB-04 Data Specifications, contact Tim Carlson at (312) 893-6816 or Laryssa Marshall at (312) 893-6814. You may also contact us at ub04@healthforum.com

The American Hospital Association (the “AHA”) has not reviewed, and is not responsible for, the completeness or accuracy of any information contained in this material, nor was the AHA or any of its affiliates, involved in the preparation of this material, or the analysis of information provided in the material. The views and/or positions presented in the material do not necessarily represent the views of the AHA. CMS and its products and services are not endorsed by the AHA or any of its affiliates.
Reinstating the Qualified Medicare Beneficiary Indicator in the Medicare Fee-For-Service Claims Processing System from CR9911

MLN Matters Number: MM10433  Related Change Request (CR) Number: 10433
Related CR Release Date: February 2, 2018  Effective Date: July 1, 2018
Related CR Transmittal Number: R3965CP  Implementation Date: For claims processed on or after July 2, 2018

PROVIDER TYPES AFFECTED

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

WHAT YOU NEED TO KNOW

Effective with Change Request (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, 2018, 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 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 2015, 7.2 million individuals (more than one out of 10 beneficiaries) were enrolled in the QMB program.
Providers and suppliers may bill State Medicaid agencies for Medicare cost-sharing amounts. However, as permitted by Federal law, States 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. CMS systems shall output Claim Adjustment Group Code “PR” along with CARC 1 and/or 2, as applicable, with monetary values expressed on outbound Medicare 835 Electronic Remittance Advices (ERAs) and on standard paper remittance advices (SPRs), as applicable. Medicare’s shared systems shall discontinue the practice of outputting Claim Adjustment Group Code OA with CARC 209 and reflecting the CARC 1 and 2 monetary amounts as zero.

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 10433 reestablishes all 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/.

**DOCUMENT HISTORY**

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>February 2, 2018</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>

Disclaimer: This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the
specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2016 American Medical Association. All rights reserved.

Copyright © 2017, the American Hospital Association, Chicago, Illinois. Reproduced with permission. No portion of the AHA copyrighted materials contained within this publication may be copied without the express written consent of the AHA. AHA copyrighted materials including the UB-04 codes and descriptions may not be removed, copied, or utilized within any software, product, service, solution or derivative work without the written consent of the AHA. If an entity wishes to utilize any AHA materials, please contact the AHA at 312-893-6816. Making copies or utilizing the content of the UB-04 Manual, including the codes and/or descriptions, for internal purposes, resale and/or to be used in any product or publication; creating any modified or derivative work of the UB-04 Manual and/or codes and descriptions; and/or making any commercial use of UB-04 Manual or any portion thereof, including the codes and/or descriptions, is only authorized with an express license from the American Hospital Association. To license the electronic data file of UB-04 Data Specifications, contact Tim Carlson at (312) 893-6816 or Laryssa Marshall at (312) 893-6814. You may also contact us at ub04@healthforum.com

The American Hospital Association (the "AHA") has not reviewed, and is not responsible for, the completeness or accuracy of any information contained in this material, nor was the AHA or any of its affiliates, involved in the preparation of this material, or the analysis of information provided in the material. The views and/or positions presented in the material do not necessarily represent the views of the AHA. CMS and its products and services are not endorsed by the AHA or any of its affiliates.
Replacement of Mammography HCPCS Codes, Waiver of Coinsurance and Deductible for Preventive and Other Services, and Addition of Anesthesia and Prolonged Preventive Services

MLN Matters Number: MM10181 Revised
Related Change Request (CR) Number: 10181
Related CR Release Date: August 18, 2017
Effective Date: January 1, 2018
Related CR Transmittal Number: R3844CP
Implementation Date: January 2, 2018

Note: This article was revised on February 9, 2018, to reposition text under different headers on page 2. All other information is unchanged

PROVIDER TYPES AFFECTED

This MLN Matters Article is intended for providers submitting claims to Part A & B Medicare Administrative Contractors (MACs) for services furnished to Medicare beneficiaries.

PROVIDER ACTION NEEDED

Change Request (CR) 10181 provides for the replacement of HCPCS codes G0202, G0204, and G0206 with Current Procedural Terminology (CPT) codes 77067, 77066, and 77065, effective January 1, 2018. CR 10181 also applies the waiver of deductible and coinsurance to 76706, 77067, prolonged preventive services, and anesthesia services furnished in conjunction with and in support of colorectal cancer services. Make sure your billing staffs are aware of these changes.

The language and policy referred to in this article are included in Chapter 18, Sections 20 and 240 (new) of the “Medicare Claims Processing Manual”, which is included as an attachment to CR 10181.

BACKGROUND

Replacement of Mammography HCPCS Codes
Effective for claims with dates of service on or after January 1, 2018, the following HCPCS codes are being replaced:

- G0202 - “screening mammography, bilateral (2-view study of each breast), including computer-aided detection Computer-Aided Detection (CAD) when performed”
- G0204 - “diagnostic mammography, including when performed; bilateral” and
- G0206 - “diagnostic mammography, including CAD when performed; unilateral”

These codes are being replaced by the following CPT codes:
- 77067 - “screening mammography, bilateral (2-view study of each breast), including CAD when performed”
- 77066 - “diagnostic mammography, including (CAD) when performed; bilateral” and
- 77065 - “diagnostic mammography, including CAD when performed; unilateral”.

As part of the January 2017 HCPCS code update, code G0389 was replaced by CPT code 76706. Type of Service (TOS) “5” was assigned to 76706, and the coinsurance and deductible were waived.

Effective January 1, 2018, the TOS for 76706 will be changed to “4” as part of the 2018 HCPCS update; the coinsurance and deductible will continue to be waived.

Summary of Changes: For claims with dates of service January 1, 2017, through December 31, 2017, report HCPCS codes G0202, G0204, and G0206. For claims with dates of service on or after January 1, 2018, report CPT codes 77067, 77066, and 77065 respectively.

Prolonged Preventive Services

Effective for claims with dates of service on or after January 1, 2018, prolonged preventive services will be payable by Medicare when billed as an add-on to an applicable preventive service that is payable from the Medicare Physician Fee Schedule, and both deductible and coinsurance do not apply. G0513 and G0514 for prolonged preventive services will be added as part of January 1, 2018, HCPCS update and the coinsurance and deductible will be waived.

Anesthesia Services

Section 4104 of the Affordable Care Act defined the term “preventive services” to include “colorectal cancer screening tests,” and as a result, it waives any coinsurance that would otherwise apply under Section 1833(a)(1) of the Social Security Act (the Act) for screening colonoscopies.

In addition, the Affordable Care Act amended Section 1833(b)(1) of the Act to waive the Part B deductible for screening colonoscopies, which includes anesthesia services as an inherent part of the screening colonoscopy procedural service. These provisions are effective for services furnished on or after January 1, 2011.

In the Calendar Year (CY) 2018 Physician Fee Schedule (PFS) Final Rule, the Centers for Medicare & Medicaid Services (CMS) modified reporting and payment for anesthesia services furnished in conjunction with and in support of colorectal cancer screening services. Anesthesia services furnished in conjunction with and in support of a screening colonoscopy are reported with CPT code 00812 (Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy). CPT Code 00812 will be added as part of January 1, 2018 HCPCS update. Effective for claims with dates of service on
or after January 1, 2018, Medicare will pay claim lines with new CPT code 00812 and waive the deductible and coinsurance.

When a screening colonoscopy becomes a diagnostic colonoscopy, anesthesia services are reported with CPT code 00811 (Anesthesia for lower intestinal endoscopic procedures, endoscopy introduced distal to duodenum; not otherwise specified) and with the PT modifier. CPT code 00811 will be added as part of the January 1, 2018 HCPCS update. Effective for claims with dates of service on or after January 1, 2018, Medicare will pay claim lines with new CPT code 00811 and waive only the deductible when submitted with the PT modifier.

**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>February 9, 2018</td>
<td>Article was revised to reposition text under different headers on page 2.</td>
</tr>
<tr>
<td>November 24, 2017</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>

**Disclaimer**
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2016 American Medical Association. All rights reserved.

Copyright © 2017, the American Hospital Association, Chicago, Illinois. Reproduced with permission. No portion of the AHA copyrighted materials contained within this publication may be copied without the express written consent of the AHA. AHA copyrighted materials including the UB-04 codes and descriptions may not be removed, copied, or utilized within any software, product, service, solution or derivative work without the written consent of the AHA. If an entity wishes to utilize any AHA materials, please contact the AHA at 312-893-6816. Making copies or utilizing the content of the UB-04 Manual, including the codes and/or descriptions, for internal purposes, resale and/or to be used in any product or publication; creating any modified or derivative work of the UB-04 Manual and/or codes and descriptions; and/or making any commercial use of UB-04 Manual or any portion thereof, including the codes and/or descriptions, is only authorized with an express license from the American Hospital Association. To license the electronic data file of UB-04 Data Specifications, contact Tim Carlson at (312) 893-6816 or Laryssa Marshall at (312) 893-6814. You may also contact us at ub04@healthforum.com

The American Hospital Association (the “AHA”) has not reviewed, and is not responsible for, the completeness or accuracy of any information contained in this material, nor was the AHA or any of its affiliates, involved in the preparation of this material, or the analysis of information provided in the material. The views and/or positions presented in the material do not necessarily represent the views of the AHA. CMS and its products and services are not endorsed by the AHA or any of its affiliates.
Hyperbaric Oxygen (HBO) Therapy (Section C, Topical Application of Oxygen)

MLN Matters Number: MM10220  
Related Change Request (CR) Number: 10220

Related CR Release Date: November 17, 2017  
Effective Date: April 3, 2017

Related CR Transmittal Number: R3921CP and R203NCD  
Implementation Date: December 18, 2017

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) 10220 informs MACs that, effective April 3, 2017, coverage of topical oxygen for the treatment of chronic wounds will be determined by the MACs. Make sure your billing staffs are aware of this change.

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) received a reconsideration request to remove the coverage exclusion of Continuous Diffusion of Oxygen Therapy (CDO) from the “Medicare National Coverage Determinations (NCD) Manual” (Pub. 100-03, Ch.1, Part 1, 20.29, Hyperbaric Oxygen (HBO) Therapy, Section C). This section of the NCD (Topical Application of Oxygen) considers treatment known as CDO as the application of topical oxygen and nationally non-covers this treatment. CMS asserts that the topical application of oxygen does not meet the definition of HBO therapy as stated in NCD 20.29.

Effective April 3, 2017, CMS decided that no NCD is appropriate at this time concerning the use of topical oxygen for the treatment of chronic wounds. As a result, CMS will amend NCD 20.29 by removing Section C, Topical Application of Oxygen. Medicare coverage of topical oxygen for the treatment of chronic wounds will be determined by your MAC.

NOTE: Although a MAC has discretion to cover topical oxygen for the treatment of chronic wounds, there shall be no coverage for any separate or additional payment for any physician’s professional services related to this procedure.
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>November 22, 2017</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>

Disclaimer: This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2016 American Medical Association. All rights reserved.

Copyright © 2017, the American Hospital Association, Chicago, Illinois. Reproduced with permission. No portion of the AHA copyrighted materials contained within this publication may be copied without the express written consent of the AHA. AHA copyrighted materials including the UB-04 codes and descriptions may not be removed, copied, or utilized within any software, product, service, solution or derivative work without the written consent of the AHA. If an entity wishes to utilize any AHA materials, please contact the AHA at 312-893-6816. Making copies or utilizing the content of the UB-04 Manual, including the codes and/or descriptions, for internal purposes, resale and/or to be used in any product or publication; creating any modified or derivative work of the UB-04 Manual and/or codes and descriptions; and/or making any commercial use of UB-04 Manual or any portion thereof, including the codes and/or descriptions, is only authorized with an express license from the American Hospital Association. To license the electronic data file of UB-04 Data Specifications, contact Tim Carlson at (312) 893-6816 or Laryssa Marshall at (312) 893-6814. You may also contact us at ub04@healthforum.com

The American Hospital Association (the “AHA”) has not reviewed, and is not responsible for, the completeness or accuracy of any information contained in this material, nor was the AHA or any of its affiliates, involved in the preparation of this material, or the analysis of information provided in the material. The views and/or positions presented in the material do not necessarily represent the views of the AHA. CMS and its products and services are not endorsed by the AHA or any of its affiliates.
ICD-10 and Other Coding Revisions to National Coverage Determinations (NCDs)

MLN Matters Number: MM10318 Revised
Related Change Request (CR) Number: 10318

Related CR Release Date: January 18, 2018
Effective Date: April 1, 2018 - Unless otherwise noted in CR10318

Related CR Transmittal Number: R2005OTN
Implementation Date: January 29, 2018 for local MAC edits; April 2, 2018 - for shared system edits (except FISS for NCDs (see below) 1, 8, 12, 19, 21); July 2, 2018 - FISS only for NCDs 1, 8, 12, 19, 21

Note: This article was revised on January 19, 2018, to reflect a revised CR10318 issued on January 18. In the article, the CR release date, MAC implementation date, transmittal number, and the Web address of the CR are revised. 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

Change Request (CR) 10318 constitutes a maintenance update of the International Code 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:

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.

CR10318 makes coding and clarifying adjustments to the following NCDs:

1. NCD20.9 Artificial Hearts
2. NCD20.9.1 Ventricular Assist Devices (VADs)
3. NCD20.16 Cardiac Output Monitoring by Thoracic Electrical Bioimpedance (TEB)
4. NCD20.29 Hyperbaric Oxygen (HBO) Therapy
5. NCD20.30 Microvolt T-Wave Alternans (MTWA)
6. NCD20.33 Transcatheter Mitral Valve Repair (TMVR)
7. NCD40.1 Diabetes Self-Management Training (DSMT)
8. NCD80.2, 80.2.1, 80.3, 80.3.1 Photodynamic Therapy, OPT, Photosensitive Drugs, Verteporfin
9. NCD110.18 Aprepitant
10. NCD110.21 Erythropoiesis Stimulating Agents (ESAs) in Cancer
11. NCD110.23 Stem Cell Transplants
12. NCD160.27 Transcutaneous Electrical Nerve Stimulation (TENS) for Chronic Low Back Pain (CLBP)
13. NCD190.3 Cytogenetic Studies
14. NCD190.11 Home Prothrombin Time/International Normalized Ratio (PT/INR) for Anticoagulation Management
15. NCD220.4 Mammograms
16. NCD220.6.17 Positron Emission Tomography (FDG) for Solid Tumors
17. NCD260.1 Adult Liver Transplantation
18. NCD220.13 Percutaneous Image-Guided Breast Biopsy
19. NCD270.1 Electrical Stimulation/Electromagnetic Therapy (ES/ET) for Wounds
20. NCD270.3 Blood-Derived Products for Chronic Non-Healing Wounds
21. NCD80.11 Vitrectomy
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/.

DOCUMENT HISTORY

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 19, 2018</td>
<td>The article was revised due to a revised CR10318 issued on January 18. In the article, the CR release date, MAC implementation date, transmittal number, and the Web address of the CR are revised. All other information remains the same.</td>
</tr>
<tr>
<td>November 16, 2017</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>

Disclaimer: This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2016 American Medical Association. All rights reserved.

Copyright © 2017, the American Hospital Association, Chicago, Illinois. Reproduced with permission. No portion of the AHA copyrighted materials contained within this publication may be copied without the express written consent of the AHA. AHA copyrighted materials including the UB-04 codes and descriptions may not be removed, copied, or utilized within any software, product, service, solution or derivative work without the written consent of the AHA. If an entity wishes to utilize any AHA materials, please contact the AHA at 312-893-6816. Making copies or utilizing the content of the UB-04 Manual, including the codes and/or descriptions, for internal purposes, resale and/or to be used in any product or publication; creating any modified or derivative work of
the UB-04 Manual and/or codes and descriptions; and/or making any commercial use of UB-04 Manual or any portion thereof, including the codes and/or descriptions, is only authorized with an express license from the American Hospital Association. To license the electronic data file of UB-04 Data Specifications, contact Tim Carlson at (312) 893-6816 or Laryssa Marshall at (312) 893-6814. You may also contact us at ub04@healthforum.com.

The American Hospital Association (the “AHA”) has not reviewed, and is not responsible for, the completeness or accuracy of any information contained in this material, nor was the AHA or any of its affiliates, involved in the preparation of this material, or the analysis of information provided in the material. The views and/or positions presented in the material do not necessarily represent the views of the AHA. CMS and its products and services are not endorsed by the AHA or any of its affiliates.
Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD)

MLN Matters Number: MM10295  Related Change Request (CR) Number: 10295
Related CR Release Date: February 2, 2018  Effective Date: May 25, 2017
Related CR Transmittal Number: R204NCD and R3969CP  Implementation Date: April 3, 2018 - MAC edits; July 2, 2018 - full implementation

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.

MACs will accept claims for CPT 93668 only when services are provided in Place of Service (POS) code 11, 19, or 22. MACs will deny claims for SET if services are not provided in POS 11, 19, or 22, using the following remittance 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.

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 CPT93668 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, HIQH, 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**

**DOCUMENT HISTORY**

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>February 6, 2018</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>

**Disclaimer:** This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only Copyright 2016 American Medical Association. All rights reserved.

Copyright © 2017, the American Hospital Association, Chicago, Illinois. Reproduced with permission. No portion of the AHA copyrighted materials contained within this publication may be copied without the express written consent of the AHA. AHA copyrighted materials including the UB-04 codes and descriptions may not be removed, copied, or utilized within any software, product, service, solution or derivative work without the written consent of the AHA. If an entity wishes to utilize any AHA materials, please contact the AHA at 312-893-6816. Making copies or utilizing the content of the UB-04 Manual, including the codes and/or descriptions, for internal purposes, resale and/or to be used in any product or publication; creating any modified or derivative work of the UB-04 Manual and/or codes and descriptions; and/or making any commercial use of UB-04 Manual or any portion thereof, including the codes and/or descriptions, is only authorized with an express license from the American Hospital Association. To license the electronic data file of UB-04 Data Specifications, contact Tim Carlson at (312) 893-6816 or Laryssa Marshall at (312) 893-6814. You may also contact us at ub04@healthforum.com

The American Hospital Association (the “AHA”) has not reviewed, and is not responsible for, the completeness or accuracy of any information contained in this material, nor was the AHA or any of its affiliates, involved in the preparation of this material, or the analysis of information provided in the material. The views and/or positions presented in the material do not necessarily represent the views of the AHA. CMS and its products and services are not endorsed by the AHA or any of its affiliates.
INFORMATION ON WEBSITE

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

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

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

NEW POLICIES

The following are new policies. Be sure to note the effective date of the new policy, as the policy will not appear as an active policy until the effective date. Prior to the effective date, the policy can be found by selecting the link "Display Future Effective Documents" within the CMS Medicare Coverage Database (MCD): http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx

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

March 2018

<table>
<thead>
<tr>
<th>Contract</th>
<th>Policy Title</th>
<th>CMS MCD Policy #</th>
<th>WPS Policy #</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>J5/J8</td>
<td>Wound Care</td>
<td>L37228</td>
<td>GSURG-056</td>
<td>04/16/2018</td>
</tr>
<tr>
<td>J5/J8</td>
<td>Wound Care Companion for Wound Care L37228</td>
<td>A55909</td>
<td>NA</td>
<td>04/16/2018</td>
</tr>
</tbody>
</table>

New article associated with LCD L37228 Wound Care.

February 2018

<table>
<thead>
<tr>
<th>Contract</th>
<th>Policy Title</th>
<th>CMS MCD Policy #</th>
<th>WPS Policy #</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>J5/J8</td>
<td>MolDX: Prometheus IBD sgi Diagnostic Policy</td>
<td>L37539</td>
<td>MolDX-035</td>
<td>03/19/2018</td>
</tr>
</tbody>
</table>

January 2018

<table>
<thead>
<tr>
<th>Contract</th>
<th>Policy Title</th>
<th>CMS MCD Policy #</th>
<th>WPS Policy #</th>
<th>Effective Date</th>
</tr>
</thead>
</table>
### 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:  

### March 2018

<table>
<thead>
<tr>
<th>Contract</th>
<th>Policy Title</th>
<th>CMS MCD Policy #</th>
<th>WPS Policy #</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>J5/J8</td>
<td>MolDX: ThermoFisher Oncomine Dx Target Test for Non-Small Cell Lung Cancer, Coding and Billing Guidelines</td>
<td>A55846</td>
<td>NA</td>
<td>02/15/2018</td>
</tr>
</tbody>
</table>

- Replaced with L37228 Wound Care and A55909 Wound Care Companion for Wound Care L37228.

February 2018 – There are no retired Policies/Articles for February 2018

### January 2018

<table>
<thead>
<tr>
<th>Contract</th>
<th>Policy Title</th>
<th>CMS MCD Policy #</th>
<th>WPS Policy #</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>J5/J8</td>
<td>MolDX: Excluded Test List</td>
<td>A55247</td>
<td>NA</td>
<td>01/01/2018</td>
</tr>
</tbody>
</table>

### 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:  

### March 2018

<table>
<thead>
<tr>
<th>Contract</th>
<th>Policy Title</th>
<th>CMS MCD Policy #</th>
<th>WPS Policy #</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>J5/J8</td>
<td>MolDX: Decipher® Prostate Cancer Classifier Assay</td>
<td>L36791</td>
<td>MolDx-010</td>
<td>03/01/2018</td>
</tr>
</tbody>
</table>

- Removed the word undetectable, added the measurement of PSA and changed 30 days to 120 days in the sentence below.

Criteria of Coverage
• Patient must have achieved initial PSA nadir (defined as PSA at or below 0.2ng/ml) within 120 days of RP surgery.

CDD has been removed from the title of this policy.

Updated CMS National Coverage Policy section:
CMS Internet-Only Manual (IOM) Publication 100-04, Medicare Claims Processing Manual, Chapter 23, Section 10 "Reporting ICD Diagnosis and Procedure Codes."

J5/J8  MolDX: ThermoFisher Oncoming Dx Target Test for Non-Small Cell Lung Cancer, Coding and Billing Guidelines

The following ICD-10 diagnosis codes have been added to this document:
- C33 Malignant neoplasm of trachea
- C34.00 Malignant neoplasm of unspecified main bronchus
- C34.01 Malignant neoplasm of right main bronchus
- C34.02 Malignant neoplasm of left main bronchus
- C34.10 Malignant neoplasm of upper lobe, unspecified bronchus or lung
- C34.11 Malignant neoplasm of upper lobe, right bronchus or lung
- C34.12 Malignant neoplasm of upper lobe, left bronchus or lung
- C34.2 Malignant neoplasm of middle lobe, bronchus or lung
- C34.30 Malignant neoplasm of lower lobe, unspecified bronchus or lung
- C34.31 Malignant neoplasm of lower lobe, right bronchus or lung
- C34.32 Malignant neoplasm of lower lobe, left bronchus or lung
- C34.80 Malignant neoplasm of overlapping sites of unspecified bronchus and lung
- C34.81 Malignant neoplasm of overlapping sites of right bronchus and lung
- C34.82 Malignant neoplasm of overlapping sites of left bronchus and lung
- C34.90 Malignant neoplasm of unspecified part of unspecified bronchus or lung
- C34.91 Malignant neoplasm of unspecified part of right bronchus or lung
- C34.92 Malignant neoplasm of unspecified part of left bronchus or lung

February 2018

J5/J8  Coding Radiopharmaceutical Agents

Removed A9580 Sodium fluoride F-18 from PET Scan radiopharmaceuticals and Group 1. A9580 will be denied effective 12/15/2017 based on Decision Memo for Positron Emission Tomography (NaF-18) to Identify Bone Metastasis of Cancer (CAG-00065R2). Updated CMS Manual Explanations URL(s).

J5/J8  Drug Administration Coding

Added J3490 edaravone (Radicava®) to the list of drugs that should not be billed using a chemotherapy administration code.

J5/J8  Human Granulocyte/Macrophage Colony Stimulating Factor

Group 1 Paragraph: J1442 Filgrastim (g-csf), excludes biosimilars

Group 1 Codes added:
Z52.011 Autologous donor, stem cells and
<table>
<thead>
<tr>
<th>Contract</th>
<th>Policy Title</th>
<th>CMS MCD Policy #</th>
<th>WPS Policy #</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>J5/J8</td>
<td>MoIDX: BCKDHB Gene Test Coding and Billing Guidelines</td>
<td>A55145</td>
<td>NA</td>
<td>02/01/2018</td>
</tr>
<tr>
<td>J5/J8</td>
<td>MoIDX: FDA-Approved BRAF Tests</td>
<td>A55161</td>
<td>NA</td>
<td>02/01/2018</td>
</tr>
<tr>
<td>J5/J8</td>
<td>MoIDX: FDA-Approved EGFR Tests</td>
<td>A55193</td>
<td>NA</td>
<td>02/01/2018</td>
</tr>
<tr>
<td>J5/J8</td>
<td>MoIDX: FDA-Approved KRAS Tests</td>
<td>A55162</td>
<td>NA</td>
<td>02/01/2018</td>
</tr>
<tr>
<td>J5/J8</td>
<td>MoIDX: Genomic Health™ Oncotype DX® Prostate Cancer Assay</td>
<td>L36789</td>
<td>MoIDX-009</td>
<td>01/01/2018</td>
</tr>
<tr>
<td>J5/J8</td>
<td>MoIDX: Molecular Diagnostic Tests (MDT)</td>
<td>L36807</td>
<td>MoIDX-004</td>
<td>01/01/2018</td>
</tr>
</tbody>
</table>

Added CPT code 81406-Mopath procedure level 7 to indicate BCKDM, full gene sequence. This service is not covered.

The following updates have been made to this document:

- Removed modifier 22 BRAF, V600E and “For lab developed tests (LDT) or tests that modify a BRAF V600 test, CPT code 81210 and NO modifier should be reported and submitted with the assigned LDT test ID.”

- Removed modifier 22 EGFR, common variant and “For lab developed tests (LDT) or tests that modify an EGFR test, CPT code 81235 and NO modifier should be reported and submitted with the assigned LDT test ID.”

- Removed modifier 22 BRAF, V600E and “For lab developed tests (LDT) or tests that modify a KRAS, codon 12 and 13 test, CPT code 81275 and NO modifier should be reported and submitted with the assigned LDT test ID.”

- Removed CDD from the LCD title.

- CPT 81541 was added in error last month and is being removed from the policy. CPT 81479 has been added back into the policy.

- 81479 unlisted molecular pathology procedure.

The following CPT codes have been added to this policy:

- 88271 DNA testing for genetic defects
- 88272 Chromosome analysis for genetic defects
- 88273 Chromosome analysis for genetic defects
- 88274 Genetic testing
<table>
<thead>
<tr>
<th>Contract</th>
<th>Policy Title</th>
<th>CMS MCD Policy #</th>
<th>WPS Policy #</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>J5/J8</td>
<td>MolDX: Oncotype DX® Genomic Prostate Score for Men with Favorable Intermediate Risk Prostate Cancer</td>
<td>DL37667</td>
<td>MolDX-038</td>
<td>01/01/2018</td>
</tr>
<tr>
<td></td>
<td>CPT code 81541 is listed in error in this draft policy. The correct CPT code is 81479. We are unable to change a draft LCD; a note has been added to the top of the LCD noting this correction. This will be updated on the Final LCD. 81479 unlisted molecular pathology.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| J5/J8    | MolDX: Prolaris™ Prostate Cancer Genomic Assay for Men with Favorable Intermediate Risk Disease | L37226         | MolDX-034    | 01/01/2018     |
|          | Added CPT code 81541 and removed CPT code 81479. 81541 oncology (prostate), mRNA gene expression profiling by real-time rt-pcr of 46 genes (31 content and 15 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a disease-specific mortality risk score. |

**January 2018**

<table>
<thead>
<tr>
<th>Contract</th>
<th>Policy Title</th>
<th>CMS MCD Policy #</th>
<th>WPS Policy #</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>J5/J8</td>
<td>2018 CPT/HCPCS Code Updates</td>
<td>NA</td>
<td>NA</td>
<td>01/01/2018</td>
</tr>
<tr>
<td></td>
<td>2018 CPT/HCPCS Code Updates:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><a href="https://www.wpsgha.com/wps/wcm/connect/mac/d46842b9-93ca-4f77-b7a9-22905e503e0d/parta-2018-cpt-hcpcs-update.pdf?MOD=AJPERES&amp;CVID=m1R7KaN">https://www.wpsgha.com/wps/wcm/connect/mac/d46842b9-93ca-4f77-b7a9-22905e503e0d/parta-2018-cpt-hcpcs-update.pdf?MOD=AJPERES&amp;CVID=m1R7KaN</a></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>J5/J8</td>
<td>Billing and Coding for Rezum® Procedure</td>
<td>A55353</td>
<td>NA</td>
<td>01/01/2018</td>
</tr>
<tr>
<td></td>
<td>Deleted the following sentence from the Article Text: “Further investigation is warranted of the Rezum® procedure for the treatment of BPH and is currently non-covered.”</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>J5/J8</td>
<td>Endoscopic Treatment of GERD</td>
<td>L34659</td>
<td>GI-010</td>
<td>01/01/2018</td>
</tr>
</tbody>
</table>
EsophyX™ removed from Coverage Indications as a Benefit not available for endoluminal treatment for Gastroesophageal Reflux Disease (GERD).

Added the following information:

Coverage for the TIF (Transoral Incisionless Fundoplication) procedure is for treatment of patients in whom proton pump inhibitor therapy fails. An example of the device used in TIF is EsophyX™. TIF using EsophyX™ for performing surgery for treating gastroesophageal reflux disease (GERD) reconstructs the valve at the top of the stomach that helps prevent acid reflux.

Indications

Coverage is appropriate for TIF if done by a well-trained surgeon for the following indications:

1. Symptomatic chronic gastroesophageal reflux (chronic being defined as > 6 months of symptoms), and
2. Symptoms must not be completely responsive to Proton Pump Inhibitors (PPIs) as judged by GERD HRQL scores of < or equal to 12 while on PPIs and > or equal to 20 when off for 14 days (also acceptable would be the difference of > or equal to 10 of the scores between off and on therapy), and
3. Hiatal hernia < or equal to 2 cm, if present.

Limitations

Coverage is not extended:

1. For those patients who may have recurrent symptoms or may fail this procedure. No literature has been submitted for repeat TIF use. These procedures (repeat TIF) would be considered investigational at this time.

Summary of Evidence

Summary of evidence for TIF:

As noted above, transoral incisionless fundoplication surgery is a method for treating gastroesophageal reflux disease. This procedure reconstructs the valve at the top of the stomach that helps prevent acid reflux.

1. Technology Coverage Statement on Minimally Invasive Surgical Options for Gastroesophageal Reflux Disease April 2016. This is a position paper from the American Gastrological Association based on its reviews of TIF publications. It is strongly supportive.
2. Bell RCW, Barnes WE, Carter BJ, et al. Transoral incisionless fundoplication: 2-year results from the prospective multicenter U.S. study. AM Surg. 2014 Nov;80(11):1093-1105. This 24-month follow-up has been reported from a prospective multicenter registry of patients with chronic GERD who received transoral fundoplication using the ESOPHYX2 system with SerosaFuse fasteners. For the 100 consecutive patients who were treated in this community-based study, the median GERD symptom duration was nine years (range, one to 35 years), the median duration of PPI use was seven
years (range, one to 20 years), and 92 percent of patients had incomplete symptom control despite maximal medical therapy. This three-year study provides evidence to demonstrate sustainable improvement in health outcomes, symptom relief, decrease in PPI utilization and improvement in esophageal pH with transoral fundoplication. This is supportive.

3. Hakansson B., Montgomery M., Cadiere G, et al. Randomised clinical trial: transoral incisionless fundoplication vs. sham intervention to control chronic GERD. Alimentary Pharmacology and Therapeutics. 2015 John Wiley & Sons Ltd. This publication is indexed in the U.S. National Library of Medicine of the National Institutes. The study was blinded and divided equally into TIF and sham procedures. The follow up period was only six (6) months, the time (average days) in remission offered by the TIF procedure (197) was significantly longer compared to those submitted to the sham intervention (107), P < 0.001. After 6 months 13/22 (59%) of the chronic GERD patients remained in clinical remission after the active intervention. The secondary outcome measures were all in of the TIF2 procedure. No safety issues were raised. This is supportive.

4. Hunter JG, Kahrilas PJ, Bell RCW, et al. Gastroenterology. 2015 Feb;148(2):324-333. The largest RCT with the lowest risk of bias is an industry-sponsored double-blind sham controlled multicenter study (RESPECT) that evaluated transoral fundoplication in patients whose symptoms were not well-controlled on proton pump inhibitors (PPIs). Out of 696 patients screened, 129 met inclusion and exclusion criteria and were randomized in a 2:1 ratio; 87 patients received transoral fundoplication combined with six months of placebo and 42 patients received sham surgery with six months of daily PPI therapy (sham/PPI). Control of esophageal pH improved after TF (mean 9.3% before and 6.3% after; P < .001), but not after sham surgery (mean 8.6% before and 8.9% after). This is supportive.

5. Clinical Spotlight Review: Endoluminal Treatments for Gastroesophageal Reflux Disease (GERD)sages.org/publications/guidelines/endoluminal-treatments-for-gastroesophageal-reflux-disease-gerd. This is a statement from the Board of Governors of the Society of American Gastrointestinal and Endoscopic Surgeons (SAGES) in Mar 2017. The recommendation is: Based on existing evidence, TIF can be performed with an acceptable safety risk in appropriately selected patients. The procedure leads to better control of GERD symptoms compared with PPI treatment in the short term (6 months) but appears to lose effectiveness during longer term follow-up and is associated with moderate patient satisfaction scores. Objective GERD measures improve similarly after TIF 2.0 compared with PPI. No comparative, controlled trials exist between TIF and surgical fundoplication, but preliminary evidence suggests that the latter can be used safely after TIF failure. (Per SAGES, this is level of evidence +++, strong recommendation).

6. Stefanidis G, Viazis N, Kotsikoros N, Long-term benefit of transoral incisionless fundoplication using the ESOPHYX device for the management of gastroesophageal reflux disease responsive to medical therapy. Diseases of the Esophagus (2017) 30, 1–8. This publication is indexed in the U.S. National Library of Medicine of the National Institutes of Health. The study initially had 45 patients who had the TIF procedure and were followed for a mean of 59 months (range 36–75). One patient had a complication during
surgery and thus was excluded. The 44 patients had follow-up upper endoscopy at 6 months, 1 year, and 3–5 years postoperatively. (72.7%) that completed the study follow up reported elimination of their main symptom, without the need for PPI administration (none PPI usage). Six patients (13.6%), five with heartburn, and one with regurgitation reported half PPI dose taken for <50% of the preceding follow up period (occasional PPI usage), six more patients (four with heartburn, one with regurgitation, and one with chest pain) reported full or half PPI dose taken for more than 50% of the preceding follow up period (daily PPI usage). This is supportive.

7. Trad, K., & et al. (2017). Transoral fundoplication offers durable symptom control for chronic GERD: 3-year report from the TEMPO randomized trial with a crossover arm. Surg Endosc. 2017 Jun;31(6):2498-2508. doi: 10.1007/s00464-016-5252-8. The TF EsophyX vs. Medical PPI Open Label Trial was conducted in 7 sites. Patients were enrolled with < 2 cm or absent hiatal hernia who suffered from GERD symptoms while on PPI treatment for at least 6 months and had abnormal esophageal acid exposure (EAE). Patients were randomized to TIF group or PPI group. At 6 months, all remaining PPI Patients elected to undergo crossover to TIF. 52 patients were assessed at 3 years for GERD symptom resolution, healing of esophagitis using endoscopy, EAE using 48-hour Bravo testing and discontinuation of PPI use. At 3-year follow-up, elimination of troublesome regurgitation and all atypical symptoms was reported by 90 % (37/41) and 88 % (42/48) of patients, respectively. The mean Reflux Symptom Index score improved from 22.2 (9.2) on PPIs at screening to 4 (7.1) off PPIs 3 years post-TF, p≤0.0001. The mean total % time pH \( \leq 4 \) improved from 10.5 (3.5) to 7.8 (5.7), p = 0.0283. Esophagitis was healed in 86 % (19/22) of patients. At the end of study, 71 % (37/52) of patients had discontinued PPI therapy. All outcome measures remained stable between 1-, 2-, and 3-year follow-ups post-TF, p≤0.0001. This study demonstrated TIF can be used to achieve long term control of chronic GERD symptoms, healing esophagitis and improvement of EAE. This is supportive.

### Analysis of Evidence
(Rationale for Determination)

While most patients with GERD can be managed non-operatively with pharmacologic therapy, advancements in endoscopic and laparoscopic surgery have expanded the options for patients with GERD who are referred for surgical/endoscopic intervention. Surgical and endoscopic intervention should be entertained only after considerable initial evaluation and medical therapy by primary care and specialty physicians. For patients who have 1) failed medical management, 2) have complications of GERD, or 3) have extra-esophageal manifestations (asthma, hoarseness, cough, chest pain, aspiration), anti-reflux surgery may be an appropriate option.

The evidence reviewed is sufficient to demonstrate sustainable improvement in health outcomes, symptom relief, decrease in PPI utilization and improvement in esophageal pH with transoral fundoplication. This option should be considered in patients not responding to PPI therapy (symptoms of regurgitation) who have
**Winter 2018 Communiqué**

**Contract** | **Policy Title** | **CMS MCD Policy #** | **WPS Policy #** | **Effective Date**
---|---|---|---|---

| documented objective evidence of GERD (pathologic acid exposure on pH testing (both off and on medication)) or esophagitis. Transoral fundoplication should be covered and reimbursed for appropriate patients who meet the selection criteria as described.  

Updated Group 1 Paragraph from N/A to Non-covered.  

Group 2 Paragraph: EsophyX™  
Group 2 Codes:  
43210: Esophagogastroduodenoscopy with esophagogastric fundoplasty, partial or complete, includes duodenoscopy when performed.  

Documentation Requirements  

The patient's medical record must contain documentation that fully supports the medical necessity for services included within this LCD. (See the Coverage Indications, Limitations and/or Medical Necessity). This documentation includes, but is not limited to, relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures, and any other records that describe or support the evaluation and treatment of the patient. Documentation should be available to the Contractor upon request.  

Bibliography Section includes references for reconsideration request 2017.

<table>
<thead>
<tr>
<th>J5/J8</th>
<th>J5/J8 MolDX: Approved Gene Testing</th>
<th>A55248</th>
<th>NA</th>
<th>01/01/2018</th>
</tr>
</thead>
</table>

Please see our 2018 CPT/HCPCS Code Update Article for information on the code changes for this LCD.  

The following tests have been added:  
81201 APC, fgs  
81202 APC, kfv  
81203 APC, dup_del  
81219 CALR, cv ex.9  

The following tests have been removed:  
81266 STR add (for transplants)  
81401 TYMS  
81402 IGH_BCL2, majbpr_mcrbp qul_quun  
81402 KIT, cv  

The table with the listing of tests by the manufacturer has been removed.

<table>
<thead>
<tr>
<th>J5/J8</th>
<th>J5/J8 MolDX: GeneSight® Assay for Refractory Depression</th>
<th>L36799</th>
<th>MolDX-015</th>
<th>01/01/2018</th>
</tr>
</thead>
</table>

The following information was added to this document:  

- Analysis of Evidence  
- (Rationale for Determination)  
- Level of Evidence  
- Quality of Evidence-Moderate
Strength of Evidence-Moderate

Weight of Evidence-Limited

The evidence of clinical utility to support the use of the GeneSight assay is limited to patients diagnosed with major depressive disorder (MDD) who are suffering with refractory moderate to severe depression (based upon DSM-V criteria) after at least one prior neuropsychiatric medication failure when ordered by a licensed psychiatrist or neuropsychiatrist contemplating an alteration in neuropsychiatric medication. Claims submitted by non-physician providers (NPPs) and physician extenders as “incident to” services will be denied. The GeneSight assay is limited to once in a lifetime.

**J5/J8**

**MolDX: Genetic Testing for Lynch Syndrome**

<table>
<thead>
<tr>
<th>Contract</th>
<th>Policy Title</th>
<th>CMS MCD Policy #</th>
<th>WPS Policy #</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>J5/J8</td>
<td>L36793</td>
<td>MolDX-011</td>
<td>01/01/2018</td>
<td></td>
</tr>
</tbody>
</table>

Changed "or" to "and" and added or a multi-gene NGS or other multi-analyte methodology that is inclusive of MSI microsatellite loci, and MLH1, MSH2, MSH6 and PMS2 genes to the first paragraph of the policy. It now reads:

This policy limits Lynch syndrome (LS) genetic testing to a stepped approach for Microsatellite Instability and Immunohistochemistry (MSI/IHC) screening, BRAF gene mutation, MLH1 gene promoter hypermethylation and targeted mismatch repair (MMR) germ-line gene testing to all patients with colorectal cancer (CRC) and endometrial cancer regardless of age, or a multi-gene NGS or other multi-analyte methodology that is inclusive of MSI microsatellite loci, and MLH1, MSH2, MSH6 and PMS2 genes.

Analysis of Evidence
(Rationale for Determination)
Level of Evidence
Quality of Evidence – High
Strength of Evidence – High
Weight of Evidence – High

Based on the high level of scientific evidence to support Medicare coverage, MSI and/or IHC genetic testing for dMMR is reasonable and necessary for all patients with colorectal and endometrial cancer. Alternatively, a NGS panel inclusive of MSI, MLH1, MSH2, MSH6 and PMS2 genes is reasonable and necessary in lieu of MSI and/or dMMR by IHC.

**J5/J8**

**MolDX: Molecular Diagnostic Tests (MDT)**

<table>
<thead>
<tr>
<th>Contract</th>
<th>Policy Title</th>
<th>CMS MCD Policy #</th>
<th>WPS Policy #</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>J5/J8</td>
<td>L36807</td>
<td>MolDX-004</td>
<td>01/01/2018</td>
<td></td>
</tr>
</tbody>
</table>

Please see our 2018 CPT/HCPCS Code Update Article for information on the code changes for this LCD that are effective January 1, 2018.

In addition to the 2018 code updates, the following CPT codes have been added to the LCD and are effective February 15, 2018:
<table>
<thead>
<tr>
<th>Contract</th>
<th>Policy Title</th>
<th>CMS MCD Policy #</th>
<th>WPS Policy #</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>J5/J8</td>
<td>MolDX: TP53 Gene Test Coding and Billing Guidelines</td>
<td>A55221</td>
<td>NA</td>
<td>01/01/2018</td>
</tr>
<tr>
<td>J5/J8</td>
<td>Not Otherwise Classified Chemotherapy Agents (NOC)</td>
<td>A55640</td>
<td>NA</td>
<td>01/01/2018</td>
</tr>
<tr>
<td>J5/J8</td>
<td>Treatment of Varicose Veins of the Lower Extremities</td>
<td>L34536 GSURG-041</td>
<td>01/01/2018</td>
<td></td>
</tr>
</tbody>
</table>

**MolDX: TP53 Gene Test Coding and Billing Guidelines**

Removed the following statement from this article: MolDX will also deny panels of tests that include the TP53 gene.

**Not Otherwise Classified Chemotherapy Agents (NOC)**

Revisions due to CPT/HCPCS code update.

Group 1 Paragraph and Group 2 Paragraph: for Atezolizumab (Tecentriq®) Code C9483 has been assigned a true code J9022. Associated information included in Group 1 Codes and Group 2 Codes removed.

Group 3 Paragraph: for Olaratumab (Lartruvo™) Code C9485 has been assigned a true code J9285. Associated information included in Group 3 Codes removed.

Added:

Group 1 Paragraph: J9999/C9399 Rituximab and hyaluronidase human/Rituxan Hycela, 1mg (FDA approval/effective date 06/22/2017).

**Treatment of Varicose Veins of the Lower Extremities**

Please see the combined article for CPT/HCPCS Code Updates. Added codes 36465, 36466, 36482, and 36483 to the Group 1 Paragraph.

In Billing and Coding Guidelines: added CPT codes 36465, 36466, 36482, and 36483 with clarification of billing instructions to Line Item 5.

When reporting sclerotherapy procedures (36465, 36466, 36470, and 36471) performed on opposite legs, report CPT code 36465, 36470 (one vein) and 36466, 36471 (multiple veins) on separate lines using the RT and LT modifiers.

When reporting procedures (36482 and 36483) performed on opposite legs, report CPT code 36482 (one vein) and 36483 (multiple veins) on separate lines using the RT and LT modifiers. For bilateral services use the 50 modifier. Only one service should be reported for each leg regardless of how many veins are treated. When the procedure is performed for cosmetic purpose, use code V50.1.

Please be advised that the practice expense for CPT codes 36465, 36466, 36470, 36471, 36473, and 36474 already contain the reimbursement for the sclerosant. Providers should not bill separately for the sclerosant.

Please be advised that the practice expense for CPT codes 36482 and 36483 already contain the reimbursement for the chemical adhesive. Providers should not bill separately for the chemical adhesive. Use CPT code 36483 to report the second
<table>
<thead>
<tr>
<th>Contract</th>
<th>Policy Title</th>
<th>CMS MCD Policy #</th>
<th>WPS Policy #</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>and subsequent veins treated in a single extremity only when treated through separate access sites.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Electronic Data Interchange (EDI)

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

MLN Matters Number: MM10151 Revised
Related CR Release Date: December 28, 2017
Related CR Transmittal: R1994OTN

Related Change Request (CR) Number: 10151
Effective Date: January 1, 2018
Implementation Date: January 2, 2018

Note: This article was revised on December 29, 2017, to reflect the revised CR10151 issued on December 28, 2017. In the article, the CR release date, transmittal number, and the Web address for accessing the CR are revised. All other information remains the same.

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

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

BACKGROUND

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

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


ADDITIONAL INFORMATION


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

DOCUMENT HISTORY

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 29, 2017</td>
<td>This article was revised to reflect the revised CR10151 issued on December 28, 2017. 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.</td>
</tr>
<tr>
<td>December 22, 2017</td>
<td>This article was revised to reflect the revised CR10151 issued on December 21, 2017. 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.</td>
</tr>
<tr>
<td>August 7, 2017</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>

Disclaimer This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a
general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2016 American Medical Association. All rights reserved.

Copyright © 2017, the American Hospital Association, Chicago, Illinois. Reproduced with permission. No portion of the AHA copyrighted materials contained within this publication may be copied without the express written consent of the AHA. AHA copyrighted materials including the UB-04 codes and descriptions may not be removed, copied, or utilized within any software, product, service, solution or derivative work without the written consent of the AHA. If an entity wishes to utilize any AHA materials, please contact the AHA at 312-893-6816. Making copies or utilizing the content of the UB-04 Manual, including the codes and/or descriptions, for internal purposes, resale and/or to be used in any product or publication; creating any modified or derivative work of the UB-04 Manual and/or codes and descriptions; and/or making any commercial use of UB-04 Manual or any portion thereof, including the codes and/or descriptions, is only authorized with an express license from the American Hospital Association. To license the electronic data file of UB-04 Data Specifications, contact Tim Carlson at (312) 893-6816 or Laryssa Marshall at (312) 893-6814. You may also contact us at ub04@healthforum.com

The American Hospital Association (the “AHA”) has not reviewed, and is not responsible for, the completeness or accuracy of any information contained in this material, nor was the AHA or any of its affiliates, involved in the preparation of this material, or the analysis of information provided in the material. The views and/or positions presented in the material do not necessarily represent the views of the AHA. CMS and its products and services are not endorsed by the AHA or any of its affiliates.
EDUCATION SCHEDULE

WPS GHA Learning Center

WPS GHA Provider Outreach & Education (POE) has numerous educational opportunities in our Learning Center (http://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 (http://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

04/11/18 Ambulance Scheduled Transports – Ask-the-Contract Teleconference (ACT)

Ambulance providers performing scheduled transports are being looked at by a variety of medical review contractors. We want to hear the questions you have and help you have a better understanding of this benefit.

Webinars

03/07/18 KEPRO - The Beneficiary and Family Centered Care Quality Improvement Organization

KEPRO is a Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) servicing most of the J5/J8 states. (Please visit https://www.keproqio.com/ to see if your state is serviced by KEPRO.) In this presentation, you will learn about the services that the BFCC-QIO provides, including discharge appeals, quality of care complaints, immediate advocacy, and patient navigation. These services are available for Medicare beneficiaries and their representatives. We will also discuss the elements of KEPRO’s Person and Family Engagement project.

New to Medicare Teleconference Series

05/01/18 New to Medicare – MSP Overview

Do you know when to send a claim to Medicare as a primary insurance? Are you aware of Medicare Secondary Payer (MSP) rules? Do you know how get MSP records updated? All of this will be answered and more.
The agenda will include:
- What is MSP?
- What providers need to do before billing Medicare
- Updating records with the Benefits Coordination & Recovery Center

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

In the Works

The WPS GHA Provider Outreach and Education team is currently working on the following topics for upcoming education:
- Claim denials
- Documentation
- Overlapping Claims
- Medicare Day of Learning - Bringing the Payer and Providers Together
  - We will offer 5 locations this year
    - 04/24/18 – St. Charles, MO
    - 05/15/18 – Saginaw, MI
    - 07/17/18 – Grand Island, NE
    - 07/19/18 – Olathe, KS
    - 08/07/18 – Ankeny, IA

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

**MEDI CARE LEARN ING 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.

QUARTERLY PROVIDER UPDATE

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

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

- Regulations and major policies currently under development during this quarter.
- Regulations and major policies completed or cancelled.
- New/Revised manual instructions


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

April 2018 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

MLN Matters Number: MM10447 Related Change Request (CR) Number: 10447
Related CR Release Date: January 5, 2018 Effective Date: April 1, 2018
Related CR Transmittal Number: R3947CP Implementation Date: April 2, 2018

PROVIDER TYPE AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 10447 instructs MACs to download and implement the April 2018 and, if released, the revised January 2018, October 2017, July 2017, and April 2017 ASP drug pricing files for Medicare Part B drugs via the Centers for Medicare & Medicaid Services (CMS) Data Center (CDC). Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after April 2, 2018, with dates of service April 1, 2018, through June 30, 2018. Make sure that your billing staffs are aware of these changes.

BACKGROUND

The Average Sales Price (ASP) methodology is based on quarterly data submitted by manufacturers to CMS. CMS supplies MACs with the ASP and Not Otherwise Classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the Outpatient Prospective Payment System (OPPS) are incorporated into the Outpatient Code Editor (OCE) through separate instructions that are available in Chapter 4, Section 50 of the Medicare Claims Processing Manual at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf.

- File: April 2018 ASP and ASP NOC -- Effective for Dates of Service of April 1, 2018, through June 30, 2018
- File: January 2018 ASP and ASP NOC -- Effective for Dates of Service of January 1, 2018, through March 31, 2018
- File: October 2017 ASP and ASP NOC -- Effective for Dates of Service of October 1, 2017, through December 31, 2017
- File: July 2017 ASP and ASP NOC -- Effective for Dates of Service of July 1, 2017, through September 30, 2017
- File: April 2017 ASP and ASP NOC -- Effective for Dates of Service of April 1, 2017, through June 30, 2017

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

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

**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/监测Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/](https://www.cms.gov/Research-Statistics-Data-and-Systems/监测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>January 5, 2018</td>
<td>Initial article released</td>
</tr>
</tbody>
</table>

**Disclaimer:** This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2016 American Medical Association. All rights reserved.

Copyright © 2017, the American Hospital Association, Chicago, Illinois. Reproduced with permission. No portion of the AHA
copyrighted materials contained within this publication may be copied without the express written consent of the AHA. AHA copyrighted materials including the UB-04 codes and descriptions may not be removed, copied, or utilized within any software, product, service, solution or derivative work without the written consent of the AHA. If an entity wishes to utilize any AHA materials, please contact the AHA at 312-893-6816. Making copies or utilizing the content of the UB-04 Manual, including the codes and/or descriptions, for internal purposes, resale and/or to be used in any product or publication; creating any modified or derivative work of the UB-04 Manual and/or codes and descriptions; and/or making any commercial use of UB-04 Manual or any portion thereof, including the codes and/or descriptions, is only authorized with an express license from the American Hospital Association. To license the electronic data file of UB-04 Data Specifications, contact Tim Carlson at (312) 893-6816 or Laryssa Marshall at (312) 893-6814. You may also contact us at ub04@healthforum.com

The American Hospital Association (the “AHA”) has not reviewed, and is not responsible for, the completeness or accuracy of any information contained in this material, nor was the AHA or any of its affiliates, involved in the preparation of this material, or the analysis of information provided in the material. The views and/or positions presented in the material do not necessarily represent the views of the AHA. CMS and its products and services are not endorsed by the AHA or any of its affiliates.
Calendar Year (CY) 2018 Annual Update for Clinical Laboratory Fee Schedule (CLFS) and Laboratory Services Subject to Reasonable Charge Payment

MLN Matters Number: MM10409
Related Change Request (CR) Number: 10409
Related CR Release Date: December 15, 2017
Effective Date: January 1, 2018
Related CR Transmittal Number: R3934CP
Implementation Date: January 2, 2018

PROVIDER TYPES AFFECTED

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

WHAT YOU NEED TO KNOW

Change Request (CR) 10409 provides instructions for the Calendar Year (CY) 2018 clinical laboratory fee schedule, mapping for new codes for clinical laboratory tests and updates for laboratory costs subject to the reasonable charge payment. Make sure your billing staffs are aware of these changes.

KEY POINTS OF CR10409

Fee Schedule through December 31, 2017

Outpatient clinical laboratory services are paid based on a fee schedule in accordance with Section 1833(h) of the Social Security Act (the Act). Payment is the lesser of the amount billed, the local fee for a geographic area, or a national limit. In accordance with the statute, the national limits are set at a percent of the median of all local fee schedule amounts for each laboratory test code. Each year, fees are updated for inflation based on the percentage change in the Consumer Price Index. However, legislation by Congress can modify the update to the fees. Co-payments and deductibles do not apply to services paid under the Medicare clinical laboratory fee schedule.

Each year, new laboratory test codes are added to the clinical laboratory fee schedule and corresponding fees are developed in response to a public comment process.
For cervical or vaginal smear tests (pap smears), the fee cannot be less than a national minimum payment amount, initially established at $14.60 and updated each year for inflation, as stated in Section 1833(h)(7) of the Act.

**Fee Schedule Beginning January 1, 2018**

Effective January 1, 2018, CLFS rates will be based on weighted median private payer 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](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/PAMA-Regulations.html). For links to the slide presentations, audio recordings, and written transcripts, see CMS Sponsored Events, at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/CMS-Sponsored-Events.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/CMS-Sponsored-Events.html).

**Update to Fees**

In accordance with Section 1833(h)(2)(A)(i) of the Act, available at: [https://www.ssa.gov/OP_Home/ssact/title18/1833.htm](https://www.ssa.gov/OP_Home/ssact/title18/1833.htm), the annual update to the local clinical laboratory fees for CY 2018 is 1.10 percent. Beginning January 1, 2018, this update only applies to pap smear tests. For a pap smear test, Section 1833(h)(7) of the Act requires payment to be the lesser of the local fee or the NLA, but not less than a national minimum payment amount. However, for pap smear tests, payment may also not exceed the actual charge. The CY 2018 national minimum payment amount is $14.65 ($14.49 times 1.10 percent update for CY 2018).

The affected codes for the national minimum payment amount are: 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88164, 88165, 88166, 88167, 88174, 88175, G0123, G0143, G0144, G0145, G0147, G0148, Q0111, Q0115, and P3000.

The annual update to payments made on a reasonable charge basis for all other laboratory services for CY 2018 is 1.10 percent (See 42 CFR 405.509(b)(1)).

The Part B deductible and coinsurance do not apply for services paid under the clinical laboratory fee schedule.

**Access to Data File**

Internet access to the CY 2018 clinical laboratory fee schedule data file will be available after December 1, 2017, at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/index.html](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, may use the Internet to retrieve the CY 2018 clinical laboratory fee schedule. It will be available in multiple formats: Excel, text, and comma delimited.

**Public Comments and Final Payment Determinations**

On July 31, 2017, the Centers for Medicare & Medicaid Services (CMS) hosted a public meeting
to solicit input on the payment relationship between CY 2017 codes and new CY 2018 CPT codes. CMS posted a summary of the meeting and the tentative payment determinations on the web site at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/Laboratory_Public_Meetings.html. Additional written comments from the public were accepted until October 23, 2017. CMS also posted a summary of the public comments and the rationale for the final payment determinations at the same CMS web site.

Pricing Information

The CY 2018 clinical laboratory fee schedule includes separately payable fees for certain specimen collection methods (codes 36415, P9612, and P9615). The fees have been established in accordance with Section 1833(h)(4)(B) of the Act.

The fees for clinical laboratory travel codes P9603 and P9604 are updated on an annual basis. The clinical laboratory travel codes are billable only for traveling to perform a specimen collection for either a nursing home or homebound patient. If there is a revision to the standard mileage rate for CY 2018, CMS will issue a separate instruction on the clinical laboratory travel fees.

The CY 2018 clinical laboratory fee schedule also includes codes that have a “QW” modifier to both identify codes and determine payment for tests performed by a laboratory having only a certificate of waiver under the Clinical Laboratory Improvement Amendments (CLIA).

Mapping Information

New code 81105 is priced at the same rate as code 81376.
New code 81106 is priced at the same rate as code 81376.
New code 81107 is priced at the same rate as code 81376.
New code 81108 is priced at the same rate as code 81376.
New code 81109 is priced at the same rate as code 81376.
New code 81110 is priced at the same rate as code 81376.
New code 81111 is priced at the same rate as code 81376.
New code 81112 is priced at the same rate as code 81376.
New code 81120 is priced at the same rate as code 81275.
New code 81121 is priced at the same rate as code 81311.
New code 81175 is priced at the same rate as code 81317.
New code 81176 is priced at the same rate as code 81218.
New code 81230 is priced at the same rate as code 81227.
New code 81231 is priced at the same rate as code 81227.
New code 81232 is priced at the same rate as code 81227.
New code 81238 is priced at the same rate as code 81321.
New code 81247 is priced at the same rate as code 81227.
New code 81248 is priced at the same rate as code 81215.
New code 81249 is priced at the same rate as code 81321.
New code 81258 is priced at the same rate as code 81215.
New code 81259 is priced at the same rate as code 81321.
New code 81269 is priced at the same rate as code 81294.
New code 81283 is priced at the same rate as code 81241.
New code 81328 is priced at the same rate as code 81227.
New code 81334 is priced at the same rate as code 81272.
New code 81335 is priced at the same rate as code 81227.
New code 81346 is priced at the same rate as code 81227.
New code 81361 is priced at the same rate as code 81227.
New code 81362 is priced at the same rate as code 81215.
New code 81363 is priced at the same rate as code 81294.
New code 81364 is priced at the same rate as code 81235.
New code 81448 is priced at the same rate as code 81435.
New code 81520 is priced at the same rate as code 0008M.
New code 81521 is priced at the same rate as code 81519.
New code 81541 is priced at the same rate as code 81519.
New code 81551 is to be gapfilled.
New code 86008 is priced at the same rate as code 86235.
New code 86794 is priced at the same rate as code 86788.
New code 87634 is priced at the same rate as code 87801.
New code 87662 is priced at the same rate as code 87501.
New code 0001U is to be gapfilled.
New code 0002U is to be gapfilled.
New code 0003U is priced at the same rate as 1.25 times code 0010M.
New code 0005U is priced at the same rate as code 0010M.
New code 0006U is priced at the same rate as code G0483.
New code 0007U is priced at the same rate as code G0480.
New code 0008U is priced at the same rate as code 81445.
New code 0009U is to be gapfilled.
New code 0010U is to be gapfilled.
New code 0011U is priced at the same rate as code G0480.
New code 0012U is to be gapfilled.
New code 0013U is to be gapfilled.
New code 0014U is to be gapfilled.
New code 0016U is priced at the same rate as code 81206.
New code 0017U is priced at the same rate as code 81270.
New code G0499 is priced at the same rate as code 87340 plus 0.05 times code 87341 plus code 86704 plus 0.5 times code 86706.
Reconsidered code 81327 is to be gapfilled.
Existing code 80305 is priced at the same rate as code G0477.
Existing code 80306 is priced at the same rate as code G0478.
Existing code 80307 is priced at the same rate as code G0479.
Existing code 81413 is priced at the same rate as code 81435.
Existing code 81414 is priced at the same rate as code 81436.
Existing code 81422 is priced at the same rate as code 81420.
Existing code 81439 is priced at the same rate as code 81435.
Existing code 81539 is priced at the same rate as code 0010M.
Existing code 84410 is priced at the same rate as code 84402 plus code 84403.
Existing code 87483 is priced at the same rate as code 87633.
Existing code G0475 is priced at the same rate as code 87389.
Existing code G0476 is priced at the same rate as code 87624.
Existing code G0659 is priced at the same rate as code G0479.
Existing code 80410 is priced at the same rate as 3 times code 82308.
Existing code 80418 is priced at the same rate as 4 times code 82024 plus 4 times code 83002 plus 4 times code 83001 plus 4 times code 84146 plus 4 times code 83003 plus 4 times code 82533 plus 4 times code 84443.
Existing code 80435 is priced at the same rate as 5 times code 82947 plus 5 times code 83003.
Existing code 81316 is priced at the same rate as code 81315.
Existing code 81326 is priced at the same rate as code 81322.
Existing code 81425 is to be gapfilled.
Existing code 81426 is to be gapfilled.
Existing code 81427 is to be gapfilled.
Existing code 81434 is priced at the same rate as code 81445.
Existing code 81470 is to be gapfilled.
Existing code 81471 is to be gapfilled.
Existing code 81506 is priced at the same rate as code 82728 plus code 82947 plus code 83036 plus code 83525 plus code 86141 plus code 83520.
Existing code 82286 is priced at the same rate as code 82310.
Existing code 82387 is priced at the same rate as code 82373.
Existing code 82759 is priced at the same rate as code 82963.
Existing code 82979 is priced at the same rate as code 84220.
Existing code 83662 is priced at the same rate as code 83663.
Existing code 83857 is priced at the same rate as code 84165.
Existing code 83987 is priced at the same rate as code 83986.
Existing code 84085 is priced at the same rate as code 84220.
Existing code 84485 is priced at the same rate as code 82977.
Existing code 84577 is priced at the same rate as code 82710.
Existing code 84580 is priced at the same rate as code 82615.
Existing code 85170 is priced at the same rate as 0.8 times code 85175.
Existing code 85337 is priced at the same rate as code 85350.
Existing code 85400 is priced at the same rate as code 85410.
Existing code 85530 is priced at the same rate as code 85520.
Existing code 85637 is priced at the same rate as code 85628.
Existing code 86821 is priced at the same rate as code 86822.
Existing code 86829 is priced at the same rate as code 86828.
Existing code 87152 is priced at the same rate as code 87158.
Existing code 87267 is priced at the same rate as code 87271.
Existing code 87475 is priced at the same rate as code 87480.
Existing code 87485 is priced at the same rate as code 87480.
Existing code 87495 is priced at the same rate as code 87797.
Existing code 87528 is priced at the same rate as code 87480.
Existing code 87537 is priced at the same rate as code 87534.
Existing code 87557 is priced at the same rate as code 87592.
Existing code 87562 is priced at the same rate as code 87592.
Existing code 88130 is priced at the same rate as code 87209.
Existing code 88245 is priced at the same rate as code 88248.
Existing code 88741 is priced at the same rate as code 88740.
Existing code 89329 is priced at the same rate as code 89331.
Existing code 0002M is priced at the same rate as code 0003M.
Existing code 0004M is to be gapfilled.
Existing code 0006M is to be gapfilled.
Existing code 0007M is to be gapfilled.
Existing code 0009M is to be gapfilled.
Existing code G0480 is priced at the same rate as 4 times code 82542 plus 0.75 times code 82542.
Existing code G0481 is priced at the same rate as 4 times code 82542 plus 2.50 times code 82542.
Existing code G0482 is priced at the same rate as 4 times code 82542 plus 4.25 times code 82542.
Existing code G0483 is priced at the same rate as 4 times code 82542 plus 6.25 times code 82542.
Existing code P2028 is priced at the same rate as code 82040.
Existing code P2029 is priced at the same rate as code 82040.
Existing code P2031 is priced at the same rate as code 82040.
Existing code P2033 is priced at the same rate as code 82040.
Existing code P2038 is priced at the same rate as code 82040.
Existing code Q0113 is priced at the same rate as code 87172.
New code 80305QW is priced at the same rate as code 80305.
New code 87633QW is priced at the same rate as code 87633.
New code 87801QW is priced at the same rate as code 87801.
New code G0475QW is priced at the same rate as code G0475.
New code 85025QW is priced at the same rate as code 85025.

The following existing codes are to be deleted:

<table>
<thead>
<tr>
<th>Code</th>
<th>Rate 1</th>
<th>Rate 2</th>
<th>Rate 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>0008M</td>
<td>83499</td>
<td>83992</td>
<td>84061</td>
</tr>
<tr>
<td>86185</td>
<td>86243</td>
<td>86378</td>
<td>86729</td>
</tr>
<tr>
<td>86822</td>
<td>87277</td>
<td>87470</td>
<td>87477</td>
</tr>
<tr>
<td>87515</td>
<td>88154</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Laboratory Costs Subject to Reasonable Charge Payment in CY 2018

For outpatients, the following codes are paid under a reasonable charge basis (See Section 1842(b)(3) of the Act). In accordance with 42 CFR 405.502
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/Downloads/405_502.pdf through 42 CFR 405.508, the
reasonable charge may not exceed the lowest of the actual charge or the customary or prevailing charge for the previous 12-month period ending June 30, updated by the inflation-indexed update. The inflation-indexed update is calculated using the change in the applicable Consumer Price Index for the 12-month period ending June 30 of each year as set forth in 42 CFR 405.509(b)(1). The inflation-indexed update for CY 2018 is 1.60 percent.

Manual instructions for determining the reasonable charge payment are in the “Medicare Claims Processing Manual,” Chapter 23, Section 80 through 80.8 available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf. If there is sufficient charge data for a code, the instructions permit considering charges for other similar services and price lists.

When services described by the Healthcare Common Procedure Coding System (HCPCS) in the following list are performed for independent dialysis facility patients, the “Medicare Claims Processing Manual,” Chapter 8, Section 60.3, available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c08.pdf, instructs that the reasonable charge basis applies. However, when these services are performed for hospital-based renal dialysis facility patients, payment is made on a reasonable cost basis. Also, when these services are performed for hospital outpatients, payment is made under the hospital Outpatient Prospective Payment System (OPPS).

### Blood Products

<table>
<thead>
<tr>
<th>P9010</th>
<th>P9011</th>
<th>P9012</th>
<th>P9016</th>
</tr>
</thead>
<tbody>
<tr>
<td>P9017</td>
<td>P9019</td>
<td>P9020</td>
<td>P9021</td>
</tr>
<tr>
<td>P9022</td>
<td>P9023</td>
<td>P9031</td>
<td>P9032</td>
</tr>
<tr>
<td>P9033</td>
<td>P9034</td>
<td>P9035</td>
<td>P9036</td>
</tr>
<tr>
<td>P9037</td>
<td>P9038</td>
<td>P9039</td>
<td>P9040</td>
</tr>
<tr>
<td>P9044</td>
<td>P9050</td>
<td>P9051</td>
<td>P9052</td>
</tr>
<tr>
<td>P9053</td>
<td>P9054</td>
<td>P9055</td>
<td>P9056</td>
</tr>
<tr>
<td>P9057</td>
<td>P9058</td>
<td>P9059</td>
<td>P9060</td>
</tr>
<tr>
<td>P9070</td>
<td>P9071</td>
<td>P9073</td>
<td>P9100</td>
</tr>
</tbody>
</table>

Also, payment for the following codes may be applied to the blood deductible as instructed in the “Medicare General Information, Eligibility and Entitlement Manual,” Chapter 3, Section 20.5 through 20.5.4, available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS050111.html.

<table>
<thead>
<tr>
<th>P9010</th>
<th>P9016</th>
<th>P9021</th>
<th>P9022</th>
</tr>
</thead>
<tbody>
<tr>
<td>P9038</td>
<td>P9039</td>
<td>P9040</td>
<td>P9051</td>
</tr>
<tr>
<td>P9054</td>
<td>P9056</td>
<td>P9057</td>
<td>P9058</td>
</tr>
</tbody>
</table>

**NOTE:** Biologic products not paid on a cost or prospective payment basis but are paid based on Section 1842(o) of the Act. The payment limits based on Section 1842(o), including the payment limits for codes P9041, P9045, P9046, and P9047, should be obtained from the Medicare Part B drug pricing files.
Your MAC will not search their files to either retract payment or retroactively pay claims, however, 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/).
Calendar Year (CY) 2018 Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule

MLN Matters Number: MM10395 Related Change Request (CR) Number: 10395
Related CR Release Date: December 1, 2017 Effective Date: January 1, 2018
Related CR Transmittal Number: R3931CP Implementation Date: January 2, 2018

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 10395 provides the Calendar Year (CY) 2018 annual update for the Medicare DMEPOS fee schedule. The instructions include information on the data files, update factors and other information related to the update of the fee schedule. Make sure your billing staffs are aware of these updates.

BACKGROUND

Section 1834(a), (h), and (i) of the Social Security Act (the Act) requires payment on a fee schedule for certain DMEPOS. Also, payment on a fee-schedule basis is a regulatory requirement at 42 CFR Section 414.102 for Parenteral and Enteral Nutrition (PEN), splints, casts, and Intraocular Lenses (IOLs) inserted in a physician’s office.

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 amounts for enteral nutrients, equipment, and supplies (enteral nutrition) based on information from CBPs. Regulations at 42 CFR Section 414.210(g) established the methodologies for adjusting DMEPOS fee schedule amounts using information from CBPs. Recent program instructions on

The DMEPOS and Parenteral and Enteral Nutrition (PEN) fee schedule files contain HCPCS codes that are subject to the adjusted fee schedule amounts as well as codes that are not subject to the fee schedule CBP adjustments. Fee schedule amounts that are adjusted using information from CBPs will not be subject to the annual DMEPOS covered item update, but will be updated pursuant to 42 CFR Section 414.210(g)(8) when information from the CBPs is updated.

Pursuant to 42 CFR Section 414.210(g)(4), for items where the Single Payment Amounts (SPAs) from CBPs no longer in effect are used to adjust fee schedule amounts, the SPAs are increased by the percentage changes in the Consumer Price Index for all Urban Consumers (CPI-U) from the last year of the applicable CBP to the current year. Information on the update factor for CY 2018 is included below.

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 (MSAs) are not included in the DMEPOS Rural ZIP code file. The DMEPOS Rural ZIP code file is updated on a quarterly basis, as necessary. Regulations at 42 CFR 414.202 define a rural area to be a geographical area represented by a postal ZIP code where at least 50 percent of the total geographical area of the ZIP code is estimated to be outside any MSA. A rural area also included any ZIP code within an MSA that is excluded from a competitive bidding area established for that MSA.

The DMEPOS fee schedule file contains fee schedule amounts for non-rural and rural areas. Also, the PEN fee schedule file includes state fee schedule amounts for enteral nutrition items and national fee schedule amounts for parenteral nutrition items.

The DMEPOS and PEN fee schedules and the rural zip code Public Use Files (PUFs) will be available for State Medicaid Agencies, managed care organizations, and other interested parties at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched.

New Codes Added

New DMEPOS codes added to the HCPCS file, effective January 1, 2018, where applicable, are:

- E0953 and E0954 in the Inexpensive/Routinely Purchased (IN) payment category
- L3761, L7700, L8625, L8694, and Q0477, which are all in the Prosthetics and Orthotics (PO) payment category.
For gap-filling pricing purposes, deflation factors are applied before updating to the current year. The deflation factors for 2017 by the payment category are:

- 0.447 for Oxygen
- 0.450 for Capped Rental
- 0.451 for Prosthetics and Orthotics
- 0.572 for Surgical Dressings
- 0.623 for Parental and Enteral Nutrition
- 0.953 for Splints and Casts
- 0.937 for Intraocular Lenses

**Codes Deleted**

No HCPCS codes will be deleted from the DMEPOS fee schedule files effective January 1, 2018.

**Specific Coding and Pricing Issues**

Effective January 1, 2018, new Off-The-Shelf orthotic (OTS) code L3761 - Elbow Orthosis (EO), with adjustable position locking joint(s) prefabricated off-the-shelf - is included in the fee schedule file. Code L3760 was split into two codes: The existing code revised, effective January 1, 2018, to only describe devices customized to fit a specific patient by an individual with expertise, and a new code describing OTS items (L3761).

The fee schedule amount for existing code L3760 will be applied to new code L3761 effective January 1, 2018. The cross-walking of fee schedule amounts for a single code that is split into two codes for distinct complete items is in accordance with the instructions stated in Chapter 3, Section 60.3.1 of the “Medicare Claims Processing Manual.” An update will be made to the list of orthotic codes that are designated as OTS at [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/OTS_Orthotics.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/OTS_Orthotics.html) to reflect added code L3761.

As part of this update, a corrected calculation is applied to the adjusted fee schedule amounts for codes A4619, E0147, and E0580. The fee schedule adjustment methodology at 42 CFR 414.210(g) was incorrectly applied to these codes, and therefore corrections to the adjusted fee schedule amounts for these codes have been made.

Effective January 1, 2018, the replacement external sound processor (HCPCS code L8691) is split into two codes in order to appropriately identify devices where the actuator is a separate component from the sound processor, microphones, and battery. The two codes are a revised L8691 and a new L8694 transducer/actuator code.

Effective January 1, 2018, the existing fee schedules for L8691 are revised to remove payment for the separate transducer/actuator component. Suppliers billing for replacement sound processors that do not separate the sound processor and the actuator should use both L8691 and L8694 to describe the replaced items. Suppliers billing for replacement sound processors that separate the sound processor and the actuator components should use either or both L8691 and L8694 as appropriate to describe the sound processor component(s).
The replacement Ventricular Assist Device (VAD) power module code Q0479 is split in order to separately identify the patient cable. Effective January 1, 2018, HCPCS code Q0477 identifies a replacement patient cable. Thus, the fees for Q0479 are revised to reflect the establishment of the new patient cable code.

The Centers for Medicare & Medicaid Services (CMS) is also adjusting the fee schedule amounts for shoe modification codes A5503 through A5507 in order to reflect more current allowed service data. Section 1833(o)(2)(C) of the Act required that the payment amounts for shoe modification codes A5503 through A5507 be established in a manner that prevented a net increase in expenditures when substituting these items for therapeutic shoe insert codes (A5512 or A5513). To establish the fee schedule amounts for the shoe modification codes, the base fees for codes A5512 and A5513 were weighted based on the approximated total allowed services for each code for items furnished during the second quarter of calendar year 2004.

For 2018, CMS is updating the weighted average insert fees used to establish the fee schedule amounts for the shoe modification codes with more current allowed service data for each insert code. The base fees for A5512 and A5513 will be weighted based on the approximated total allowed services for each code for items furnished during the calendar year 2016. The fee schedule amounts for shoe modification codes A5503 through A5507 are being revised to reflect this change, effective January 1, 2018.

As part of this file update, the jurisdiction for HCPCS code E0781 is revised from ‘J’ to ‘D’.

HCPCS code Q0477 (Power Module Patient Cable for Use with Electric or Electric/Pneumatic Ventricular Assist Device, Replacement Only) is being added to the HCPCS file, effective January 1, 2018, to describe a replacement accessory for Ventricular Assist Devices (VADs). Similar to the other VAD supplies and accessories coded at Q0478 thru Q0495, Q0497-Q0502, and Q0504 thru Q0509, CMS has determined the reasonable useful lifetime for code Q0477 to be one year. Therefore, CMS will deny claims for Q0477 before the lifetime of these items has expired. Suppliers and providers will need to add modifier RA to claims for code Q0477 in cases where the battery is being replaced because it was lost, stolen, or irreparably damaged.

Fees for the ‘KU’ modifier when billed with wheelchair codes E0953 and E0954 are included in the January 2018 file for billing when these items are furnished in connection with Group 3 complex rehabilitative power wheelchairs.

**Diabetic Testing Supplies**

The fee schedule amounts for non-mail order Diabetic Testing Supplies (DTS) (without KL modifier) for codes A4233, A4234, A4235, A4236, A4253, A4256, A4258, and A4259 are not updated by the annual covered item update. In accordance with Section 636(a) of the American Taxpayer Relief Act of 2012, the fee schedule amounts for these codes were adjusted in CY 2013 so that they are equal to the Single Payment Amounts (SPAs) for mail order DTS established in implementing the national mail order CBP under Section 1847 of the Act. The National Mail-Order Recompete DTS SPAs are available at https://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home.
The non-mail order DTS amounts on the fee schedule file will be updated each time the SPAs are updated. This can happen no less often than every time the mail order CBP contracts are recompeted. The CBP for mail order diabetic supplies is effective July 1, 2016, to December 31, 2018. The program instructions reviewing these changes are included in Transmittal 2709, Change Request (CR) 8325, dated May 17, 2013, and Transmittal 2661, CR8204, dated February 22, 2013. You can review related article MM8325 at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8325.pdf and MM8204 at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8204.pdf.

2018 Fee Schedule Update Factor of 1.1 Percent

For CY 2018, an update factor of 1.1 percent is applied to certain DMEPOS fee schedule amounts. In accordance with the statutory Sections 1834(a)(14) of the Act, certain DMEPOS fee schedule amounts are updated for 2018 by the percentage increase in the CPI- U for the 12-month period ending June 30, 2017, adjusted by the change in the economy-wide productivity equal to the 10-year moving average of changes in annual economy-wide private non-farm business Multi-Factor Productivity (MFP). The MFP adjustment is 0.5 percent and the CPI-U percentage increase is 1.6 percent. Thus, the 1.6 percentage increase in the CPI-U is reduced by the 0.5 percentage increase in the MFP resulting in a net increase of 1.1 percent for the update factor.

2018 Update to the Labor Payment Rates

The CY 2018 allowed payment amounts for HCPCS labor payment codes K0739, L4205, and L7520 are in the table below. Since the percentage increase in the CPI- U for the 12-month period ending with June 30, 2017, is 1.6 percent, this change is applied to the 2017 labor payment amounts to update the rates for CY 2018.

<table>
<thead>
<tr>
<th>STATE</th>
<th>K0739</th>
<th>L4205</th>
<th>L7520</th>
<th>STATE</th>
<th>K0739</th>
<th>L4205</th>
<th>L7520</th>
</tr>
</thead>
<tbody>
<tr>
<td>AK</td>
<td>$28.74</td>
<td>$32.75</td>
<td>$38.53</td>
<td>NC</td>
<td>$15.26</td>
<td>$22.74</td>
<td>$30.87</td>
</tr>
<tr>
<td>AL</td>
<td>$15.26</td>
<td>$22.74</td>
<td>$30.87</td>
<td>ND</td>
<td>$19.02</td>
<td>$32.67</td>
<td>$38.53</td>
</tr>
<tr>
<td>AR</td>
<td>$15.26</td>
<td>$22.74</td>
<td>$30.87</td>
<td>NE</td>
<td>$15.26</td>
<td>$22.71</td>
<td>$43.04</td>
</tr>
<tr>
<td>AZ</td>
<td>$18.87</td>
<td>$22.71</td>
<td>$37.98</td>
<td>NH</td>
<td>$16.39</td>
<td>$22.71</td>
<td>$30.87</td>
</tr>
<tr>
<td>CA</td>
<td>$23.41</td>
<td>$37.33</td>
<td>$43.49</td>
<td>NJ</td>
<td>$20.58</td>
<td>$22.71</td>
<td>$30.87</td>
</tr>
<tr>
<td>CO</td>
<td>$15.26</td>
<td>$22.74</td>
<td>$30.87</td>
<td>NM</td>
<td>$15.26</td>
<td>$22.74</td>
<td>$30.87</td>
</tr>
<tr>
<td>CT</td>
<td>$25.48</td>
<td>$23.25</td>
<td>$30.87</td>
<td>NV</td>
<td>$24.31</td>
<td>$22.71</td>
<td>$42.07</td>
</tr>
<tr>
<td>DC</td>
<td>$15.26</td>
<td>$22.71</td>
<td>$30.87</td>
<td>NY</td>
<td>$28.09</td>
<td>$22.74</td>
<td>$30.87</td>
</tr>
<tr>
<td>DE</td>
<td>$28.09</td>
<td>$22.71</td>
<td>$30.87</td>
<td>OH</td>
<td>$15.26</td>
<td>$22.71</td>
<td>$30.87</td>
</tr>
</tbody>
</table>
### 2018 National Monthly Fee Schedule Amounts for Stationary Oxygen Equipment

CMS is implementing the 2017 monthly fee schedule payment amounts for stationary oxygen equipment (HCPCS codes E0424, E0439, E1390, and E1391), effective for claims with dates of service from January 1, 2018, through December 31, 2018. As required by statute, the addition of the separate payment classes for Oxygen Generating Portable Equipment (OGPE) and stationary and portable oxygen contents must be annually budget neutral. Medicare expenditures must account for these separate oxygen payment classes.

Therefore, the fee schedule amounts for stationary oxygen equipment are reduced by a certain percentage each year to balance the increase in payments made for the additional separate oxygen payment classes. For dates of service January 1, 2018, through December 31, 2018, the monthly fee schedule payment amounts for stationary oxygen equipment range from approximately $66 to $76 incorporating the budget neutrality adjustment factor.

When updating the stationary oxygen equipment amounts, corresponding updates are made to

<table>
<thead>
<tr>
<th>STATE</th>
<th>K0739</th>
<th>L4205</th>
<th>L7520</th>
<th>STATE</th>
<th>K0739</th>
<th>L4205</th>
<th>L7520</th>
</tr>
</thead>
<tbody>
<tr>
<td>FL</td>
<td>$15.26</td>
<td>$22.74</td>
<td>$30.87</td>
<td>OK</td>
<td>$15.26</td>
<td>$22.74</td>
<td>$30.87</td>
</tr>
<tr>
<td>GA</td>
<td>$15.26</td>
<td>$22.74</td>
<td>$30.87</td>
<td>OR</td>
<td>$15.26</td>
<td>$22.71</td>
<td>$44.38</td>
</tr>
<tr>
<td>HI</td>
<td>$18.87</td>
<td>$32.75</td>
<td>$38.53</td>
<td>PA</td>
<td>$16.39</td>
<td>$23.39</td>
<td>$30.87</td>
</tr>
<tr>
<td>IA</td>
<td>$15.26</td>
<td>$22.71</td>
<td>$36.95</td>
<td>PR</td>
<td>$15.26</td>
<td>$22.74</td>
<td>$30.87</td>
</tr>
<tr>
<td>ID</td>
<td>$15.26</td>
<td>$22.71</td>
<td>$30.87</td>
<td>RI</td>
<td>$18.19</td>
<td>$23.41</td>
<td>$30.87</td>
</tr>
<tr>
<td>IL</td>
<td>$15.26</td>
<td>$22.71</td>
<td>$30.87</td>
<td>SC</td>
<td>$15.26</td>
<td>$22.74</td>
<td>$30.87</td>
</tr>
<tr>
<td>IN</td>
<td>$15.26</td>
<td>$22.71</td>
<td>$30.87</td>
<td>SD</td>
<td>$17.06</td>
<td>$22.71</td>
<td>$41.27</td>
</tr>
<tr>
<td>KS</td>
<td>$15.26</td>
<td>$22.71</td>
<td>$38.53</td>
<td>TN</td>
<td>$15.26</td>
<td>$22.74</td>
<td>$30.87</td>
</tr>
<tr>
<td>KY</td>
<td>$15.26</td>
<td>$29.11</td>
<td>$39.47</td>
<td>TX</td>
<td>$15.26</td>
<td>$22.74</td>
<td>$30.87</td>
</tr>
<tr>
<td>LA</td>
<td>$15.26</td>
<td>$22.71</td>
<td>$30.87</td>
<td>UT</td>
<td>$15.30</td>
<td>$22.71</td>
<td>$48.07</td>
</tr>
<tr>
<td>MA</td>
<td>$25.48</td>
<td>$22.71</td>
<td>$30.87</td>
<td>VA</td>
<td>$15.26</td>
<td>$22.71</td>
<td>$30.87</td>
</tr>
<tr>
<td>MD</td>
<td>$15.26</td>
<td>$22.71</td>
<td>$30.87</td>
<td>VI</td>
<td>$15.26</td>
<td>$22.74</td>
<td>$30.87</td>
</tr>
<tr>
<td>ME</td>
<td>$25.48</td>
<td>$22.71</td>
<td>$30.87</td>
<td>VT</td>
<td>$16.39</td>
<td>$22.71</td>
<td>$30.87</td>
</tr>
<tr>
<td>MI</td>
<td>$15.26</td>
<td>$22.71</td>
<td>$30.87</td>
<td>WA</td>
<td>$24.31</td>
<td>$33.31</td>
<td>$39.58</td>
</tr>
<tr>
<td>MN</td>
<td>$15.26</td>
<td>$22.71</td>
<td>$30.87</td>
<td>WI</td>
<td>$15.26</td>
<td>$22.71</td>
<td>$30.87</td>
</tr>
<tr>
<td>MO</td>
<td>$15.26</td>
<td>$22.71</td>
<td>$30.87</td>
<td>WV</td>
<td>$15.26</td>
<td>$22.71</td>
<td>$30.87</td>
</tr>
<tr>
<td>MS</td>
<td>$15.26</td>
<td>$22.74</td>
<td>$30.87</td>
<td>WY</td>
<td>$21.28</td>
<td>$30.31</td>
<td>$43.04</td>
</tr>
<tr>
<td>MT</td>
<td>$15.26</td>
<td>$22.71</td>
<td>$38.53</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
the fee schedule amounts for HCPCS codes E1405 and E1406 for oxygen and water vapor enriching systems. Since 1989, the payment amounts for codes E1405 and E1406 have been established based on a combination of the Medicare payment amounts for stationary oxygen equipment and nebulizer codes E0585 and E0570, respectively.

2018 Maintenance and Servicing Payment Amount for Certain Oxygen Equipment

CMS is also updating for 2018 the payment amount for maintenance and servicing for certain oxygen equipment. Payment for claims for maintenance and servicing of oxygen equipment was instructed in Transmittal 635, CR6792, dated February 5, 2010, and Transmittal 717, CR6990, dated June 8, 2010. (You can review related articles MM6792 at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6792.pdf and MM6990 at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6990.pdf.) To summarize, payment for maintenance and servicing of certain oxygen equipment can occur every 6 months beginning 6 months after the end of the 36th month of continuous use or end of the supplier’s or manufacturer’s warranty, whichever is later for either HCPCS code E1390, E1391, E0433, or K0738, billed with the “MS” modifier. Payment cannot occur more than once per beneficiary, regardless of the combination of oxygen concentrator equipment and/or transfilling equipment used by the beneficiary, for any 6-month period.

Per 42 CFR 414.210(e)(5)(iii), the 2010 maintenance and servicing fee for certain oxygen equipment was based on 10 percent of the average price of an oxygen concentrator. For CY 2011 and subsequent years, the maintenance and servicing fee is adjusted by the covered item update for DME as set forth in §1834(a)(14) of the Act. Thus, the 2017 maintenance and servicing fee is adjusted by the 1.1 percent MFP-adjusted covered item update factor to yield a CY 2018 maintenance and servicing fee of $70.74 for oxygen concentrators and transfilling equipment.

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>January 5, 2018</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>

**Disclaimer:** This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only Copyright 2016 American Medical Association. All rights reserved.

Copyright © 2017, the American Hospital Association, Chicago, Illinois. Reproduced with permission. No portion of the AHA copyrighted materials contained within this publication may be copied without the express written consent of the AHA. AHA copyrighted materials including the UB-04 codes and descriptions may not be removed, copied, or utilized within any software, product, service, solution or derivative work without the written consent of the AHA. If an entity wishes to utilize any AHA materials, please contact the AHA at 312-893-6816. Making copies or utilizing the content of the UB-04 Manual, including the codes and/or descriptions, for internal purposes, resale and/or to be used in any product or publication; creating any modified or derivative work of the UB-04 Manual and/or codes and descriptions; and/or making any commercial use of UB-04 Manual or any portion thereof, including the codes and/or descriptions, is only authorized with an express license from the American Hospital Association. To license the electronic data file of UB-04 Data Specifications, contact Tim Carlson at (312) 893-6816 or Laryssa Marshall at (312) 893-6814. You may also contact us at [ub04@healthforum.com](mailto:ub04@healthforum.com)

The American Hospital Association (the “AHA”) has not reviewed, and is not responsible for, the completeness or accuracy of any information contained in this material, nor was the AHA or any of its affiliates, involved in the preparation of this material, or the analysis of information provided in the material. The views and/or positions presented in the material do not necessarily represent the views of the AHA. CMS and its products and services are not endorsed by the AHA or any of its affiliates.
Clinical Laboratory Fee Schedule – Medicare Travel Allowance
Fees for Collection of Specimens

MLN Matters Number: MM10448
Related Change Request (CR) Number: 10448
Related CR Release Date: December 22, 2017
Effective Date: January 1, 2018
Related CR Transmittal Number: R3942CP
Implementation Date: January 22, 2018

PROVIDER TYPES AFFECTED

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

WHAT YOU NEED TO KNOW

Change Request (CR) 10448 revises the payment of travel allowances when billed on a per mileage basis using Health Care Common Procedure Coding System (HCPCS) code P9603 and when billed on a flat-rate basis using HCPCS code P9604 for Calendar Year (CY) 2018. Make sure your billing staff is aware of these changes.

BACKGROUND

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

The travel codes allow for payment either on a per mileage basis for code P9603 or on a flat rate per trip basis for P9604. Payment of the travel allowance is made only if a specimen collection fee is also payable. The travel allowance is intended to cover the estimated travel costs of collecting a specimen including the laboratory technician’s salary and travel expenses. Your MAC has the discretion to choose either a mileage basis or a flat rate, and how to set each type of allowance. Many MACs established local policy to pay based on a flat rate basis only.

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

The per mile travel allowance (P9603) is to be used in situations where the average trip to the patients’ homes is longer than 20 miles round trip, and is to be prorated in situations where specimens are drawn from non-Medicare patients in the same trip.
The allowance per mile was computed using the Federal mileage rate of $0.545 per mile plus an additional $0.45 per mile to cover the technician’s time and travel costs. MACs have the option of establishing a higher per mile rate in excess of the minimum $1.00 per mile if local conditions warrant it. The minimum mileage rate will be reviewed and updated throughout the year, as well as in conjunction with the CLFS, as needed. At no time will the laboratory be allowed to bill for more miles than are reasonable, or for miles that are not actually traveled by the laboratory technician.

The per flat-rate trip basis travel allowance (P9604) for CY2018 is $10.00.

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>January 2, 2018</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>

Disclaimer: This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2016 American Medical Association. All rights reserved.

Copyright © 2017, the American Hospital Association, Chicago, Illinois. Reproduced with permission. No portion of the AHA copyrighted materials contained within this publication may be copied without the express written consent of the AHA. AHA copyrighted materials including the UB-04 codes and descriptions may not be removed, copied, or utilized within any software, product, service, solution or derivative work without the written consent of the AHA. If an entity wishes to utilize any AHA materials, please contact the AHA at 312-893-6816. Making copies or utilizing the content of the UB-04 Manual, including the codes and/or descriptions, for internal purposes, resale and/or to be used in any product or publication; creating any modified or derivative work of the UB-04 Manual and/or codes and descriptions; and/or making any commercial use of UB-04 Manual or any portion thereof, including the codes and/or descriptions, is only authorized with an express license from the American Hospital Association. To license the electronic data file of UB-04 Data Specifications, contact Tim Carlson at (312) 893-6816 or Laryssa Marshall at (312) 893-6814. You may also contact us at ub04@healthforum.com

The American Hospital Association (the “AHA”) has not reviewed, and is not responsible for, the completeness or accuracy of any information contained in this material, nor was the AHA or any of its affiliates, involved in the preparation of this material, or the analysis of information provided in the material. The views and/or positions presented in the material do not necessarily represent the views of the AHA. CMS and its products and services are not endorsed by the AHA or any of its affiliates.
Correction to Prevent Payment on Inpatient Information Only Claims for Beneficiaries Enrolled in Medicare Advantage Plans

MLN Matters Number: MM10238 Revised  
Related CR Release Date: December 22, 2017  
Related CR Transmittal Number: R3943CP

Related Change Request (CR) Number: 10238  
Effective Date: April 1, 2015  
Implementation Date: April 2, 2018

Note: This article was revised on December 22, 2017, to reflect a revised CR10238 issued on December 22. In the article, a reference to a discharge date in the last paragraph of the Background section is changed to say admission/from date. Also, the CR release date, transmittal number, and the Web address of the CR are revised. All other information remains the same.

PROVIDER TYPES AFFECTED

This MLN Matters Article is intended for hospitals billing Medicare Administrative Contractors (MACs) for inpatient services provided to Medicare beneficiaries enrolled in a Medicare Advantage (MA) plan.

WHAT YOU NEED TO KNOW

Change Request (CR) 10238 instructs MACs to allow the Common Working File (CWF) to set edit 5233 on inpatient information only claims billed with condition codes 04 and 30 for Investigational Device Exemption (IDE) Studies and Clinical Studies Approved Under Coverage with Evidence Development (CED), which will in turn allow the Fiscal Intermediary Standard System (FISS) to zero out payment. CR 10238 contains no new policy. It improves the implementation of existing Medicare payment policies.

BACKGROUND

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, (Public Law: 99-272), provides for an additional payment to an urban hospital of 100 or more beds that serves a disproportionate share of low-income patients. Part of the calculation used to determine whether or not a hospital is eligible for Medicare Disproportionate Share Hospital (DSH) add-on payments is based on the percentage of days for which the beneficiary was entitled to Medicare Part A and received Supplemental Security Income (SSI) payments from the Social Security

Page 1 of 3
Administration (SSA).

The Centers for Medicare & Medicaid Services (CMS) uses claims data to calculate a hospital’s percentage of total Medicare days for which Medicare beneficiaries were simultaneously entitled to both SSI and Medicare. In order for MA enrolled inpatient days to be included in this Medicare/SSI fraction, the hospital must submit an informational only bill (Type of Bill (TOB) 11X) which includes Condition Code 04 to their MAC.

CMS was notified that a CWF edit that is required to prevent payment on information only claims for MA beneficiaries for IDE studies and Clinical Studies Approved Under CED, which should be paid by the Medicare Advantage Plan, is bypassed for claims billed with condition code (CC) 30, thereby causing a Medicare Fee-for-Service (FFS) payment in error.

To correct prior claims, hospitals should note that their MAC will reprocess inpatient information only claims with a payment greater than $0, condition codes 04 and 30, one of the approved IDE or CED study numbers listed in the spreadsheet attachment to CR 10238 and an admission/from date on or after April 1, 2015, and before March 31, 2018, within 90 days of the implementation date of CR 10238.

**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>December 22, 2017</td>
<td>The article was revised to reflect a revised CR10238 issued on December 22. In the article, a reference to a discharge date in the last paragraph of the Background section is changed to say admission/from date. Also, the CR release date, transmittal number, and the Web address of the CR are revised. All other information remains the same.</td>
</tr>
<tr>
<td>October 27, 2017</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>

Disclaimer: This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright
Global Surgical Days for Critical Access Hospital (CAH) Method II

MLN Matters Number: MM10425  
Related Change Request (CR) Number: 10425

Related CR Release Date: January 26, 2018  
Effective Date: July 1, 2018

Related CR Transmittal Number: R2013OTN  
Implementation Date: July 2, 2018

PROVIDER TYPE AFFECTED

This MLN Matters® Article is intended for Critical Access Hospital (CAH) Method II providers submitting claims to A/B Medicare Administrative Contractors (A/B MACs) for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

This article is based on Change Request (CR) 10425 which discusses the global surgical days for Method II Critical Access Hospital (CAH) providers. CR 10425 contains no new policy. It improves the implementation of existing Medicare payment policies. Make sure that your billing staffs are aware of these changes.

BACKGROUND

CR10425 is for the global surgical periods for Critical Access Hospital (CAH) Method II providers to mirror the logic historically applied to physicians and non-physician practitioners that bill their own services to Medicare’s Multi-Carrier System (MCS).

Physicians and non-physician practitioners billing on Type of Bill (TOB) 85X for professional services rendered in a Method II CAH have the option of reassigning their billing rights to the CAH. When the billing rights are reassigned to the Method II CAH, payment is made to the CAH for professional services (using revenue codes 96X, 97X, or 98X) based on the Medicare Physician Fee Schedule (MPFS) supplemental file.

The global surgical package, also called global surgery, includes all necessary services normally furnished by a surgeon before, during, and after a procedure. Medicare payment for the surgical procedure includes the pre-operative, intra-operative, and post-operative services routinely performed by the surgeon or by members of the same group with the same specialty.
Position 13-15 of the MPFS Data Base provides the postoperative periods that apply to each surgical procedure.

The payment rules for surgical procedures apply to codes with entries of 000, 010, 090, and, sometimes, YYY, and are defined below. This field provides the postoperative time frames that apply to payment for each surgical procedure or another indicator that describes the applicability of the global concept to the service.

- **000** = Endoscopic or minor procedure with related preoperative and postoperative relative values on the day of the procedure only included in the fee schedule payment amount; evaluation and management services on the day of the procedure generally not payable.

- **010** = Minor procedure with preoperative relative values on the day of the procedure and postoperative relative values during a 10-day postoperative period included in the fee schedule amount; evaluation and management services on the day of the procedure and during this 10-day postoperative period generally not payable.

- **090** = Major surgery with a (one) 1-day preoperative period and 90-day postoperative period included in the fee schedule payment amount.

- **XXX** = Global concept does not apply.

- **YYY** = A/B MAC (Part A) determines whether global concept applies and establishes postoperative period, if appropriate, at time of pricing.

Codes with "YYY" are A/B MAC (Part B)-priced codes, for which A/B MACs (Part B) determine the global period (the global period for these codes will be 0, 10, or 90 days). Note that not all A/B MAC (Part B)-priced codes have a "YYY" global surgical indicator; sometimes the global period is specified.

CAH Method II providers should follow the same guidelines as per Part B physician services that are available in the Medicare Claims Processing Manual (Pub. 100-04, Chapter 12; (Physicians/Nonphysician Practitioners), Section 40 (Surgeons and Global Surgery)).

Note that Medicare will reject line items that contain an E/M CPT code (92012, 92014, 99211-99215, 99217-99223, 99231-99236, 99238, 99239, 99241-99245, 99251-99255, 99261-99263, 99271-99275, 99291, 99292, 99301-99303, 99311-99313, 99315, 99316, 99331-99333, 99347-99350, 99374, 99375, 99377, and 99378) that is covered by the global period using the following remittance codes:

- Group code of CO - Contractual Obligation
- Claim Adjustment Reason Code 97 – Payment is included in the allowance for another service/procedure
• Remittance Advice Remark Code M144 – Pre-/post-operative care payment is included in the allowance for the surgery/procedure.

MACs, however, will allow E/M services rendered during the global period when submitted with modifier 24 or 25, as appropriate.

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>January 26, 2018</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>

Disclaimer This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2016 American Medical Association. All rights reserved.

Copyright © 2017, the American Hospital Association, Chicago, Illinois. Reproduced with permission. No portion of the AHA copyrighted materials contained within this publication may be copied without the express written consent of the AHA. AHA copyrighted materials including the UB-04 codes and descriptions may not be removed, copied, or utilized within any software, product, service, solution or derivative work without the written consent of the AHA. If an entity wishes to utilize any AHA materials, please contact the AHA at 312-893-6816. Making copies or utilizing the content of the UB-04 Manual, including the codes and/or descriptions, for internal purposes, resale and/or to be used in any product or publication; creating any modified or derivative work of the UB-04 Manual and/or codes and descriptions; and/or making any commercial use of UB-04 Manual or any portion thereof, including the codes and/or descriptions, is only authorized with an express license from the American Hospital Association. To license the electronic data file of UB-04 Data Specifications, contact Tim Carlson at (312) 893-6816 or Laryssa Marshall at (312) 893-6814. You may also contact us at ub04@healthforum.com

The American Hospital Association (the “AHA”) has not reviewed, and is not responsible for, the completeness or accuracy of any information contained in this material, nor was the AHA or any of its affiliates, involved in the preparation of this material, or the analysis of information provided in the material. The views and/or positions presented in the material do not necessarily represent the views of the AHA. CMS and its products and services are not endorsed by the AHA or any of its affiliates.
Off-Cycle Update to the Skilled Nursing Facility (SNF) Prospective Payment System (PPS) Fiscal Year (FY) 2018 Pricer

MLN Matters Number: MM10377
Related Change Request (CR) Number: 10377
Related CR Release Date: November 22, 2017
Effective Date: October 1, 2017
Related CR Transmittal Number: R3928CP
Implementation Date: January 2, 2018

PROVIDER TYPES AFFECTED

This MLN Matters® Article is intended for freestanding Skilled Nursing Facilities (SNFs), SNFs affiliated with acute care facilities, and all non-Critical Access Hospital (CAH) swing-bed rural hospitals submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

Change Request (CR) 10377 adds logic into the Skilled Nursing Facility (SNF) Prospective Payment System (PPS) Pricer to apply the Quality Reporting Program (QRP) payment reduction for Fiscal Year (FY) 2018 for those facilities that do submit require quality data. Please make sure your billing staffs are aware of this update.

BACKGROUND

Section 1888(e)(6)(B)(i)(II) of the Social Security Act (the Act) requires that each SNF submit, for FYs beginning on or after the specified application date (as defined in Section 1899B(a)(2)(E) of the Act), data on quality measures specified under Section 1899B(c)(1) of the Act and data on resource use and other measures specified under Section 1899B(d)(1) of the Act in a manner and within the time frames specified by the Secretary.

The SNF QRP applies to freestanding SNFs, SNFs affiliated with acute care facilities, and all non-Critical Access Hospital (CAH) swing-bed rural hospitals.

Beginning with FY 2018 and in each subsequent year, if an SNF does not submit required quality data; their payment rates for the year are reduced by 2 (two) percentage points for that FY. Application of the 2-percent reduction may result in an update that is less than 0.0 for an FY and in payment rates for an FY being less than such payment rates for the preceding FY. In
addition, reporting-based reductions to the market basket increase factor will not be cumulative; rather they will only apply for the FY involved.

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>November 22, 2017</td>
<td>Initial article released</td>
</tr>
</tbody>
</table>

Disclaimer: This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2016 American Medical Association. All rights reserved.
Quarterly Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment

MLN Matters Number: MM10445 Related Change Request (CR) Number: CR10445
Related CR Release Date: February 8, 2018 Effective Date: January 1, 2018, for new HCPCS codes, otherwise April 1, 2018
Related CR Transmittal Number: R3973CP Implementation Date: April 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) 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 Desciptor, 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 GENE 1/1/18 5
• 0033U HTR2A (5-hydroxytryptamine receptor 2A), HTR2C (5-hydroxytryptamine receptor 2C) (eg, citalopram metabolism) gene analysis, common variants (ie, 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.

The following new codes are effective April 1, 2018:
New code 0001UQW is priced at the same rate as code 0001U.
New code 0002UQW is priced at the same rate as code 0002U.
New code 0003UQW is priced at the same rate as code 0003U.
New code 0005UQW is priced at the same rate as code 0005U.
New code 0006UQW is priced at the same rate as code 0006U.
New code 0007UQW is priced at the same rate as code 0007U.
New code 0008UQW is priced at the same rate as code 0008U.
New code 0009UQW is priced at the same rate as code 0009U.
New code 0010UQW is priced at the same rate as code 0010U.
New code 0011UQW is priced at the same rate as code 0011U.
New code 0012UQW is priced at the same rate as code 0012U.
New code 0013UQW is priced at the same rate as code 0013U.
New code 0014UQW is priced at the same rate as code 0014U.
New code 0016UQW is priced at the same rate as code 0016U.
New code 0017UQW is priced at the same rate as code 0017U.
New code 81105QW is priced at the same rate as code 81105.
New code 81106QW is priced at the same rate as code 81106.
New code 81107QW is priced at the same rate as code 81107.
New code 81108QW is priced at the same rate as code 81108.
New code 81109QW is priced at the same rate as code 81109.
New code 81110QW is priced at the same rate as code 81110.
New code 81111QW is priced at the same rate as code 81111.
New code 81112QW is priced at the same rate as code 81112.
New code 81120QW is priced at the same rate as code 81120.
New code 81121QW is priced at the same rate as code 81121.
New code 81175QW is priced at the same rate as code 81175.
New code 81176QW is priced at the same rate as code 81176.
New code 81230QW is priced at the same rate as code 81230.
New code 81231QW is priced at the same rate as code 81231.
New code 81232QW is priced at the same rate as code 81232.
New code 81238QW is priced at the same rate as code 81238.
New code 81247QW is priced at the same rate as code 81247.
New code 81248QW is priced at the same rate as code 81248.
New code 81249QW is priced at the same rate as code 81249.
New code 81258QW is priced at the same rate as code 81258.
New code 81259QW is priced at the same rate as code 81259.
New code 81269QW is priced at the same rate as code 81269.
New code 81283QW is priced at the same rate as code 81283.
New code 81328QW is priced at the same rate as code 81328.
New code 81334QW is priced at the same rate as code 81334.
New code 81335QW is priced at the same rate as code 81335.
New code 81346QW is priced at the same rate as code 81346.
New code 81361QW is priced at the same rate as code 81361.
New code 81362QW is priced at the same rate as code 81362.
New code 81363QW is priced at the same rate as code 81363.
New code 81364QW is priced at the same rate as code 81364.
New code 81448QW is priced at the same rate as code 81448.
New code 81520QW is priced at the same rate as code 81520.
New code 81521QW is priced at the same rate as code 81521.
New code 81541QW is priced at the same rate as code 81541.
New code 81551QW is priced at the same rate as code 81551.
New code 86008QW is priced at the same rate as code 86008.
New code 86794QW is priced at the same rate as code 86794.
New code 87662QW is priced at the same rate as code 87662.

**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>February 9, 2018</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>

Disclaimer: This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2016 American Medical Association. All rights reserved.

Copyright © 2017, the American Hospital Association, Chicago, Illinois. Reproduced with permission. No portion of the AHA copyrighted materials contained within this publication may be copied without the express written consent of the AHA. AHA copyrighted materials including the UB-04 codes and descriptions may not be removed, copied, or utilized within any software, product, service, solution or derivative work without the written consent of the AHA. If an entity wishes to utilize any AHA materials, please contact the AHA at 312-893-6816. Making copies or utilizing the content of the UB-04 Manual, including the codes and/or descriptions, for internal purposes, resale and/or to be used in any product or publication; creating any modified or derivative work of the UB-04 Manual and/or codes and descriptions; and/or making any commercial use of UB-04 Manual or any portion thereof, including the codes and/or descriptions, is only authorized with an express license from the American Hospital Association. To license the electronic data file of UB-04 Data Specifications, contact Tim Carlson at (312) 893-6816 or Laryssa Marshall at (312) 893-6814. You may also contact us at ub04@healthforum.com.

The American Hospital Association (the “AHA”) has not reviewed, and is not responsible for, the completeness or accuracy of any information contained in this material, nor was the AHA or any of its affiliates, involved in the preparation of this material, or the analysis of information provided in the material. The views and/or positions presented in the material do not necessarily represent the views of the AHA. CMS and its products and services are not endorsed by the AHA or any of its affiliates.
Update to the Federally Qualified Health Center (FQHC) Prospective Payment System (PPS) for Calendar Year (CY) 2018 - Recurring File Update

MLN Matters Number: MM10334  Related Change Request (CR) Number: 10334
Related CR Release Date: November 16, 2017  Effective Date: January 1, 2018
Related CR Transmittal Number: R3922CP  Implementation Date: January 2, 2018

PROVIDER TYPES AFFECTED

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

WHAT YOU NEED TO KNOW

Change Request (CR) 10334 informs MACs that, effective January 1, 2018, the following items apply to FQHC claims:

1. Beginning in 2017, the FQHC Prospective Payment System (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 2016 base payment rate of $163.49.
2. The Pricer update, effective for January 1, 2018, also corrects the Geographic Adjustment Factor (GAF) for carrier/locality 0118272 (San Diego-Carlsbad, Ca) to be 1.054 for CY 2017.
3. MACs will mass adjust all FQHC claims with dates of service on or after January 1, 2017, through December 31, 2017 for carrier locality 0118272 within 90 days of the implementation of CR10334.

BACKGROUND

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. Section 1834(o)(2)(B)(ii) of the Social Security Act (the Act) requires that the payment for the first year after the implementation year be increased by the percentage increase in the Medicare
Economic Index (MEI). In subsequent years, the FQHC PPS base payment rate will be increased by the percentage increase in a market basket of FQHC goods and services, or if such an index is not available, by the percentage increase in the MEI.

In accordance with Section 1834(o)(1)(A) of the Act, the FQHC PPS base rate is adjusted for each FQHC by the FQHC 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. For CY 2018, the FQHC PPS GAFs have been updated in order to be consistent with the statutory requirements.

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>November 20, 2017</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>

Disclaimer: This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2016 American Medical Association. All rights reserved.

Copyright © 2017, the American Hospital Association, Chicago, Illinois. Reproduced with permission. No portion of the AHA copyrighted materials contained within this publication may be copied without the express written consent of the AHA. AHA copyrighted materials including the UB-04 codes and descriptions may not be removed, copied, or utilized within any software, product, service, solution or derivative work without the written consent of the AHA. If an entity wishes to utilize any AHA materials, please contact the AHA at 312-893-6816. Making copies or utilizing the content of the UB-04 Manual, including the codes and/or descriptions, for internal purposes, resale and/or to be used in any product or publication; creating any modified or derivative work of the UB-04 Manual and/or codes and descriptions; and/or making any commercial use of UB-04 Manual or any portion thereof, including the codes and/or descriptions, is only authorized with an express license from the American Hospital Association. To license the electronic data file of UB-04 Data Specifications, contact Tim Carlson at (312) 893-6816 or Laryssa Marshall at (312) 893-6814. You may also contact us at ub04@healthforum.com

The American Hospital Association (the “AHA”) has not reviewed, and is not responsible for, the completeness or accuracy of any information contained in this material, nor was the AHA or any of its affiliates, involved in the preparation of this material, or the analysis of information provided in the material. The views and/or positions presented in the material do not necessarily represent the views of the AHA. CMS and its products and services are not endorsed by the AHA or any of its affiliates.
Update to the Federally Qualified Health Center (FQHC) Prospective Payment System (PPS) for Calendar Year (CY) 2018 - Recurring File Update

MLN Matters Number: MM10480 Related Change Request (CR) Number: 10480
Related CR Release Date: February 8, 2018 Effective Date: April 1, 2018
Related CR Transmittal Number: R3972CP Implementation Date: April 2, 2018

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 in the FQHC Pricer. Make sure your billing staffs are aware of these changes.

BACKGROUND

Effective for dates of service on or after January 1, 2016, Indian Health Service (IHS) and tribal facilities and organizations may seek to become certified as 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_2.2.413_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.
- 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 PPS Geographic Adjustment Factors (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/.
Discrete Document History

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>February 9, 2018</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>

Disclaimer: This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2016 American Medical Association. All rights reserved.

Copyright © 2017, the American Hospital Association, Chicago, Illinois. Reproduced with permission. No portion of the AHA copyrighted materials contained within this publication may be copied without the express written consent of the AHA. AHA copyrighted materials including the UB-04 codes and descriptions may not be removed, copied, or utilized within any software, product, service, solution or derivative work without the written consent of the AHA. If an entity wishes to utilize any AHA materials, please contact the AHA at 312-893-6816. Making copies or utilizing the content of the UB-04 Manual, including the codes and/or descriptions, for internal purposes, resale and/or to be used in any product or publication; creating any modified or derivative work of the UB-04 Manual and/or codes and descriptions; and/or making any commercial use of UB-04 Manual or any portion thereof, including the codes and/or descriptions, is only authorized with an express license from the American Hospital Association. To license the electronic data file of UB-04 Data Specifications, contact Tim Carlson at (312) 893-6816 or Laryssa Marshall at (312) 893-6814. You may also contact us at ub04@healthforum.com

The American Hospital Association (the “AHA”) has not reviewed, and is not responsible for, the completeness or accuracy of any information contained in this material, nor was the AHA or any of its affiliates, involved in the preparation of this material, or the analysis of information provided in the material. The views and/or positions presented in the material do not necessarily represent the views of the AHA. CMS and its products and services are not endorsed by the AHA or any of its affiliates.
WPS GHA PROVIDER SERVICES

For additional information on the content of this newsletter, changes in policy or procedures, how to obtain a hardcopy of a Local Coverage Determination (LCD), or if you experience difficulties obtaining a policy on our website, please contact a customer service representative at the telephone numbers_addresses listed below.

<table>
<thead>
<tr>
<th>J5 MAC (IA, KS, MO, NE, AND NATIONAL)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Iowa</strong></td>
<td><strong>Kansas</strong></td>
</tr>
<tr>
<td>WPS GHA</td>
<td>WPS GHA</td>
</tr>
<tr>
<td>General Correspondence</td>
<td>General Correspondence</td>
</tr>
<tr>
<td>P.O. Box 7665</td>
<td>P.O. Box 7576</td>
</tr>
<tr>
<td>Madison, WI 53707-7665</td>
<td>Madison, WI 53707-7576</td>
</tr>
<tr>
<td>(866) 518-3285</td>
<td>(866) 518-3285</td>
</tr>
<tr>
<td><strong>Missouri</strong></td>
<td><strong>Nebraska</strong></td>
</tr>
<tr>
<td>WPS GHA</td>
<td>WPS GHA</td>
</tr>
<tr>
<td>General Correspondence</td>
<td>General Correspondence</td>
</tr>
<tr>
<td>P.O. Box 8890</td>
<td>P.O. Box 8799</td>
</tr>
<tr>
<td>Madison, WI 53708-8890</td>
<td>Madison, WI 53708-8799</td>
</tr>
<tr>
<td>(866) 518-3285</td>
<td>(866) 518-3285</td>
</tr>
<tr>
<td><strong>National</strong></td>
<td></td>
</tr>
<tr>
<td>WPS GHA</td>
<td>WPS GHA</td>
</tr>
<tr>
<td>General Correspondence</td>
<td>General Correspondence</td>
</tr>
<tr>
<td>P.O. Box 7861</td>
<td>P.O. Box 7861</td>
</tr>
<tr>
<td>Madison, WI 53707-7861</td>
<td>Madison, WI 53707-7861</td>
</tr>
<tr>
<td>(866) 518-3285</td>
<td>(866) 518-3285</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>J8 MAC (IN, MI)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Indiana</strong></td>
<td><strong>Michigan</strong></td>
</tr>
<tr>
<td>WPS GHA</td>
<td>WPS GHA</td>
</tr>
<tr>
<td>General Correspondence</td>
<td>General Correspondence</td>
</tr>
<tr>
<td>P.O. Box 8602</td>
<td>P.O. Box 8604</td>
</tr>
<tr>
<td>Madison, WI 53708-8602</td>
<td>Madison, WI 53708-8604</td>
</tr>
<tr>
<td>(866) 234-7331</td>
<td>(866) 234-7331</td>
</tr>
</tbody>
</table>

VISIT WPSGHA.COM FOR ALL YOUR MEDICARE NEEDS

WPS GHA would like to remind providers that the *Communiqué* does not include all the information needed by Medicare providers. While the publication does include general information, articles, and updates, the most comprehensive source of WPS GHA information is the WPS GHA website (http://www.wpsgha.com/). Visit us today!

WPS GHA MEDI CARE eNEWS MESSAGES

Stay up-to-date on Medicare issues by signing up for our free WPS GHA Medicare eNews. By subscribing, you can enjoy a free, easy, and secure way to stay current on the latest Medicare information, with the option to unsubscribe at any time. To receive our eNews messages, go to https://corp-ws.wpsic.com/apps/commercial/unauth/medicareListservUserWelcomeLoadAction.do. Follow the site’s instructions for signing up and simply check your email regularly to receive the latest Medicare information.