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

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Common Working File (CWF) to Modify CWF Provider Queries to Only Accept National Provider Identifier (NPI) as Valid Provider Number

MLN Matters Number: MM10098
Related Change Request (CR) Number: CR10098
Related CR Release Date: July 27, 2017
Effective Date: January 1, 2018
Related CR Transmittal Number: R1877OTN
Implementation Date: January 2, 2018

PROVIDER TYPES AFFECTED

This MLN Matters® Article is intended for physicians, providers, and suppliers querying Medicare’s Common Working File (CWF) for checking eligibility and entitlement status for Medicare beneficiaries.

PROVIDER ACTION NEEDED

This article is based on Change Request (CR) 10098, which informs the MACs about modifications to the CWF Provider Queries, ELGA, ELGH, HIQA, HIQH, and HUQA, to only accept the National Provider Identifier (NPI) as a valid Provider Number. Make sure that your billing staffs are aware of these changes.

BACKGROUND

Providers, clearinghouses, and/or third-party vendors, herein referred to as “Trading Partners,” verify an individual's Medicare eligibility and entitlement status prior to and/or while the individual is receiving services before billing Medicare for services rendered to Medicare beneficiaries using HIPAA Eligibility Transaction System (HETS) and/or CWF.

Within CWF, Trading Partners use CWF Provider Queries, ELGA, ELGH, HIQA, HIQH, and HUQA. Currently, Trading Partners are allowed to use either legacy Provider Numbers (CMS Certification Number (CCN) or Unique Physician Identification Number (UPIN)) or NPI on CWF Provider Queries.

The Centers for Medicare & Medicaid Services (CMS) is requiring CWF to modify CWF Provider Queries to only accept NPI as a valid Provider Number.
ADDITIONAL INFORMATION


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

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Implementing FISS Updates to Accommodate Section 603 Bipartisan Budget Act of 2015 - Phase 2

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9907 announces that, starting on January 1, 2017, off-campus outpatient department(s) of a provider services that fall under the Bipartisan Budget Act of 2015 (§603) are required to be correctly identified. If a hospital claim is submitted with a service facility location that was not included on the CMS 855A enrollment form, the claim will be Returned to the Provider (RTP) until the CMS 855A enrollment form and claims processing system are updated. Make sure your billings staffs are aware of these changes.

Background

The Social Security Act (Section 1833 (t)) as amended by the Bipartisan Budget Act of 2015 (Section 603), authorizes the Centers for Medicare & Medicaid Services (CMS) to implement amended policies related to treatment of off-campus outpatient department(s) of a provider services.

Hospital providers are required to include all practice locations on the CMS 855A enrollment form, and CMS has performed a re-validation process (March 25, 2011 – March 23, 2015) where in the last 4 years all hospital providers have completed an 855A enrollment form to either:

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1. Initially enroll in Medicare,
2. Add a new practice location, or
3. Revalidate its enrollment information.

Starting on January 1, 2017, off-campus outpatient department(s) of provider services that fall under the Bipartisan Budget Act of 2015 (§603) are required to be correctly identified.

If a hospital claim is submitted with a service facility location that was not included on the CMS 855A enrollment form, it will be Returned to the Provider (RTP) until the hospital updates its CMS 855A enrollment form and Medicare’s claims processing system are updated accordingly.

CR9907 also requires that either modifier PO or PN be present on all service lines with HCPCS codes when the service facility address is present. For more details on these modifiers please review MLN Matters article MM9930.

Collection and retention of CMS 855 enrollment data has been cleared through a Paperwork Reduction Act Notice in the Federal Register. The authority for the various types of data to be collected is found in:
- The Social Security Act (Sections 1816, 1819, 1833, 1834, 1842, 1861, 1866, and 1891), and

Additional Information


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

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

Note: This article was revised on May 18, 2017, to reflect the revised CR9672 issued on May 17. The article was revised to change the effective and implementation dates, the CR release date, transmittal number, and the Web address for accessing the CR. All other information remains the same.

Provider Types Affected

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

What You Need to Know

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

Additional Information

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

**Document History**

- May 5, 2017 - Initial article released.
- May 18, 2017 - The article is revised to reflect the revised CR9672 issued on May 17. The article is revised to change the effective and implementation dates, the CR release date, transmittal number, and the Web address for accessing the CR. All other information remains the same.
Changes to the End-Stage Renal Disease (ESRD) Facility Claim (Type of Bill 72X) to Accommodate Dialysis Furnished to beneficiaries with Acute Kidney Injury (AKI)

Note: This article was revised on June 19, 2017, to refer to code G0491 as a HCPCS code rather than a CPT code. In addition, a clarification was made on page 3 in the paragraphs relating to the ESRD Conditions of Coverage and the Low Volume Payment Adjustment. Information regarding home or self-dialysis, billing for physician services, payment for erythropoietin stimulating agents, telehealth, and modifiers, value codes, condition codes, and occurrence codes is also added starting on page 4. A link to CR9807 was added. All other information is unchanged.

Provider Types Affected

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

What You Need to Know

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

On June 29, 2015, The Trade Preferences Extension Act of 2015 was enacted in which Section 808 amended Section 1861(s)(2)(F) of the Social Security Act (42 U.S.C. 1395x(s)(2)(F)) by extending renal dialysis services paid under Section 1881(b)(14) to beneficiaries with AKI effective January 1, 2017.

Beginning January 1, 2017, ESRD facilities will be able to furnish dialysis to AKI patients. The AKI provision was signed into law on June 29, 2015. (See Sec. 808 Public Law 114-27.)

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

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

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

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

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

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

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

**Applicability of Other ESRD and CMS Adjustments**

**ESRD Network Fee**

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

**ESRD Quality Incentive Program (QIP)**

The ESRD QIP is not applicable for beneficiaries with AKI at this time.

**Sequestration Adjustments**

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

**ESRD Conditions for Coverage (CfCs)**

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

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

Home or Self-Dialysis Training Add-On Payment Adjustment

The home or self-dialysis training add-on is not applicable to claims for treatments provided to patients with AKI.

Billing for Physicians’ Services for Patients with AKI

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

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

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

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

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

ESAs are included in the bundled payment amount for treatments administered to patients with AKI. The Non-ESRD HCPCS codes should be used (J0881, J0885, J0887). This policy will be implemented with CR 9987 on October 2, 2017.

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


**Modifier, Value Code, Condition Code, and Occurrence Codes**

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

**Additional Information**


42 CFR 413.171 is available at [http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=3233ff9e843c3f74275cab5dc8cf088c&mc=true&n=pt42.2.413&r=PART&tv=HTML#se42.2.413_1171](http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=3233ff9e843c3f74275cab5dc8cf088c&mc=true&n=pt42.2.413&r=PART&tv=HTML#se42.2.413_1171).

42 CFR 494 is available at [http://www.ecfr.gov/cgi-bin/textidx?SID=0ef1f211399c42665d1bfb2ed9b6783a&mc=true&tpl=/ecfrbrowse/Title42/42cf494_main_02.tpl](http://www.ecfr.gov/cgi-bin/textidx?SID=0ef1f211399c42665d1bfb2ed9b6783a&mc=true&tpl=/ecfrbrowse/Title42/42cf494_main_02.tpl).


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


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Implementation of Modifier CG for Type of Bill 72x

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9989 informs MACs about the implementation of modifier CG for dialysis claim lines that do not meet the MAC’s medical justification requirements for dialysis treatments. Make sure that your billing staffs are aware of these changes.

Background

When the End Stage Renal Disease (ESRD) Prospective Payment System (PPS) was implemented in 2011, the Centers for Medicare & Medicaid Services (CMS) adopted a per treatment unit of payment. This per treatment unit of payment is the same base rate that is paid for all dialysis treatment modalities furnished by an ESRD facility (hemodialysis (HD) and the various forms of peritoneal dialysis (PD)). Consistent with CMS policy since implementation of the composite rate payment system in the 1980s, CMS also adopted the 3-times weekly payment limit for HD under the ESRD PPS. When a beneficiary’s plan of care requires more than three weekly dialysis treatments, whether HD or daily PD, CMS applies payment edits to ensure that Medicare payment on the monthly claim is consistent with the 3-times weekly dialysis treatment payment limit. Thus, for a 30-day month, payment is limited to 13 treatments, and for a 31-day month payment it is limited to 14
treatments, with exceptions made for medical justification.

In order to accurately capture all treatments provided to a beneficiary, CMS is implementing a new modifier (CG – Policy Criteria Applies) for the 72x type of bill (TOB) with Revenue Codes 0821 or 0881 and HCPCS 90999 when used in the billing of dialysis treatments for patients with ESRD in excess of the 13 or 14 monthly allowable treatments.

**Note:** This does not apply to training treatments (condition code 73 or 87). These services should be paid when modifier CG is present and they are within the current limitations.

Modifier CG (Policy Criteria Applies) is used to identify dialysis treatments (CPT 90999) in excess of 13 or 14 per month that do not meet medical justification requirements as defined by the MACs. This modifier shall be appended to the claim line for the date of service associated with the excess treatment. This modifier indicates that the facility attests the additional treatment does not meet medical justification requirements and should not be paid separately.

MACs will continue to use existing processes to determine medical justification for claim lines in excess of 13/14 per month that do not include the new modifier. When a claim line includes modifier CG and medical justification, the claim line should not be separately payable.

Medicare will deny claim lines on TOB 72x with Revenue Codes 0821 or 0881, HCPCS code 90999 and Modifier CG using Group Code CO and Claims Adjustment Reason Code 96 (Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT). Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.)

**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/).
Instructions to Process Services Not Authorized by the Veterans Administration (VA) in a Non-VA Facility Reported with Value Code (VC) 42

Note: This article was revised on May 25, 2017, due to an updated Change Request (CR) that clarified language, which is stated in this article (in bold) on page 2. The transmittal number, CR release date and link to the CR also changed. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

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

Background

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

The Centers for Medicare & Medicaid Services (CMS) issued MLN Matters® Special Edition Article (SE) 1517 to provide clarification and coding reminders for billing.
Medicare when the Department of Veterans Affairs (VA) is involved for a portion of the services.

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

When a Medicare beneficiary is also eligible for veterans health benefits and elects to obtain his/her health care at a VA facility, law entitles the VA to collect from the beneficiary’s supplemental insurer the coinsurance and deductibles that would have been payable had the beneficiary instead received services from a Medicare provider (law, however, prohibits Medicare from paying for these claims). Currently, through an interagency agreement between CMS and the VA, CMS systems adjudicate the VA claims on a no-pay basis to determine the amounts Medicare would have paid for equivalent services rendered by Medicare providers along with the coinsurance and deductible amounts applicable.

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

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

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

Additional Information


If you have any questions, please contact your MAC at their toll-free number. That number is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/.
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<td>The article was revised due to an updated CR that clarified language, which is stated in this article (in bold) on page 2. The transmittal number, CR release date and link to the CR also changed.</td>
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<td>February 17, 2017</td>
<td>The article was revised on, to reflect a revised CR9818 issued on February 14. In the article, the CR release date, transmittal number, and the Web address for accessing the CR were revised.</td>
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July 2017 Integrated Outpatient Code Editor (I/OCE) Specifications Version 18.2

MLN Matters Number: MM10115  Related Change Request (CR) Number: 10115
Related CR Release Date: May 18, 2017  Effective Date: July 1, 2017
Related CR Transmittal Number: R3777CP  Implementation Date: July 3, 2017

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 10115 informs providers that the I/OCE is being updated July 1, 2017. The I/OCE routes all institutional outpatient claims (which includes non-Outpatient Prospective Payment System (OPPS) hospital claims) through a single integrated OCE. Make sure that your billing staffs are aware of these changes.

BACKGROUND

CR10115 provides the Integrated OCE instructions and specifications for the Integrated OCE that will be used under the 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 not under the Home Health Prospective Payment System or to a hospice patient for the treatment of a non-terminal illness. The I/OCE specifications will be posted to the CMS Website at http://www.cms.gov/OutpatientCodeEdit/.

The following table summarizes the modifications of the I/OCE for the July 2017 v18.2 release. Note that some I/OCE modifications may be retroactively added to prior releases. If so, the retroactive date appears in the ‘Effective Date’ column.
<table>
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<tr>
<th>Effective Date</th>
<th>Edits Affected</th>
<th>Modification</th>
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<tbody>
<tr>
<td>1/1/2017</td>
<td></td>
<td>Modify the logic for Community Mental Health Center (CMHC) claims (bill type 76x) eligible for outlier payment limitations related to condition code MY; if present with or without condition code 66, new payment method flag 9 is assigned to OPPS payable lines (see special processing logic and Appendix E of Attachment to CR10115).</td>
</tr>
<tr>
<td>1/1/2016</td>
<td></td>
<td>Assign a payment APC of ‘00000’ for drug HCPCS codes with SI = G or K (see special processing logic and note in Appendix E).</td>
</tr>
<tr>
<td>7/1/2017</td>
<td>95</td>
<td>Reactivate edit 95 as a line item informational only edit returned when weekly Partial Hospitalization Program (PHP) services do not meet the 20-hour per week service requirement (see special processing logic, tables 4, 5 and 7; note in Appendix C-a flowchart). A new value of 3 returned in the line item denial or rejection flag field is returned indicating the rejection has no impact on payment for the line(s) returning edit 95. Edit description is modified to: Weekly partial hospitalization services require a minimum of 20 hours of service as evidenced in PHP plan of care (LIR) Edit criteria is modified to: A PHP claim contains weekly PH services that total less than 20 hours per 7-day span.</td>
</tr>
<tr>
<td>1/1/2016</td>
<td></td>
<td>Add modifiers XE, XP, XS, and XU to the critical care ancillary services logic to process under the current exceptions for modifier 59 (see special processing logic).</td>
</tr>
<tr>
<td>5/1/2017</td>
<td>68</td>
<td>Implement National Coverage Determination (NCD) mid-quarter effective editing for procedure codes 0004U and 0005U.</td>
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<tr>
<td>10/7/2016</td>
<td>67</td>
<td>Implement FDA mid-quarter effective editing for procedure code 90651.</td>
</tr>
<tr>
<td>1/1/2017</td>
<td></td>
<td>Add new payment method flag 9 (see table 7 and Appendix E).</td>
</tr>
<tr>
<td>7/1/2017</td>
<td></td>
<td>Add new line item denial or rejection flag value of 3 (see table 7).</td>
</tr>
<tr>
<td>1/1/2016</td>
<td></td>
<td>Update the multiple imaging composite Ambulatory Payment Classification (APC) family lists to remove the following codes with Status Indicator (SI) = Q1: 76604, 76775, 76870; add note for code 75635 as an exception to the composite logic in Appendix K.</td>
</tr>
<tr>
<td>7/1/2017</td>
<td></td>
<td>Update the following lists for the release (see quarterly data files): - Coinsurance/Deductible N/A list - Device-procedure list (edit 92) - Terminated procedures for device credit - Comprehensive APC ranking - Male-only procedure list (edit 8)</td>
</tr>
<tr>
<td>7/1/2017</td>
<td></td>
<td>Make all HCPCS/APC/SI changes as specified by CMS (quarterly data files).</td>
</tr>
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</table>
Implement version 23.2 of the National Correct Coding Initiative (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/.

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Next Generation Accountable Care Organization (NGACO) Year Three Benefit Enhancements

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

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

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

BACKGROUND

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

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

Asynchronous Telehealth

CMS is expanding the current telehealth waiver to include asynchronous (also known as “store-and-forward”) telehealth in the specialties of teledermatology and teleophthalmology.

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

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

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

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

**ADDITIONAL INFORMATION**


If you have any questions, please contact your MAC at their toll-free number. That number is available at [https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/](https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/).
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New Common Working File (CWF) Medicare Secondary Payer (MSP) Type for Liability Medicare Set-Aside Arrangements (LMSAs) and No-Fault Medicare Set-Aside Arrangements (NFMSAs)

**Note:** This article was revised on June 9, 2017, due to the release of an updated Change Request (CR). The CR date, transmittal number and the link to the transmittal changed. All other information remains the same.

**Provider Types Affected**

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

**What You Need to Know**

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

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

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

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

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

Key Points of CR9893

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

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

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

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

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

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

**Additional Information**


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

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<td>February 17, 2017</td>
<td>Initial article released</td>
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October Quarterly Update to 2017 Annual Update of HCPCS Codes Used for SNF CB Enforcement

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

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

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

BACKGROUND

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

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

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

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

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

ADDITIONAL INFORMATION


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

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

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

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

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

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9911 modifies the Medicare claims processing systems to help providers more readily identify the Qualified Medicare Beneficiary (QMB) status of each patient and to support providers’ ability to follow QMB billing requirements. Beneficiaries enrolled in the QMB program are not liable to pay Medicare cost-sharing for all Medicare A/B claims. CR 9911 adds an indicator of QMB status to Medicare’s claims processing systems. This system enhancement will trigger notifications to providers (through the Provider Remittance Advice) and to beneficiaries (through the Medicare Summary Notice)

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

**Background**

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

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

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

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

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

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

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

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

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

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

Additional Information


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

If you have any questions, please contact your MAC at their toll-free number. That number is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/.
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MLN Matters Number: MM10107
Related Change Request (CR) Number: CR 10107
Related CR Release Date: May 18, 2017
Effective Date: July 1, 2017
Related CR Transmittal Number: R3776CP
Implementation Date: July 3, 2017

PROVIDER TYPES AFFECTED

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

WHAT YOU NEED TO KNOW

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

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

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

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

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

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

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

Make sure your billing staffs are aware of these changes.

ADDITIONAL INFORMATION


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

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Quarterly Influenza Virus Vaccine Code Update – January 2018

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

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

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

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

BACKGROUND

Effective for claims processed with dates of service (DOS) on or after January 1, 2018, influenza virus vaccine code 90756 (Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, antibiotic free, 0.5mL dosage, for intramuscular use) will be payable by Medicare. This new code will be included on the 2018 Medicare Physician Fee Schedule Database file update and the annual Healthcare Common Procedure Coding System (HCPCS) update.

During the interim period of August 1, 2017, through December 31, 2017, MACs will use code Q2039 (Influenza virus vaccine, not otherwise specified) to handle bills for this new influenza virus vaccine product (Influenza virus vaccine, quadrivalent (ccIIV4). Q2039 is already an active code.
The new influenza virus vaccine code 90756 will then be implemented with the January 2018 release for DOS on or after January 1, 2018.

Effective for dates of service on or after August 1, 2017, MACs will use the CMS Seasonal Influenza Vaccines Pricing website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html to determine the payment rate for influenza virus vaccine code Q2039 and 90756.

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

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

**New Vaccine Description**

**Code 90756** – Long Description: Influenza virus vaccine, quadrivalent (ccIV4), derived from cell cultures, subunit, antibiotic free, 0.5mL dosage, for intramuscular use TOS Code: V

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

**Payment Basis**

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

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

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

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

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

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

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

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

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

• Group Code: CO (Contractual Obligation)

ADDITIONAL INFORMATION


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

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Quarterly Update to the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS)

MLN Matters Number: MM10193
Related Change Request (CR) Number: CR 10193
Related CR Release Date: August 11, 2017
Effective Date: October 1, 2017
Related CR Transmittal Number: R3833CP
Implementation Date: October 2, 2017

PROVIDER TYPE 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) 10193 provides the October 1, 2017, update to the lists of items and services that are subject to Part B Consolidated Billing (CB) and are therefore no longer separately payable when provided to ESRD beneficiaries by providers other than ESRD facilities. Make sure your billing staff is aware of these changes.

BACKGROUND

The Medicare Improvements for Patients and Providers Act (MIPPA; Section 153(b)) required the implementation of an ESRD PPS effective January 1, 2011. The ESRD PPS provides a single payment to ESRD facilities that covers all of the resources used in furnishing an outpatient dialysis treatment.

The ESRD PPS includes 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 CB and are therefore no longer separately payable when provided to ESRD beneficiaries by providers other than ESRD facilities.

For October, the CB requirements for laboratory services included in the ESRD PPS are updated by adding the following Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes to the list:
• G0499 - Hepatitis B screening in non-pregnant, high risk individual includes Hepatitis B Surface Antigen (HBSAG) followed by a neutralizing confirmatory test for initially reactive results, and antibodies to HBSAG (anti-hbs) and hepatitis B core antigen (anti-hbc)

• 87341 - Infectious agent antigen detection by immunoassay technique, (e.g., enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multistep method; Hepatitis B Surface Antigen (HBSAG) neutralization

**ADDITIONAL INFORMATION**


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

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

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

PROVIDER TYPES AFFECTED

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

WHAT YOU NEED TO KNOW

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

BACKGROUND

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

CR 10156 revises several laboratory NCD code lists as follows:

- Add ICD-10-CM code E034, effective 10/1/2016, to the list of ICD-10-CM codes that are covered by Medicare for the Lipids Testing (190.23A) NCD.
- Add ICD-10-CM code E034, effective 10/1/2016, to the list of ICD-10-CM codes that are covered by Medicare for the Lipids Testing (190.23B) NCD.
- Add ICD-10-CM codes D4959 and R9349, effective 10/1/2016, to the list of ICD-10-CM codes that are covered by Medicare for the Human Chorionic Gonadotropin (190.27) NCD.
E103319, E103399, E103419, E103499, E103519, E103539, E103549, E103559, E103599, E1037X9, E113219, E113299, E113319, E113399, E113419, E113499, E113519, E113529, E113539, E113549, E113559, E113599, E1137X9, E133219, E133299, E133319, E133399, E133419, E133499, E133519, E133529, E133539, E133549, E133559, E133599, and E1337X9 from the list of ICD-10-CM codes that are covered by Medicare for the Glycated Hemoglobin/Glycated Protein (190.21) NCD.

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

**ADDITIONAL INFORMATION**

MACs will not search their files to either retract payment for claims already paid or retroactively pay claims, but they will adjust such claims that you bring to their attention.


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

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

MLN Matters Number: MM10086
Related CR Release Date: May 26, 2017
Related CR Transmittal Number: R1854OTN
Related Change Request (CR) Number: 10086
Effective Date: October 1, 2017
Implementation Date: October 2, 2017, shared system edits, July 14, 2017, local edits

PROVIDER TYPE AFFECTED

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

PROVIDER ACTION NEEDED

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

BACKGROUND

The translations from International Classification of Diseases, Ninth Revision (ICD-9) to ICD-10 are not consistent 1:1 matches, nor are all ICD-10 codes appearing in a complete General Equivalence Mappings (GEMs) mapping guide or other mapping guides appropriate when reviewed against individual NCD policies. In addition, for those policies that expressly allow MAC discretion, there may be changes to those NCDs based on current review of those NCDs against ICD-10 coding. For these reasons, there may be certain ICD-9 codes that were once considered appropriate prior to ICD-10 implementation that are no longer considered acceptable.

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

CR10086 makes coding and clarifying adjustments to the following NCDs:

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


**ADDITIONAL INFORMATION**


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

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

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

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

BACKGROUND

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

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

Coding (as well as payment) are separate and distinct areas of the Medicare Program from coverage policy/criteria. Revisions to codes within an NCD are carefully and thoroughly
reviewed and vetted by the Centers for Medicare & Medicaid Services (CMS) and are not intended to change the original intent of the NCD. The exception to this is when coding revisions are released as official implementation of new or reconsidered NCD policy following a formal national coverage analysis.

NOTE: The translations from ICD-9 to ICD-10 are not consistent 1-1 matches, nor are all ICD-10 codes appearing in a complete General Equivalence Mappings (GEMS) mapping guide or other mapping guides appropriate when reviewed against individual NCD policies. In addition, for those policies that expressly allow MAC discretion, there may be changes to those NCDs based on current review of those NCDs against ICD-10 coding. For these reasons, there may be certain ICD-9 codes that were once considered appropriate prior to ICD-10 implementation that are no longer considered acceptable.

CR10084 makes coding and clarifying adjustments to the following NCDs:

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

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

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

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

- Group Code PR (Patient Responsibility) assigning financial responsibility to the beneficiary (if a claim is received with occurrence code 32, or with occurrence code 32 and a GA modifier, indicating a signed ABN is on file)
- Group Code CO (Contractual Obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file)

ADDITIONAL INFORMATION

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

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"Medicare Benefit Policy Manual" - Chapter 10, Ambulance Locality and Advanced Life Support (ALS) Assessment

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

PROVIDER TYPES AFFECTED

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

WHAT YOU NEED TO KNOW

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

BACKGROUND

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

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

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

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

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

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

ADDITIONAL INFORMATION


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

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

MLN Matters® Number: MM9246 Revised Related Change Request (CR) #: 9246
Related CR Release Date: October 15, 2015 Effective Date: February 5, 2015
Related CR Transmittal #: R3374CP and Implementation Date: January 4, 2016 R185NCD

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

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

Provider Types Affected

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

Provider Action Needed

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

Background

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

- Be reasonable and necessary for the prevention or early detection of illness or disability;
• Be recommended with a grade of A or B by the United States Preventive Services Task Force (USPSTF); and
• Be appropriate for individuals entitled to benefits under Part A or enrolled under Part B.

CMS reviewed the evidence for lung cancer screening with low dose computed tomography (LDCT) and determined that the criteria listed above were met, enabling CMS to cover this “additional preventive service” under Medicare Part B.

CMS issued NCD 210.14 on August 21, 2015, that provides for Medicare coverage of screening for lung cancer with LDCT. Effective for claims with dates of service on and after February 5, 2015, Medicare beneficiaries must meet all of the following criteria:

• Be 55–77 years of age;
• Be asymptomatic (no signs or symptoms of lung cancer);
• Have a tobacco smoking history of at least 30 pack-years (one pack-year = smoking one pack per day for one year; 1 pack = 20 cigarettes);
• Be a current smoker or one who has quit smoking within the last 15 years; and,
• Receive a written order for lung cancer screening with LDCT that meets the requirements described in the NCD.

Written orders for lung cancer LDCT screenings must be appropriately documented in the beneficiary’s medical record, and must contain the following information:

• Date of birth;
• Actual pack–year smoking history (number);
• Current smoking status, and for former smokers, the number of years since quitting smoking;
• A statement that the beneficiary is asymptomatic (no signs or symptoms of lung cancer); and,
• The National Provider Identifier (NPI) of the ordering practitioner.

Counseling and Shared Decision-Making Visit

Before the first lung cancer LDCT screening occurs, the beneficiary must receive a written order for LDCT lung cancer screening during a lung cancer screening counseling and shared decision-making visit that includes the following elements and is appropriately documented in the beneficiary’s medical records:

• Must be furnished by a physician (as defined in section 1861(r)(1) of the Act) or qualified non-physician practitioner (meaning a Physician Assistant (PA), Nurse Practitioner (NP), or Clinical Nurse Specialist (CNS) as defined in section1861(aa)(5) of the Act); and

• Must include all of the following elements:
  o Determination of beneficiary eligibility including age, absence of signs or symptoms of lung cancer, a specific calculation of cigarette smoking pack-years; and if a former smoker, the number of years since quitting;
  o Shared decision-making, including the use of one or more decision aids, to include benefits and harms of screening, follow-up diagnostic testing, over-diagnosis, false positive rate, and total radiation exposure;
Counseling on the importance of adherence to annual lung cancer LDCT screening, impact of co-morbidities, and ability or willingness to undergo diagnosis and treatment;

Counseling on the importance of maintaining cigarette smoking abstinence if former smoker; or the importance of smoking cessation if current smoker and, if appropriate, furnishing of information about tobacco cessation interventions; and,

If appropriate, the furnishing of a written order for lung cancer screening with LDCT.

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

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

**Coinsurance and Deductibles**

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

**Health Care Common Procedure Coding System (HCPCS) Codes**

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

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

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

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

**Institutional Billing Requirements**

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

Medicare will pay for these services as follows:

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

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

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

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

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

• CARC 170 - Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
• RARC N95 – This provider type/provider specialty may not bill this service.
• Group Code CO (Contractual Obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).
  **NOTE:** For modifier GZ, MACs will use CARC 50.

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

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

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

• CARC 119 – Benefit maximum for this time period or occurrence has been reached.
• RARC N386 - This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at [www.cms.gov/mcd/search.asp](http://www.cms.gov/mcd/search.asp). If you do not have web access, you may contact the contractor to request a copy of the NCD.

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

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

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

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

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

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

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

• CARC 167 – This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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

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

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

### Additional Information

The official instruction, CR9246, consists of two transmittals:

1. **Transmittal R3374CP**, which updates the “Medicare Claims Processing Manual;” and
2. **Transmittal R185NCD**, which updates the “Medicare NCD Manual.”

If you have any questions, please contact your MAC at their toll-free number. That number is available at [https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/](https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/).
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<td>June 12, 2017</td>
<td>The article was revised on June 9, 2017, to include a paragraph on page 3 to show that IDTFs may be eligible facilities.</td>
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<td>June 24, 2016</td>
<td>The article was revised to add a link to a related article <a href="MM9540">MM9540</a>. That article provides an ICD-10 code that has been added for Lung Cancer Screening with Low Dose Computed Tomography (LDCT).</td>
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<td>November 16, 2015</td>
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National Coverage Determination (NCD 20.8.4):
Leadless Pacemakers

MLN Matters Number: MM10117
Related CR Release Date: July 28, 2017
Related CR Transmittal Number: R201NCD and R3815CP

Related Change Request (CR) Number: 10117
Effective Date: January 18, 2017
Implementation Date: August 29, 2017 for local MAC system edits and January 2, 2018 for shared system edits

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

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

BACKGROUND

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

• CARC 58: Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
• RARC N386: This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.hhs.gov/mcd/search.asp. If you do have web access, you may contact the contractor to request a copy of the NCD.
• Group Code – Contractual Obligation (CO)

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

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

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

Note: This revision to the Medicare NCD Manual is a National Coverage Determination (NCD). NCDs are binding on all carriers, fiscal intermediaries, and MACs with the Federal government
that review and/or adjudicate claims, determinations, and/or decisions, quality improvement organizations, qualified independent MACs, the Medicare appeals council, and Administrative Law Judges (ALJs) (see 42 CFR Section 405.1060(a)(4)(2005)). An NCD that expands coverage is also binding on a Medicare Advantage organization. In addition, an ALJ may not review an NCD (see Section 1869(f)(1)(A)(i) of the Social Security Act).

**ADDITIONAL INFORMATION**


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

**DOCUMENT HISTORY**

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<td>August 1, 2017</td>
<td>Initial article released.</td>
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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.
Percutaneous Image-guided Lumbar Decompression (PILD) for Lumbar Spinal Stenosis (LSS)

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

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

PROVIDER TYPE AFFECTED

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

PROVIDER ACTION NEEDED

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

BACKGROUND

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

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

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

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

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

**ADDITIONAL INFORMATION**


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

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INFORMATION ON WEBSITE

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

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

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

NEW POLICIES

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

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

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**New Article associated with LCD L37205 Chemotherapy Drugs and their Adjuncts and A55639 Chemotherapy Agents for Non-Oncologic Conditions.**

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### RETIRED POLICIES

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

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

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<td>J5A/J8A</td>
<td>Chemotherapy Drugs and their Adjuncts with Billing &amp; Coding Guidelines</td>
<td>L35053</td>
<td>HONC-010</td>
<td>09/15/2017</td>
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</table>

This LCD with Billing & Coding Guidelines are being retired and replaced by a LCD with the same name of Chemotherapy Drugs and their Adjuncts, new LCD ID# L37205 and Associated Articles: A55639 Chemotherapy Agents for Non-Oncologic Conditions, A55640 Not Otherwise Classified Chemotherapy Agents (NOC).
### July 2017

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<tr>
<td>J5A/J8A</td>
<td>MolDX: Corus® CAD Test Coding and Billing Guidelines</td>
<td>A55158</td>
<td>NA</td>
<td>07/01/2017</td>
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</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 appropriate link below for more information:


### September 2017

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<tr>
<td>J5A/J8A</td>
<td>Category III Codes</td>
<td>L35490</td>
<td>PHYS-084</td>
<td>01/18/2017</td>
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Added the following information based on NCD 20.8.4 Leadless Pacemakers, effective 01/18/2017. Added the following Group 3 Paragraph for coverage of Leadless Pacemakers: Effective for dates of service on or after January 18, 2017, contractors shall cover leadless pacemakers through CED when procedures are performed in CMS-approved CED studies per NCD 20.8.4.

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

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

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CPT/HCPCS Group 1 Code table:
Reformatted for clarification to incorporate the following:
- C9485 Injection, Olaratumab, 10 mg from Group 3 Paragraph J9999/C9485 for Olaratumab (Lartruvo™);
Reformatted for clarification to incorporate the following:
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<td>J3490: Unclassified drugs to support Article Guidance of this document. Effective date 09/16/2017.</td>
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<td>J5A/J8A</td>
<td>Vitamin D Testing</td>
<td>L34658</td>
<td>PATH-032</td>
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<td>Added “obesity” to the list of indications for the measurement of vitamin D levels in the narrative section. Added the following codes to Group 1 for 82306 (Vitamin D levels).</td>
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<td>• B38.0-B38.89 – Acute pulmonary coccidioidomycosis – Other forms of coccidioidomycosis</td>
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<td>• B39.0-B39.5 – Acute pulmonary histoplasmosis capsulati – Histoplasmosis duboissi</td>
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<td>• C82.00-C82.99 – Follicular lymphoma grade 1, unspecified site – Follicular lymphoma, unspecified, extranodal and solid organ sites</td>
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<td>• J63.2 – Berylliosis</td>
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<td>• M80.00XA-M80.88XS – Age-related osteoporosis with current pathological fracture, unspecified site – Other osteoporosis with current pathological fracture, vertebrae</td>
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<td>• Z68.30-Z68.45 – Body mass index (BMI) 30.0-30.9, adult - Body mass index (BMI) 70 or greater, adult</td>
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<td>• Z98.0 – Intestinal bypass and anastomosis status</td>
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August 2017

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<td>Added F11.23 Opioid dependence with withdrawal to Group 1 Codes.</td>
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<td>MolDX: OncoCee™ Billing and Coding Guidelines</td>
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</table>

The following instructions for claim submission were added:
Labs may either use the SV101-7 or SV202-7 (preferred) or the NTE field to submit this required information.
**Enter the appropriate DEX Z-Code™ identifier adjacent to the CPT code in the comment/narrative field for the following Part B claim field/types:**
- Loop 2400 or SV101-7 for the 5010A1 837P
- Box 19 for paper claim

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

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<tbody>
<tr>
<td>J5A/J8A</td>
<td>Visual Electrophysiology Testing</td>
<td>L37015</td>
<td>OPHTH-057</td>
<td>08/01/2017</td>
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</table>

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

**July 2017**

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<tr>
<td>J5A/J8A</td>
<td>Drug Administration Coding</td>
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<td>07/01/2017</td>
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Added J3590 bezlotoxumab, Zinplava™. Added subcutaneous injection, 1mg to J3357. Changed J3590 to Q9989 for Ustekinumab, for Intravenous Injection, 1 mg effective 07/1/2017.

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<td>J5A/J8A</td>
<td>Drugs and Biologics (Non-chemotherapy)</td>
<td>INJ-041</td>
<td>L34741</td>
<td>07/01/2017</td>
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</tbody>
</table>

Added the following diagnosis codes to Group 2 Table to Proliferative diabetic retinopathy in patients without diabetic macular edema with FDA approval/effective date 04/15/2017. The Group 2 Paragraph now states:

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

**Group 2 Codes:**
- E10.3291 Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, right eye
- E10.3292 Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, left eye
- E10.3293 Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, bilateral
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<td>Neovascular (wet) Age-Related Macular Degeneration</td>
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<td></td>
<td>Diabetic macular edema</td>
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<td></td>
<td>Proliferative diabetic retinopathy in patients with diabetic macular edema</td>
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<td></td>
<td>Group 3 Codes: E08.3211-E08.3213, E08.3311-E08.3313, E08.3411-E08.3413,</td>
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<td>3230-H35.3233.</td>
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<td>Prior Groups 3-20 have been renumbered to accommodate the new Group 3 for Afiblercept (Eylea).</td>
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<td>J5A/J8A</td>
<td>Facet Joint Injections, Medial Branch Blocks, and Facet Joint Radiofrequency Neurotomy</td>
<td>L35996</td>
<td>NEURO-016</td>
<td>07/01/2017</td>
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<td></td>
<td>Under Definitions, added the following sentence for clarification: &quot;All time intervals are</td>
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<td>determined on a rolling basis. For example, the limitation of coverage to five sessions in a</td>
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<td>year refers to a rolling 12 month period. The year begins with the first session and completes</td>
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<td>one year later. The next rolling year begins with the first session after completion of the</td>
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<td>preceding rolling year.&quot;</td>
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<td>J5A/J8A</td>
<td>Immune Globulins</td>
<td>L34771</td>
<td>INJ-012</td>
<td>07/01/2017</td>
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<td></td>
<td>In Group 12: removed asterisk for code G61.89 (Other inflammatory polineuropathies), removed</td>
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<td>asterisk clarification after Group 12 for code G61.89 (Medical Necessity ICD-10 Codes Asterisk</td>
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<td>Explanation *Note: G61.89 should be used to indicate multifocal motor neuropathy), and added</td>
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<td>code G61.82 (Multifocal motor neuropathy).</td>
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<td>J5A/J8A</td>
<td>MoiDX 4q25-AF Risk Genotype Testing Coding and Billing Guidelines</td>
<td>A55137</td>
<td>NA</td>
<td>07/01/2017</td>
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<td>SV202-7 (preferred) or the NTE field to submit this required information.</td>
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<td>field for the following Part B claim field/types:</td>
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<td>• Box 19 for paper claim</td>
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<td></td>
<td>• Line SV202-7 for 837I electronic claim</td>
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<td></td>
<td>• Block 80 for the UB04 claim</td>
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<td>J5A/J8A</td>
<td>MolDX: 9p21 Genotype Test Coding and Billing Guideline</td>
<td>A55138</td>
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<td>J5A/J8A</td>
<td>MolDX: Afirma™ Assay by Veracyte Update</td>
<td>A55139</td>
<td>NA</td>
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<td>The following instructions for claim submission were added: Labs may either use the SV101-7 or SV202-7 (preferred) or the NTE field to submit this required information. Enter the appropriate DEX Z-Code™ identifier adjacent to the CPT code in the comment/narrative field for the following Part B claim field/types: • Loop 2400 or SV101-7 for the 5010A1 837P • Box 19 for paper claim Enter the appropriate DEX Z-Code™ identifier adjacent to the CPT code in the comment/narrative field for the following Part A claim field/types: • Line SV202-7 for 837I electronic claim • Block 80 for the UB04 claim form</td>
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<td>J5A/J8A</td>
<td>MolDX: AlloMap Billing and Coding Guidelines</td>
<td>A55140</td>
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<td>07/01/2017</td>
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<td>The following instructions for claim submission were added: Labs may either use the SV101-7 or SV202-7 (preferred) or the NTE field to submit this required information. Enter the appropriate DEX Z-Code™ identifier adjacent to the CPT code in the comment/narrative field for the following Part B claim field/types: • Loop 2400 or SV101-7 for the 5010A1 837P • Box 19 for paper claim Enter the appropriate DEX Z-Code™ identifier adjacent to the CPT code in the comment/narrative field for the following Part A claim field/types: • Line SV202-7 for 837I electronic claim • Block 80 for the UB04 claim form</td>
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<td>J5A/J8A</td>
<td>MolDX: ApoE Genotype Coding and Billing Guidelines</td>
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<td>The following instructions for claim submission were added: Labs may either use the SV101-7 or SV202-7 (preferred) or the NTE field to submit this required information. Enter the appropriate DEX Z-Code™ identifier adjacent to the CPT code in the comment/narrative field for the following Part B claim field/types: • Loop 2400 or SV101-7 for the 5010A1 837P • Box 19 for paper claim</td>
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<td>J5A/J8A</td>
<td>MoIDX: Aspartoacyclase 2 Deficiency (ASPA) Testing Coding and Billing Guidelines</td>
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<td>J5A/J8A</td>
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<td>J5A/J8A</td>
<td>MoIDX: Avise PG Assay Billing/Coding Update</td>
<td>A55144</td>
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<td>J5A/J8A</td>
<td>MoIDX: BCR-ABL Coding and Billing Guidelines</td>
<td>A55233</td>
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Enter the appropriate DEX Z-Code™ identifier adjacent to the CPT code in the comment/narrative field for the following Part A claim field/types:
- Line SV202-7 for 837I electronic claim
- Block 80 for the UB04 claim form

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

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

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

Enter the appropriate DEX Z-Code™ identifier adjacent to the CPT code in the comment/narrative field for the following Part B claim field/types:
- Loop 2400 or SV101-7 for the 5010A1 837P
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Enter the appropriate DEX Z-Code™ identifier adjacent to the CPT code in the comment/narrative field for the following Part A claim field/types:
- Line SV202-7 for 837I electronic claim
- Block 80 for the UB04 claim form

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

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

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

Enter the appropriate DEX Z-Code™ identifier adjacent to the CPT code in the comment/narrative field for the following Part A claim field/types:
- Line SV202-7 for 837I electronic claim
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Enter the appropriate DEX Z-Code™ identifier adjacent to the CPT code in the comment/narrative field for the following Part B claim field/types:
- Loop 2400 or SV101-7 for the 5010A1 837P
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- Line SV202-7 for 837I electronic claim
- Block 80 for the UB04 claim form

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

Enter the appropriate DEX Z-Code™ identifier adjacent to the CPT code in the comment/narrative field for the following Part A claim field/types:
- Line SV202-7 for 837I electronic claim
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Enter the appropriate DEX Z-Code™ identifier adjacent to the CPT code in the comment/narrative field for the following Part B claim field/types:
- Loop 2400 or SV101-7 for the 5010A1 837P
- Box 19 for paper claim

Enter the appropriate DEX Z-Code™ identifier adjacent to the CPT code in the comment/narrative field for the following Part A claim field/types:
### MolDX: CYP2B6 Test Coding and Billing Guidelines

**Contract:** J5A/J8A  
**Policy Title:** MolDX: CYP2B6 Test Coding and Billing Guidelines  
**Policy #:** A55234  
**Effective Date:** 07/01/2017

The following instructions for claim submission were added:

Labs may either use the SV101-7 or SV202-7 (preferred) or the NTE field to submit this required information.

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

- Loop 2400 or SV101-7 for the 5010A1 837P
- Box 19 for paper claim

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

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

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

**Contract:** J5A/J8A  
**Policy #:** L36398  
**Effective Date:** 07/01/2017

Added the following diagnosis codes to Group 1 Paragraph:

ICD-10 Codes that Support Medical Necessity:

**Group 1 Paragraph:** 81225  
**Group 1 Codes:**

- I25.111 Atherosclerotic heart disease of native coronary artery with angina pectoris with documented spasm
- I25.118 Atherosclerotic heart disease of native coronary artery with other forms of angina pectoris
- I25.119 Atherosclerotic heart disease of native coronary artery with unspecified angina pectoris
- I25.701 Atherosclerosis of coronary artery bypass graft(s), unspecified, with angina pectoris with documented spasm
- I25.708 Atherosclerosis of coronary artery bypass graft(s), unspecified, with other forms of angina pectoris
- I25.709 Atherosclerosis of coronary artery bypass graft(s), unspecified, with unspecified angina pectoris
- I25.711 Atherosclerosis of autologous vein coronary artery bypass graft(s) with angina pectoris with documented spasm
- I25.718 Atherosclerosis of autologous vein coronary artery bypass graft(s) with other forms of angina pectoris
- I25.719 Atherosclerosis of autologous vein coronary artery bypass graft(s) with unspecified angina pectoris
- I25.721 Atherosclerosis of autologous artery coronary artery bypass graft(s) with...
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<td>submit this required information.</td>
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<td></td>
<td>Enter the appropriate DEX Z-Code™ identifier adjacent to the CPT code in the</td>
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<td>comment/narrative field for the following Part A claim field/types:</td>
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<td></td>
<td>• Line SV202-7 for 8371 electronic claim</td>
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<td>• Block 80 for the UB04 claim form</td>
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<p>| J5A/J8A | MolDX: HEXA Gene Analysis Coding and Billing Guidelines                       | A55168          | NA           | 07/01/2017     |
|          | The following instructions for claim submission were added:                  |                 |              |                |
|          | Labs may either use the SV101-7 or SV202-7 (preferred) or the NTE field to  |                 |              |                |
|          | submit this required information.                                            |                 |              |                |
|          | Enter the appropriate DEX Z-Code™ identifier adjacent to the CPT code in the|                 |              |                |
|          | comment/narrative field for the following Part B claim field/types:          |                 |              |                |
|          |   • Loop 2400 or SV101-7 for the 5010A1 837P                                |                 |              |                |
|          |   • Box 19 for paper claim                                                  |                 |              |                |
|          | Enter the appropriate DEX Z-Code™ identifier adjacent to the CPT code in the|                 |              |                |
|          | comment/narrative field for the following Part A claim field/types:          |                 |              |                |
|          |   • Line SV202-7 for 8371 electronic claim                                  |                 |              |                |
|          |   • Block 80 for the UB04 claim form                                        |                 |              |                |</p>
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<td>A55170</td>
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<td>J5A/J8A</td>
<td>MolDX: know error® Billing and Coding Guidelines Update</td>
<td>A55172</td>
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<td>07/01/2017</td>
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Comment/narrative field for the following Part B claim field/types:
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- Box 19 for paper claim

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<td>07/01/2017</td>
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<td>A55174</td>
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<td>07/01/2017</td>
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<td>A55189</td>
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<td>MoIDX: L1CAM Gene Sequencing Coding and Billing Guidelines</td>
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<td>J5A/J8A</td>
<td>Polysomnography and Other Sleep Studies</td>
<td>L36839</td>
<td>NEURO-018</td>
<td>07/01/2017</td>
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<td>G. Sleep Center or Laboratory Credentials: reformatted bullet points to left margin. No change in coverage. All centers billing sleep studies must maintain proper certification documentation as defined above. The sleep clinic must be affiliated with a hospital or be under the direction and control of a physician (MD/DO), even though the diagnostic test may be performed in the absence of direct physician supervision. This information must be documented and available upon request. Sleep disorder clinics may at times render therapeutic as well as diagnostic services. Therapeutic services may be covered in a hospital outpatient setting or in a freestanding facility provided they meet the pertinent requirements for the particular type of services and are reasonable and necessary for the patient, and are performed under the direct supervision of a physician. (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 70, D. Coverage of Therapeutic Services).</td>
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Electronic Data Interchange (EDI)

Claim Status Category and Claim Status Codes Update

MLN Matters Number: MM10043
Related Change Request (CR) # 10043

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

Related CR Transmittal Number: R3782CP
Implementation Date: October 2, 2017

PROVIDER TYPE AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 10043 informs MACs about system changes to update, as needed, the Claim Status and Claim Status Category Codes used for the Accredited Standards Committee (ASC) X12 276/277 Health Care Claim Status Request and Response and ASC X12 277 Health Care Claim Acknowledgment transactions. Make sure that your billing staffs are aware of these changes.

BACKGROUND

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

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

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

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

ADDITIONAL INFORMATION


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

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

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

PROVIDER TYPE AFFECTED

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

PROVIDER ACTION NEEDED

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

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

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

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

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

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

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

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

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

ADDITIONAL INFORMATION

The official instruction, CR10041, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-

82 of 153 Summer 2017 Communiqué WPS GHA
If you have any questions, please contact your MAC at their toll-free number. That number is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/.

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

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

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

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

BACKGROUND

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

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

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

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

**ADDITIONAL INFORMATION**


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

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

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

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

BACKGROUND

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

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


### ADDITIONAL INFORMATION


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

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

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

## PROVIDER TYPE AFFECTED

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

## WHAT YOU NEED TO KNOW

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

## BACKGROUND

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

## ADDITIONAL INFORMATION


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Clarifying Medical Review of Hospital Claims for Part A Payment

MLN Matters Number: MM10080  Related Change Request (CR) # 10080
Related CR Release Date: May 12, 2017  Effective Date: June 13, 2017
Related CR Transmittal Number: R716PI  Implementation Date: June 13, 2017

PROVIDER TYPES AFFECTED

This MLN Matters® Article is intended for providers that submit institutional claims to Medicare Administrative Contractors (MACs) for inpatient hospital services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

Change Request (CR) 10080 clarifies the medical review requirements for Part A payment of short stay hospital claims (more commonly referred to as the "Two-Midnight" Rule) for MACs, Supplemental Medical Review Contractors (SMRC), Recovery Audit Contractors and the Comprehensive Error Rate Testing (CERT) contractors. (Note, such reviews are currently, mainly overseen by Quality Improvement Organizations). Make sure that your staffs are aware of these policies.

BACKGROUND

CR 10080 updates the Medicare Program Integrity Manual (PIM), Chapter 6, Section 6.5.2, to ensure consistency with recent regulations, as published by the Centers for Medicare & Medicaid Services (CMS). It clarifies the medical review requirements for Part A payment of short stay hospital claims (more commonly referred to as the "Two-Midnight" Rule) status.

For purposes of determining the appropriateness of Medicare Part A payment, Medicare contractors will conduct reviews of medical records for inpatient acute Hospital Inpatient Prospective Payment System (PPS) hospital, Critical Access Hospital (CAH), Inpatient Psychiatric Facility (IPF) and Long Term Care Hospital (LTCH) claims, as appropriate and as permitted by CMS, based on data analysis and their prioritized medical review strategies. Review of the medical record must indicate that hospital care was medically necessary, reasonable, and appropriate for the diagnosis and condition of the beneficiary at any time during the stay, and that the stay was appropriate for Medicare Part A payment.
These updates apply to MACs, as well as Medicare’s SMRC, Recovery Audit Contractors, and the CERT contractor. The following describes the updates:

A. Determining the Appropriateness of Part A Payment

The term “patient status review” refers to reviews conducted by Medicare contractors to determine a hospital’s compliance with Medicare requirements to bill for Medicare Part A payment. “Patient status reviews” may result in determinations that claims are not properly payable under Medicare Part A. “Patient status reviews” do not involve changing a beneficiary’s status from inpatient to outpatient.

Medicare contractors will conduct such reviews in accordance with two distinct, but related medical review policies:

1. A **Two-Midnight presumption** which helps guide contractor selection of claims for medical review

   Per the Two-Midnight presumption, Medicare contractors will presume hospital stays spanning two or more midnights after the beneficiary is formally admitted as an inpatient are reasonable and necessary for Part A payment. Generally, Medicare contractors will not focus their medical review efforts on stays spanning 2 or more midnights after formal inpatient admission absent evidence of systematic gaming, abuse, or delays in the provision of care in an attempt to qualify for the Two-Midnight presumption. (Due to its function, the CERT contractor would not exclude such claims from its review and calculation of the improper payment rate).

2. A **Two-Midnight benchmark** which helps guide contractor reviews of short stay hospital claims for Part A payment

   Per the Two-Midnight benchmark, hospital stays are generally payable under Part A if the admitting practitioner expects the beneficiary to require medically necessary hospital care spanning two or more midnights and such reasonable expectation is supported by the medical record documentation. Medicare Part A payment is generally not appropriate for hospital stays expected to span less than two midnights.

   If a stay is not reasonably expected to span two or more midnights, Medicare contractors will assess the claim to determine if an exception exists that would nonetheless make Part A payment appropriate, including:

   1. If the procedure is on the Secretary’s list of “inpatient only” procedures (identified through annual regulation)

   2. If the procedure is a CMS-identified, national exception to the Two-Midnight benchmark

   3. If the admission otherwise qualifies for a case-by-case exception to the Two-Midnight benchmark because the medical record documentation supports the admitting
physician/practitioner’s judgment that the beneficiary required hospital care on an inpatient basis despite the lack of a Two-Midnight expectation. Medicare contractors will note CMS’ expectation that stays under 24 hours would rarely qualify for an exception to the Two-Midnight benchmark.

Hospital treatment decisions for beneficiaries are based on the medical judgment of physicians and other qualified practitioners. The Two-Midnight rule does not prevent such practitioners from providing any service at any hospital, regardless of the expected duration of the service. Rather, it provides a benchmark to help guide consistent Part A payment decisions.

**Reviewing Hospital Claims for Patient Status: The Two-Midnight benchmark determines if the stay involved an “Inpatient Only” procedure**

When conducting patient status reviews, assuming all other coverage requirements are met, the Medicare review contractor will determine Medicare Part A payment to be appropriate if a medically necessary procedure classified by the Secretary as an “inpatient only” procedure is performed. “Inpatient only” procedures are so designated per 42 C.F.R. Section 419.22(n), and are detailed in the annual Outpatient Prospective Payment System (OPPS) regulation.

MACs will review the medical documentation and make an initial determination of whether a medically necessary inpatient only procedure is documented within the medical record. If so, and if the other requisite elements for payment are present, then the Medicare review contractor will deem Medicare Part A payment to be appropriate, without regard to the expected or actual length of stay.

If the Medicare review contractor does not identify an inpatient only procedure during the initial review, the claim should be assessed in accordance with the Two-Midnight benchmark.

**Calculating Time Relative to the Two-Midnight Benchmark**

Per the Two-Midnight benchmark, Medicare contractors will assess short stay (that is, less than 2 midnights after formal inpatient admission) hospital claims for their appropriateness for Part A payment. Generally, hospital claims are payable under Part A if the contractor identifies information in the medical record supporting a reasonable expectation on the part of the admitting practitioner at the time of admission that the beneficiary would require a hospital stay that crossed at least 2 midnights.

Medicare review contractor reviews will assess the information available at the time of the original physician/practitioners’ decision as follows:

1. The expectation for sufficient documentation is well rooted in good medical practice. Physician/practitioners need not include a separate attestation of the expected length of stay; rather, this information may be inferred from the physician/practitioner’s standard medical documentation, such as his/her plan of care, treatment orders, and progress notes.
2. Medicare contractors will consider the complex medical factors that support both the decision to keep the beneficiary at the hospital and the expected length of the stay. These complex medical factors may include, but are not limited to, the beneficiary's medical history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk (probability) of an adverse event occurring during the time period for which hospitalization is considered.

3. For purposes of determining whether the admitting practitioner had a reasonable expectation of hospital care spanning 2 or more midnights at the time of admission, the Medicare contractors will take into account the time the beneficiary spent receiving contiguous outpatient services within the hospital prior to inpatient admission.
   a. This pre-admission time may include services such as observation services, treatments in the emergency department (ED), and procedures provided in the operating room or other treatment area.
   b. If the beneficiary was transferred from one hospital to another, then for the purpose of determining whether the beneficiary satisfies the Two-Midnight benchmark at the recipient hospital, the Medicare contractors will take into account the time and treatment provided to the beneficiary at the initial hospital. In the event that a beneficiary was transferred from one hospital to another, the Medicare review contractor may request documentation that was authored by the transferring hospital to support the medical necessity of the services provided and to verify when the beneficiary began receiving hospital care. Medicare contractors will generally expect this information to be provided by the recipient hospital seeking Part A payment.
   c. Medicare contractors will continue to follow CMS' longstanding instruction that Medicare Part A payment is prohibited for care rendered for social purposes or reasons of convenience that are not medically necessary. Therefore, Medicare contractors will exclude extensive delays in the provision of medically necessary care from the Two-Midnight benchmark calculation. Factors that may result in an inconvenience to a beneficiary, family, physician or facility do not, by themselves, support Part A payment for an inpatient admission. When such factors affect the beneficiary's health, Medicare contractors will consider them in determining whether Part A payment is appropriate for an inpatient admission.

NOTE: While, as discussed above, the time a beneficiary spent as an outpatient before being admitted as an inpatient is considered during the medical review process for purposes of determining the appropriateness of Part A payment, such time does not qualify as inpatient time. (See the Medicare Benefit Policy Manual, Chapter 1, Section 10 for additional information regarding the formal order for inpatient admission.)

Unforeseen Circumstances Interrupting Reasonable Expectation

The Two-Midnight benchmark is based on the expectation at the time of admission that medically necessary hospital care will span 2 or more midnights. Medicare contractors will, during the course of their review, assess the reasonableness of such expectations. In the event that a stay does not span 2 or more midnights, Medicare contractors will look to see if there was an intervening event that nonetheless supports the reasonableness of the
physician/practitioner’s original judgment.

An event that interrupts an otherwise reasonable expectation that a beneficiary’s stay will span two or more midnights is commonly referred to by CMS and its contractors as an unforeseen circumstance. Such events must be documented in the medical record, and may include, but are not limited to, unexpected death, transfer to another hospital, departure against medical advice, clinical improvement, and election of hospice in lieu of continued treatment in the hospital.

**Stays Expected to Span Less than 2 Midnights**

When a beneficiary enters a hospital for a surgical procedure not specified by Medicare as inpatient only under 42 C.F.R. Section 419.22(n), a diagnostic test, or any other treatment, and the physician expects to keep the beneficiary in the hospital for less than two midnights, the services are generally inappropriate for inpatient payment under Medicare Part A, regardless of the hour that the patient came to the hospital or whether the beneficiary used a bed.

The Medicare review contractor will assess such claims to see if they qualify for a general or case-by-case exception to this generalized instruction, which would make the claim appropriate for Medicare Part A payment, assuming all other requirements are met.

**Exceptions to the Two-Midnight Rule:**

1. **Medicare’s Inpatient-Only List**
   
   Inpatient admissions where a medically necessary Inpatient-Only procedure is performed are generally appropriate for part A payment regardless of expected or actual length of stay.

2. **Nationally-Identified Rare & Unusual Exceptions to the Two-Midnight Rule**
   
   If a general exception to the Two-Midnight benchmark, as identified by CMS, is present within the medical record, the Medicare review contractor will consider the inpatient admission to be appropriate for Part A payment so long as other requirements for Part A payment are met. CMS has identified the following national or general exception to the Two-Midnight rule:

   a. **Mechanical Ventilation Initiated During Present Visit:**

      CMS believes newly initiated mechanical ventilation to be rarely provided in hospital stays less than two midnights, and to embody the same characteristics as those procedures included in Medicare’s inpatient–only list. While CMS believes a physician will generally expect beneficiaries with newly initiated mechanical ventilation to require two or more midnights of hospital care, if the physician expects that the beneficiary will only require one midnight of hospital care, but still orders inpatient admission, Part A payment is nonetheless generally appropriate.

3. **Physician-Identified Case-by-Case Exceptions to the Two-Midnight Rule**
For hospital stays that are expected to span less than 2 midnights, an inpatient admission may be payable under Medicare Part A on a case-by-case or individualized basis if the medical record supports the admitting physician/practitioner’s judgment that the beneficiary required hospital care on an inpatient basis despite the lack of a 2-midnight expectation. Medicare contractors will consider, when assessing the physician’s decision, complex medical factors including but not limited to:

- The beneficiary history and comorbidities
- The severity of signs and symptoms
- Current medical needs
- The risk of an adverse event

Medicare contractors will note CMS’ expectation that stays under 24 hours would rarely qualify for an exception to the Two-Midnight benchmark and as such, may be prioritized for medical review.

ADDITIONAL INFORMATION


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


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EDUCATION SCHEDULE

WPS GHA Learning Center

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

Event Schedule

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

New offerings!

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

Don't Miss This FREE Full Day Educational Opportunity! This exciting program includes both Part A and Part B topics to gain insight into the cause for errors and how to avoid them in the future, including:

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

Claims

Actions on Claims
10/05/2017 — Overland Park, KS – 9:00 am – 12:00 pm CT
10/12/2017 — University Center, MI — 8:30 am – 11:30 am ET
10/26/2017 — Indianapolis, IN — 8:30 am – 11:30 am ET
11/16/2017 — Ankeny, IA — 8:30 am – 11:30 am CT

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

Don’t Get Wrapped Up in Overlapping Claims (Part A)
10/18/2017 — St. Charles, MO — 8:30 am - 4:00 pm CT

Some of the topics to be covered include billing during a leave of absence (LOA)/interrupted stay, what “hospital bundling” includes, how to determine the proper patient status to use on your claim, the main cause of SNF overlaps (aside from Consolidated Billing), the 3/1 day
(72/24 hour) payment window, End Stage Renal Disease (ESRD) Consolidated Billing, Home Health Consolidated Billing, what Place of Service (POS) Part B providers should use and steps you can take to resolve overlapping claim issues with another provider.

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

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

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

In this course, we will review recent denial data, examine reason code narratives and share best practices and claims processing tips to prevent future denials.

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

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

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

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

Consolidated Billing

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

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

Documentation

Does Your Medicare Documentation Measure Up?
10/10/2017 — University Center, MI — 8:30 am – 4:00 pm ET
Join WPS GHA for a live seminar in which we will identify and discuss Medicare medical review contractors, become familiar with Medicare documentation guidelines and talk over the do’s and don’ts of them. We will also review actual documentation that was considered in coverage determinations.

**Medicare Part A Denials - Building Strong Facility Documentation**

10/11/2017 — University Center, MI — 8:30 am – 4:00 pm ET
10/25/2017 — Indianapolis, IN — 8:30 am – 4:00 pm ET
11/15/2017 — Ankeny, IA – 8:30 am – 4:00 pm CT

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

**Upcoming clinical and denial courses being planned**

12/12/2017 and 12/13/2017 – Seattle, WA - 8:30 am – 4:00 pm PT

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

**Important Notice Regarding Seminar Materials**

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

**MEDICARE LEARNING NETWORK (MLN)**

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

In addition to educational products, the MLN also offers providers and suppliers opportunities to learn more about the Medicare program through MLN National Provider Calls. These national conference calls, held by CMS for the Medicare Fee-For-Service provider and supplier community, educate and inform participants about new policies and/or changes to the Medicare program. Offered free of charge, continuing education credits may be awarded for participation in certain National Provider Calls. To learn more about MLN National Provider Calls including
upcoming calls, registration information, and links to previous call materials, visit

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

The Quarterly Provider Update can be accessed on the CMS website at:
https://www.cms.gov/Regulations-and-Guidance/Regulations-and-
Policies/QuarterlyProviderUpdates/index.html.

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:
UNSOLICITED/VOLUNTARY REFUNDS

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

Correcting Payment of Inpatient Prospective Payment System (IPPS) Transfer Claims Assigned to Medicare Severity-Diagnosis Related Group (MS DRG) 385

MLN Matters Number: MM10145
Related Change Request (CR) Number: 10145
Related CR Release Date: July 27, 2017
Effective Date: January 1, 2018
Related CR Transmittal Number: R1870OTN
Implementation Date: January 2, 2018

PROVIDER TYPE AFFECTED

This MLN Matters Article is intended for Inpatient Hospitals submitting transfer claims assigned to MS DRG 385 to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

This article, based on Change Request (CR) 10145, informs the MACs about a correction to Medicare’s Fiscal Intermediary Shared System (FISS) assignment of review code for Inpatient Prospective Payment System (IPPS) transfer claims assigned Medicare Severity Diagnosis Related Group (MS-DRG) 385, so that the IPPS Pricer will calculate the per diem transfer payment. Another correction allows Part A deductible, identified by a value code, on MSP same day transfer claims. Please be sure your billing staffs are aware of these corrections.

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) recently discovered that IPPS transfer claims classified into MS DRG 385 are receiving the full prospective payment as defined in 42 Code of Federal Regulations (CFR) 412.2(b), instead of the graduated per diem rate for each day of the patient’s stay in that hospital, not to exceed the amount that would have been paid if the patient had been discharged to another setting (42 CFR 412.4 (f)).

Prior to October 1, 2007, transferring hospitals with discharges classified into DRG 385 (Neonates, Died or Transferred) had their payments calculated on the same basis as those receiving the full prospective payment because the weighting factors for this DRG assume that
the patient will be transferred, since a transfer is part of the definition.

With the implementation of MS-DRGs in FY 2008, MS DRG 385 became inflammatory bowel disease with major complication or comorbidity (MCC). Since the definition of this MS DRG does not include a transfer, it should be subject to the transfer payment policy.

An unrelated correction also contained in this CR will allow Medicare covered and payable expenses paid by a primary payer and billed with the value code for Medicare Part A deductible

As a result, MACs will no longer bypass transfer logic when assigning review codes on IPPS claims classified into MS-DRG 385 with a discharge status code 02, 07, 66, 82, or 94 and the through date of service is equal to or later than 01/01/2018.

An unrelated correction also contained in this CR will allow the Part A deductible, identified by a value code, on Medicare Secondary Payer (MSP) same day transfer claims, as it currently does for regular MSP claims, for Medicare covered services that are paid by the primary payer.

CR 10145 contains no new policy. It improves the implementation of existing Medicare payment policies and allows the claims processing system to conform to 42 CFR 411.30 (b) which states, “Expenses for Medicare covered services that are paid for by primary payers are credited toward the Medicare Part A and Part B deductibles.”

ADDITIONAL INFORMATION


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

DOCUMENT HISTORY

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
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<td>July 28, 2017</td>
<td>Initial Article Released</td>
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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.
Fiscal Year (FY) 2017 Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital (LTCH) PPS Changes

Note: This article was revised on August 11, 2017, to reflect a revised Change Request (CR) 9723 issued on August 9, 2017. In the CR, the out migration values in attachment 7 of the CR were revised. 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 hospitals that submit claims to Medicare Administrative Contractors (MACs) for inpatient hospital services provided to Medicare beneficiaries by short-term acute care and long-term care hospitals (LTCHs).

Provider Action Needed

This article is based on CR 9723 which implements policy changes for FY 2017 IPPS and LTCH PPS and covers services effective for hospital discharges occurring on or after October 1, 2016, through September 30, 2017, unless otherwise noted. Failure to adhere to these new policies could affect payment of Medicare claims. Make sure that your billing staff is aware of these IPPS and LTCH PPS changes for FY 2017.

Background

The Social Security Amendments of 1983 (P.L. 98-21) provided for establishment of a Prospective Payment system (PPS) for Medicare payment of inpatient hospital services. In addition, the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA), as amended by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), required that a budget neutral, per discharge PPS for LTCHs based on Diagnosis-Related Groups (DRGs) be implemented for cost reporting periods beginning on or after October 1, 2002. The
Centers for Medicare & Medicaid Services (CMS) is required to make updates to these prospective payment systems annually.

CMS displayed the following policy changes for FY 2017 in the Federal Register on August 2, 2016, with a publication date of August 22, 2016. All items covered in CR9723 are effective for hospital discharges occurring on or after October 1, 2016, through September 30, 2017, unless otherwise noted.

**IPPS FY 2017 Update**

### FY 2017 IPPS Rates and Factors

**Table 1--FY 2017 IPPS Rates and Factors**

| Standardized Amount | • 1.0165 if Quality = ‘1’ and EHR = ‘blank’ in Provider Specific File (PSF); or |
| Applicable Percentage Increase | • 1.00975 if Quality = ‘0’ and EHR = ‘blank’ in PSF; or |
| | • 0.99625 if Quality = ‘1’ and EHR = ‘Y’ in PSF; or |
| | • 0.9895 if Quality = ‘0’ and EHR = ‘Y’ in PSF |
| Common Fixed Loss Cost | $23,573 |
| Outlier Threshold | |
| Federal Capital Rate | $446.79 |

**Operating Rates for Wage Index > 1**

<table>
<thead>
<tr>
<th>Hospital Submitted Quality Data and is a Meaningful Electronic Health Record (EHR) User (Update = 1.65 Percent)</th>
<th>Hospital Did NOT Submit Quality Data and is a Meaningful EHR User (Update = 0.975 Percent)</th>
<th>Hospital Submitted Quality Data and is NOT a Meaningful EHR User (Update = -0.375 Percent)</th>
<th>Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User (Update = -1.05 Percent)</th>
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</thead>
<tbody>
<tr>
<td>Labor</td>
<td>Nonlabor</td>
<td>Labor</td>
<td>Nonlabor</td>
</tr>
<tr>
<td>National</td>
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<td>$1,676.91</td>
<td>$3,813.74</td>
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<td>PR National</td>
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<td>$3,839.23</td>
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## Operating Rates Wage Index < or = 1

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<th>Labor</th>
<th>Nonlabor</th>
<th>Labor</th>
<th>Nonlabor</th>
<th>Labor</th>
<th>Nonlabor</th>
<th>Labor</th>
<th>Nonlabor</th>
</tr>
</thead>
<tbody>
<tr>
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<td>$3,420.01</td>
<td>$2,096.13</td>
<td>$3,397.30</td>
<td>$2,082.21</td>
<td>$3,351.88</td>
<td>$2,054.37</td>
<td>$3,329.16</td>
</tr>
<tr>
<td>PR National</td>
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<td>$2,096.13</td>
<td>$3,420.01</td>
<td>$2,096.13</td>
<td>$3,420.01</td>
<td>$2,096.13</td>
<td>$3,420.01</td>
</tr>
</tbody>
</table>

### MS-DRG Grouper and Medicare Code Editor (MCE) Changes

For discharges occurring on or after October 1, 2016, the Fiscal Intermediary Shared System (FISS) calls the appropriate GROUPER based on discharge date. For discharges occurring on or after October 1, 2016, the MCE selects the proper internal code edit tables based on discharge date. Medicare contractors should have received the MCE documentation in August 2016. Note that the MCE version continues to match the Grouper version.

Effective October 1, 2016, MS-DRGs 228 through 230 (Other cardiothoracic procedures w MCC, w CC and w/o CC/MCC, respectively) are collapsed from three severity levels to two severity levels by deleting MS-DRG 230 and revising MS-DRG 229, as follows:

- **MS-DRG 229 Other cardiothoracic procedures w/o MCC**
- **MS-DRG 230 Other cardiothoracic procedures w/o CC/MCC**

Effective October 1, 2016, the title for MS-DRG 884 (Organic Disturbance and Mental Retardation) is revised to MS-DRG 884 (Organic Disturbances and Intellectual Disability).

### Post-acute Transfer and Special Payment Policy

No new MS-DRGs will be added to the list of MS-DRGs subject to the post-acute care transfer policy and special payment policy. See Table 5 of the FY 2017 IPPS/LTCH PPS Final Rule for a listing of all Post-acute and Special Post-acute MS-DRGs at [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html). Then click on the link on the left side of the screen titled, “FY 2017 IPPS Final Rule Home Page” or “Acute Inpatient Files for Download.”

### New Technology Add-On

The following items will continue to be eligible for new-technology add-on payments in FY 2017:

1. **Name of Approved New Technology:** CardioMEMSTM HF Monitoring System
   - **Maximum Add on Payment:** $8,875
   - Identify and make new technology add-on payments with ICD-10-PCS procedure code 02HQ30Z or 02HR30Z
2. Name of Approved New Technology: Blinatumomab (BLINCYTO™)
   • Maximum Add on Payment: $27,017.85
   • Identify and make new technology add-on payments with ICD 10 PCS procedure code XW03351 or XW04351

3. Name of Approved New Technology: LUTONIX® Drug Coated Balloon (DCB) Percutaneous Transluminal Angioplasty (PTA) and IN.PACT™Admiral™ Paclixel Coated Percutaneous Transluminal Angioplasty (PTA) Balloon Catheter
   • Maximum Add on Payment: $1,035.72
   • Identify and make new technology add-on payments with any of the following ICD-10-PCS procedure codes: 047K041, 047K0D1, 047K0Z1, 047K341, 047K3D1, 047K3Z1, 047K441, 047K4D1, 047K4Z1, 047L041, 047L0D1, 047L0Z1, 047L341, 047L3D1, 047L3Z1, 047L441, 047L4D1, 047L4Z1, 047M041, 047M0D1, 047M0Z1, 047M341, 047M3D1, 047M3Z1, 047M441, 047M4D1, 047M4Z1, 047N041, 047N0D1, 047N0Z1, 047N341, 047N3D1, 047N3Z1, 047N441, 047N4D1, 047N4Z1

The following items will be eligible for new-technology add-on payments in FY 2017:

   • Maximum Add on Payment: $15,750
   • Identify and make new technology add-on payments with ICD-10-PCS procedure codes XNS0032, XNS0432, XNS3032, XNS3432, XNS4032 or XNS4432

5. Name of Approved New Technology: GORE IBE device system
   • Maximum Add on Payment: $5,250
   • Identify and make new technology add-on payments with ICD-10-PCS procedure codes: 04VC0EZ; 04VC0FZ; 04VC3EZ; 04VC3FZ; 04VC4EZ; 04VC4FZ; 04VD0EZ; 04VD0FZ; 04VD3EZ; 04VD3FZ; 04VD4EZ; or 04VD4FZ

6. Name of Approved New Technology: Idarucizumab
   • Maximum Add on Payment: $1,750
   • Identify and make new technology add-on payments with ICD-10-PCS procedure codes: XW03331 or XW04331

7. Name of Approved New Technology: Defitelio®
   • Maximum Add on Payment: $75,900
   • Identify and make new technology add-on payments with ICD-10-PCS procedure codes: XW03392 and XW04392

8. Name of Approved New Technology: Vistogard™
   • Maximum Add on Payment: $37,500
   • Identify and make new technology add-on payments with any of the following ICD-10-PCS diagnosis codes T45.1X1A, T45.1X1D, T45.1X1S, T45.1X5A, T45.1X5D, and T45.1X5S in combination with ICD-10-PCS procedure code XW0DX82
Cost of Living Adjustment (COLA) Update for IPPS PPS

The IPPS incorporates a COLA for hospitals located in Alaska and Hawaii. There are no changes to the COLAs for FY 2017, and are the same COLAs established for FY 2014. These COLAs are shown in the following table:

### Table 2: FY 2017 Cost-of-Living Adjustment Factors (COLAs):

#### Alaska Hospitals

<table>
<thead>
<tr>
<th>Alaska</th>
<th>Cost of Living Adjustment Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>City of Anchorage and 80-kilometer (50-mile) radius by road</td>
<td>1.23</td>
</tr>
<tr>
<td>City of Fairbanks and 80-kilometer (50-mile) radius by road</td>
<td>1.23</td>
</tr>
<tr>
<td>City of Juneau and 80-kilometer (50-mile) radius by road</td>
<td>1.23</td>
</tr>
<tr>
<td>Rest of Alaska</td>
<td>1.25</td>
</tr>
</tbody>
</table>

#### Hawaii Hospitals

<table>
<thead>
<tr>
<th>Hawaii</th>
<th>Cost of Living Adjustment Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>City and County of Honolulu</td>
<td>1.25</td>
</tr>
<tr>
<td>County of Hawaii</td>
<td>1.19</td>
</tr>
<tr>
<td>County of Kauai</td>
<td>1.25</td>
</tr>
<tr>
<td>County of Maui and County of Kalawao</td>
<td>1.25</td>
</tr>
</tbody>
</table>

### FY 2017 Wage Index Changes and Issues

#### 1. New Wage Index Labor Market Areas and Transitional Wage Indexes

a. Effective October 1, 2014, CMS revised the labor market areas used for the wage index based on the most recent labor market area delineations issued by the Office of Management and Budget (OMB) using 2010 Census data.

In order to mitigate potential negative payment impacts due to the adoption of the new OMB delineations, for the few hospitals that were located in an urban county prior to October 1, 2014, that became rural effective October 1, 2014, under the new OMB delineations, CMS assigned a hold-harmless urban wage index value of the labor market area in which they are physically located for FY 2014 for 3 years beginning in FY 2015. That is, for FYs 2015, 2016, and 2017, assuming no other form of wage index reclassification or redesignation is granted, these hospitals are assigned the area wage index value of the urban CBSA in which they were geographically located in FY 2014.

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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 2015 American Medical Association. All rights reserved.
Note that for hospitals that are receiving the 3-year hold-harmless wage index, the transition is only for the purpose of the wage index and does not affect the hospital’s urban or rural status for any other payment purposes.

b. As discussed in the FY 2017 IPPS/LTCH PPS final rule (81 FR 56913), among other changes, OMB Bulletin No. 15-01 made the following changes that are relevant to the IPPS wage index:

- Garfield County, OK, with principal city Enid, OK, which was a Micropolitan (geographically rural) area, now qualifies as an urban new CBSA 21420 called Enid, OK.

2. Treatment of Certain Providers Redesignated Under the Social Security Act (Section 1886(d)(8)(B))

42 CFR 412.64(b)(3)(ii) implements section (1886(d)(8)(B)) of the Social Security Act which redesignates certain rural counties adjacent to one or more urban areas as urban for the purposes of payment under the IPPS. (These counties are commonly referred to as “Lugar counties”.) Accordingly, hospitals located in Lugar counties are deemed to be located in an urban area and their IPPS payments are determined based upon the urban area to which they are redesignated. A hospital that waives its Lugar status in order to receive the out-migration adjustment has effectively waived its deemed urban status, and is considered rural for all IPPS purposes.

3. Section 505 Hospitals (Out-Commuting Adjustment)

Section 505 of the Medicare Modernization Act of 2003 (MMA), also known as the “outmigration adjustment, is an adjustment that is based primarily on commuting patterns and is available to hospitals that are not reclassified by the Medicare Geographic Classification Review Board (MGCRB), reclassified as a rural hospital under § 412.103, or redesignated under the Social Security Act (Section 1886(d)(8)(B)).

Treatment of Certain Urban Hospitals Reclassified as Rural Hospitals Under § 412.103 and Hospitals reclassified under the Medicare Geographic Classification Review Board (MGCRB)

An urban hospital that reclassifies as a rural hospital under § 412.103 is considered rural for all IPPS purposes. Note, hospitals reclassified as rural under § 412.103 are not eligible for the capital DSH adjustment since these hospitals are considered rural under the capital PPS (see § 412.320(a)(1)).

Prior to April 21, 2016, the regulations at § 412.230(a)(5)(ii) and § 412.230(a)(5)(iii) prohibited hospitals from simultaneously receiving an urban to rural reclassification under § 412.103 and a redesignation under the MGCRB. Also, the regulations did not allow a LUGAR hospital (that is, a hospital located in a Lugar county) to keep its LUGAR status if it was approved for an urban to rural reclassification under § 412.103. In light of court decisions that ruled as unlawful the regulation precluding a hospital from maintaining simultaneous MGCRB and § 412.103 reclassifications, on April 18, 2016, CMS issued an interim final rule with comment period (CMS-1664-IFC) amending the regulations to conform to the court decisions. The IFC is effective April 21, 2016, and was finalized in the Federal Register published on August 2, 2016. The IFC allows hospitals nationwide that have an MGCRB reclassification or LUGAR status during FY 2016 and subsequent years the opportunity to simultaneously seek urban to rural reclassification under §
412.103 for IPPS payment and other purposes, and keep their existing MGCRB reclassification or LUGAR status.

**Multicampus Hospitals with Inpatient Campuses in Different CBSAs**

Beginning with the FY 2008 wage index, CMS instituted a policy that allocates the wages and hours to the CBSA in which a hospital campus is located when a multi-campus hospital has campuses located in different CBSAs. Medicare payment to a hospital is based on the geographic location of the hospital facility at which the discharge occurred. Note that, under certain circumstances, it is permissible for individual campuses to have reclassifications to another CBSA. In general, subordinate campuses are subject to the same rules regarding withdrawals and cancellations of reclassifications as main providers.

**Medicare-Dependent, Small Rural Hospital (MDH) Program Expiration**

The MDH program provides enhanced payment to support small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges. The MDH program is currently effective through September 30, 2017, as provided by Section 205 of the Medicare Access and CHIP Reauthorization Act of 2015. Provider Types 14 and 15 continue to be valid through September 30, 2017.

In the Calendar Year (CY) 2016 OPPS Final Rule, CMS provided for a transition period for these hospitals to mitigate the financial impact of losing MDH status to hospitals that (1) lost their MDH status because they are no longer in a rural area due to the adoption of the new OMB delineations in FY 2015 and (2) have not reclassified from urban to rural under the regulations at §412.103 before January 1, 2016. During the transition period (January 1, 2016, through September 30, 2017), such hospitals (“qualifying former MDHs”) will receive a transitional add-on payment. For discharges occurring on or after October 1, 2016, through September 30, 2017, qualifying former MDHs will receive an add-on payment equal to one-third of “the MDH add-on” (that is, one-third of 75 percent of the amount by which the Federal rate payment is exceeded by the hospital’s hospital-specific rate). Information on the requirements implementing this transitional add-on payment for former MDHs are in CR9408, which is available at [https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3390CP.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3390CP.pdf).

Based on the best available information, CMS has identified the hospitals it believes qualify for this transitional add-on payment. The Pricer logic has been modified to calculate this transitional add-on payment in the HSP-payment field in the Pricer for the qualifying hospitals identified by CMS.

**Hospital Specific (HSP) Rate Factors for Sole Community Hospitals (SCHs) and Medicare-Dependent, Small Rural Hospitals (MDHs)**

For FY 2017, the HSP amount in the PSF for SCHs and MDHs will continue to be entered in FY 2012 dollars. PRICER will apply the cumulative documentation and coding adjustment factor for FYs 2011 through 2014 of 0.9480, the FY 2017 2-midnight rule one-time prospective increase of 1.006 (as well as the removal of 0.998 2-midnight rule adjustment applied in FY 2014), and apply all of the updates and DRG budget neutrality factors to the HSP amount for FY 2013 and beyond.
Low-Volume Hospitals – Criteria and Payment Adjustments for FY 2017

The temporary changes to the low-volume hospital payment adjustment originally provided by the Affordable Care Act, and extended by subsequent legislation, expanded the definition of a low-volume hospital and modified the methodology for determining the payment adjustment for hospitals meeting that definition. Section 204 of the Medicare Access and CHIP Reauthorization Act of 2015 extended the temporary changes to the low-volume hospital payment adjustment through September 30, 2017.

In order to qualify as a low-volume hospital in FY 2017, a hospital must be located more than 15 road miles from another “subsection (d) hospital” and have less than 1600 Medicare discharges (which includes Medicare Part C discharges and is based on the latest available MedPAR data). The applicable low-volume percentage increase is determined using a continuous linear sliding scale equation that results in a low-volume hospital payment adjustment ranging from an additional 25 percent for hospitals with 200 or fewer Medicare discharges to a zero percent additional payment adjustment for hospitals with 1,600 or more Medicare discharges. For FY 2017, qualifying low-volume hospitals and their payment adjustment are determined using Medicare discharge data from the March 2016 update of the FY 2015 MedPAR file. Table 14 of the FY 2017 IPPS/LTCH PPS final rule (available at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2017-IPPS-Final-Rule-Home-Page.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2017-IPPS-Final-Rule-Home-Page.html)) lists the “subsection (d)” hospitals with fewer than 1,600 Medicare discharges based on the March 2016 update of the FY 2015 MedPAR file and their low-volume hospital payment adjustment for FY 2017 (if eligible). CMS notes that the list of hospitals with fewer than 1,600 Medicare discharges in Table 14 does not reflect whether or not the hospital meets the mileage criterion (that is, the hospital is located more than 15 road miles from any other subsection (d) hospital, which, in general, is an IPPS hospital).

A hospital must notify and provide documentation to its MAC that it meets the mileage criterion as outlined in prior program guidance and the FY 2017 IPPS/LTCH PPS final rule.

To receive a low-volume hospital payment adjustment under § 412.101 for FY 2017, a hospital must make a written request for low-volume hospital status that was received by its MAC no later than September 1, 2016, in order for the applicable low-volume hospital payment adjustment to be applied to payments for discharges occurring on or after October 1, 2016. Under this procedure, a hospital that qualified for the low-volume hospital payment adjustment in FY 2016 may continue to receive a low-volume hospital payment adjustment for FY 2017 without reapplying if it continues to meet the Medicare discharge criterion established for FY 2017 (as shown in Table 14 of the FY 2017 IPPS/LTCH PPS Final Rule) and the mileage criterion. However, the hospital must have send written verification that was received by its MAC no later than September 1, 2016, stating that it continues to be more than 15 miles from any other “subsection (d)” hospital. This written verification could be a brief letter to the MAC stating that the hospital continues to meet the low-volume hospital distance criterion as documented in a prior low-volume hospital status request. If a hospital’s written request for low-volume hospital status for FY 2017 was received after September 1, 2016, and if the MAC determines that the hospital meets the criteria to qualify as a low-volume hospital, the MAC shall apply the applicable low-volume hospital payment adjustment to determine the payment for the hospital’s FY 2017 discharges, effective prospectively within 30 days of the date of its low-volume hospital status determination.
Hospital Quality Initiative

The hospitals that will receive the quality initiative bonus are listed at [www.qualitynet.org](http://www.qualitynet.org).

Hospital Acquired Condition Reduction Program (HAC)

Section 3008 of the Affordable Care Act establishes a program, beginning in FY 2015, for IPPS hospitals to improve patient safety, by imposing financial penalties on hospitals that perform poorly with regard to certain HACs. Under the HAC Reduction Program, a one (1) percent payment reduction applies to a hospital whose ranking is in the top quartile (25 percent) of all applicable hospitals, relative to the national average, of HACs acquired during the applicable period, and applies to all of the hospital's discharges for the specified fiscal year.

A list of providers subject to the HAC Reduction Program for FY 2017 was not publicly available in the final rule because the review and correction process was not yet completed. Updated hospital level data for the HAC Reduction Program will be made publicly available following the review and corrections process.

Hospital Value Based Purchasing

Section 3001 of the Affordable Care Act added Section 1886(o) to the Social Security Act, establishing the Hospital Value-Based Purchasing (VBP) Program. This program began adjusting base operating DRG payment amounts for discharges from subsection (d) hospitals, beginning in FY 2013. Under its current agreement with CMS, Maryland hospitals are not subject to the Hospital VBP Program for the FY 2017 program year. The regulations that implement this provision are in subpart I of 42 CFR part 412 (§ 412.160 through § 412.162).

For FY 2017 CMS will implement the base operating DRG payment amount reduction and the value-based incentive payment adjustments as a single value-based incentive payment adjustment factor applied to claims for discharges occurring in FY 2017. CMS expects to post the value-based incentive payment adjustment factors for FY 2017 in the near future in Table 16B of the FY 2017 IPPS/LTCH PPS final rule.

Hospital Readmissions Reduction Program

The readmissions payment adjustment factors for FY 2017 are in Table 15 of the FY 2017 IPPS/LTCH PPS final rule. Hospitals that are not subject to a reduction under the Hospital Readmissions Reduction Program in FY 2017 (such as Maryland hospitals), have a readmission adjustment factor of 1.0000. For FY 2017, hospitals should only have a readmission adjustment factor between 1.0000 and 0.9700.

NOTE: Hospitals located in Maryland (for FY 2017) and in Puerto Rico are not subject to the Hospital Readmissions Reduction Program, and therefore, are not listed in Table 15.

Medicare Disproportionate Share Hospitals (DSH) Program

Section 3133 of the Affordable Care Act modified the Medicare DSH program beginning in FY 2014, by providing that hospitals received 25 percent of the amount they previously would have received under the current statutory formula for Medicare DSH. The remainder, equal to 75 percent of what otherwise would have been paid as Medicare DSH, will become an uncompensated care payment after the amount is reduced for changes in the percentage of individuals that are uninsured. Each Medicare DSH hospital will receive a portion of this uncompensated care pool based on its share of total uncompensated care reported by Medicare DSH hospitals. A Medicare DSH hospital’
s share of uncompensated care is based on its share of insured low income days, defined as the sum of Medicare Supplemental Security Income (SSI) days and Medicaid days, relative to all Medicare DSH hospitals’ insured low income days.

The Medicare DSH payment will be reduced to 25 percent of the amount they previously would have received under the current statutory formula in PRICER. The calculation of the Medicare DSH payment adjustment will remain unchanged and the 75 percent reduction to the DSH payment will be applied in PRICER.

The total uncompensated care payment amount to be paid to Medicare DSH hospitals was finalized in the FY 2017 IPPS Final Rule. The uncompensated care payment will be paid on the claim as an estimated per discharge amount to the hospitals that have been projected to receive Medicare DSH for FY 2017. The estimated per claim amount is determined by dividing the total uncompensated care payment by the average number of claims from the most recent three years of claims data (FY2013-2015). The estimated per discharge uncompensated care payment amount will be included in the outlier payment determinations. In addition, the estimated per discharge uncompensated care payment amount will be included as a Federal payment for Sole Community Hospitals to determine if a claim is paid under the hospital-specific rate or Federal rate and for Medicare Dependent Hospitals to determine if the claim is paid 75 percent of the difference between payment under the hospital-specific rate and payment under the Federal rate. The total uncompensated care payment amount displayed in the Medicare DSH Supplemental Data File on the CMS website will be reconciled at cost report settlement with the interim estimated uncompensated care payments that are paid on a per discharge basis.

**Recalled Devices**

A hospital's IPPS payment is reduced, for specified MS-DRGs when the implantation of a device is replaced without cost or with a credit equal to 50 percent or more of the cost of the replacement device.

New MS-DRGs are added to the list subject to the policy for payment under the IPPS for replaced devices offered without cost or with a credit when they are formed from procedures previously assigned to MS-DRGs that were already on the list.

There are no new MS-DRGs for FY 2017 subject to the policy for replaced devices offered without cost or with a credit.

**LTCH PPS FY 2017 Update**

**FY 2017 LTCH PPS Rates and Factors**

FY 2017 LTCH PPS Rates and Factors are as follows:
FY 2017 LTCH PPS Rates and Factors

<table>
<thead>
<tr>
<th>LTCH PPS Standard Federal Rates</th>
<th>Rates based on successful reporting of quality data.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Full update (quality indicator on PSF = 1): $42,476.41</td>
</tr>
<tr>
<td></td>
<td>• Reduced update (quality indicator on PSF = 0 or blank): $41,641.49</td>
</tr>
<tr>
<td>Labor Share</td>
<td>66.5%</td>
</tr>
<tr>
<td>Non-Labor Share</td>
<td>33.5%</td>
</tr>
<tr>
<td>High-Cost Outlier Fixed-Loss Amount for Standard Federal Rate Discharges</td>
<td>$21,943</td>
</tr>
<tr>
<td>High-Cost Outlier Fixed-Loss Amount for Site-Neutral Rate Discharges</td>
<td>$23,573</td>
</tr>
</tbody>
</table>

The LTCH PPS Pricer has been updated with the Version 34.0 MS-LTC-DRG table, weights and factors, effective for discharges occurring on or after October 1, 2016, and on or before September 30, 2017.

1. Application of the Site Neutral Payment Rate

Section 1206(a) of Public Law 113–67 amended Section 1886(m) of the Social Security Act to establish patient-level criteria for payments under the LTCH PPS for implementation beginning for cost reporting periods beginning on or after October 1, 2015.

The application of the site neutral payment rate is codified in the regulations at § 412.522. Additional information on the final policies implementing the application of the site neutral payment rate can be found in the FY 2016 Final Rule (80 FR 49601-49623). Section 231 of the Consolidated Appropriations Act created a temporary exception to the site neutral payment rate for certain discharges from certain LTCHs. Additional information on the provisions of Section 231 can be found in the Interim Final Rule with Comment Period (IFC) published in the Federal Register on April 21, 2016 (81 FR 25430) and finalized in the FY 2017 IPPS/LTCH Final Rule (81 FR 57068). Information on the requirements implementing the application of the site neutral payment rate is available in CRs 9015 and 9599.

The provisions of Section 1206(a) of Public Law 113-67 establishes a transitional blended payment rate for site neutral payment rate LTCH discharges occurring in cost reporting periods beginning during FY 2016 or FY 2017, which is implemented in the regulations at § 412.522(c)(1). The blended payment rate is comprised of 50 percent of the site neutral payment rate for the discharge and 50 percent of the LTCH PPS standard Federal payment rate that would have applied to the discharge if the provisions of Public Law 113-67 had not been enacted. This transitional blended payment rate for site neutral payment rate LTCH discharges is included in the Pricer logic.

Discharge Payment Percentage

Beginning with LTCHs’ FY 2016 cost reporting periods, the statute requires LTCHs to be notified of their “discharge payment percentage” (DPP), which is the ratio (expressed as a percentage) of the LTCHs’ FFS discharges which received LTCH PPS standard Federal rate payment to the LTCHs’ total number of LTCH PPS discharges. MACs shall continue to provide notification to the LTCH (other than a sub-clause II LTCH) of its DPP upon final settlement of the cost report.

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 2015 American Medical Association. All rights reserved.
LTCH Quality Reporting (LTCHQR) Program

The Affordable Care Act (Section 3004(a)) requires the establishment of the Long-Term Care Hospital Quality Reporting (LTCHQR) Program. For FY 2017, the annual update to a standard Federal rate will continue to be reduced by 2.0 percentage points if a LTCH does not submit quality reporting data in accordance with the LTCHQR Program for that year.

Cost of Living Adjustment (COLA) under the LTCH PPS

The LTCH PPS incorporates a COLA for hospitals located in Alaska and Hawaii. There are no changes to the COLAs for FY 2017, and are the same COLAs established in the FY 2014 IPPS/LTCH PPS final rule. The applicable COLAs are the same as those in Tables 2 listed earlier in this article.

Additional Information


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

Document History

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<tr>
<td>August 11, 2017</td>
<td>Article revised to reflect a revised CR9723 issued on August 9, 2017. In the CR, the out migration values in attachment 7 of the CR were revised. In the article, the CR release date, transmittal number, and the Web address for accessing the CR are revised.</td>
</tr>
<tr>
<td>October 26, 2016</td>
<td>Initial article released.</td>
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Fiscal Year 2018 and After Payments to Skilled Nursing Facilities That Do Not Submit Required Quality Data

Provider Types Affected

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

What You Need to Know

Change Request (CR) 9944 reminds SNFs of payment reductions in Fiscal Year 2018, and each subsequent year, for SNFs that do not submit required quality data to Medicare.

Background

The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) added Section 1899B to the Social Security Act that:

- Imposed new data reporting requirements for certain Post-Acute Care (PAC) providers, including Skilled Nursing Facilities (SNFs)
- Required that the Centers for Medicare & Medicaid Services (CMS) implement a SNF Quality Reporting Program (QRP).

As defined in the Social Security Act (Section 1899B(a)(2)(E)), for Fiscal Years (FYs) beginning on or after the specified application date, the Social Security Act (Section 1888(e)(6)(B)(i)(II)) requires that each SNF submit (in a manner and within the time frames specified by CMS):

- Data on quality measures specified under the Social Security Act (Section 1899B(c)(1))
- Data on resource use and other measures specified under the Social Security Act (Section 1899B(d)(1)).
Note that the SNF QRP applies to freestanding SNFs, SNFs affiliated with acute care facilities, and all non-Critical Access Hospital swing-bed rural hospitals.

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

CR9944 revises Chapter 3, Section 80 of the “Medicare Quality Reporting Incentive Programs Manual” to reflect changes to the payment reduction reconsideration process. The revised manual section is included with CR9944.

Your MAC will notify you by letter if your SNF was non-compliant with the QRP requirements and are, therefore, subject to the payment reduction.

Additional Information


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

Document History

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<tr>
<td>July 17, 2017</td>
<td>Initial article released.</td>
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Implementation of the Transitional Drug Add-On Payment Adjustment for ESRD Drugs

MLN Matters Number: MM10065
Related Change Request (CR) Number: CR 10065

Related CR Release Date: August 4, 2017
Effective Date: January 1, 2018

Related CR Transmittal Number: R1889OTN
Implementation Date: January 2, 2018

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. 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 Transitional Drug Add-on Payment Adjustment (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 drug should 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 drug 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 transitional drug add-on payment adjustment, if the new injectable or intravenous drug or biological is used to treat or manage a condition for which there is not an existing ESRD PPS functional category.
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 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 and biologicals 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 drug class that qualifies 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. CR10065 has an example of the calculation used in PRICER.

**ADDITIONAL INFORMATION**


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

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Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) Fiscal Year (FY) 2018

MLN Matters Number: MM10214        Related Change Request (CR) Number: 10214
Related CR Release Date: August 4, 2017        Effective Date: October 1, 2017
Related CR Transmittal Number: R3826CP        Implementation Date: October 2, 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.

PROVIDER ACTION NEEDED

Change Request (CR) 10214 identifies changes that are required as part of the annual Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) update from the fiscal year (FY) 2018 IPF PPS Notice, displayed on August 2, 2017. These changes are applicable to IPF discharges occurring during fiscal year October 1, 2017 through September 30, 2018. This Recurring Update applies to “Claims Processing Manual”, Chapter 3, Section 190.4.3. Make sure your billing staff is aware of these changes.

BACKGROUND

On November 15, 2004, the Centers for Medicare & Medicaid Services (CMS) published in the Federal Register a final rule that established the PPS for IPF under the Medicare program in accordance with provisions of Section 124 of Public Law 106-113, the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999 (BBRA). Payments to IPFs under the IPF PPS are based on a federal per diem base rate that includes both inpatient operating and capital-related costs (including routine and ancillary services), but excludes certain pass-through costs (that is, bad debts, and graduate medical education). CMS is required to make updates to this prospective payment system annually.
Key Points of CR 10214

Market Basket Update

For FY 2018, CMS is using the 2012-based IPF market basket to update the IPF PPS payments (that is, the Federal per diem base rate and Electroconvulsive Therapy (ECT) payment per treatment). The 2012-based IPF market basket update for FY 2018 is 2.6 percent. However, this 2.6 percent is subject to two reductions required by the Social Security Act (the Act), as described below.

Section 1886(s)(2)(A)(ii) of the Act requires the application of an “Other Adjustment” that reduces any update to the IPF market basket update by percentages specified in Section 1886(s)(3) of the Act for Rate Year (RY) beginning in 2010 through the RY beginning in 2019. For the FY beginning in 2017 (that is, FY 2018), Section 1886(s)(3)(E) of the Act requires the reduction to be 0.75 percentage point. CMS implemented that provision in the FY 2018 IPF PPS Notice.

In addition, Section 1886(s)(2)(A)(i) of the Act requires the application of the Productivity Adjustment described in Section 1886(b)(3)(B)(xi)(II) of the Act to the IPF PPS for the RY beginning in 2012 (that is, a RY that coincides with a FY), and each subsequent RY. For the FY beginning in 2017 (that is, FY 2018), the reduction is 0.6 percentage point. CMS implemented that provision in the FY 2018 IPF PPS Notice.

CMS updated the IPF PPS base rate for FY 2018 by applying the adjusted market basket update of 1.25 percent (which includes the 2012-based IPF market basket update of 2.6 percent, an ACA required 0.75 percentage point reduction to the market basket update, and an ACA required productivity adjustment reduction of 0.6 percentage point) and the wage index budget neutrality factor of 1.0006 to the FY 2017 Federal per diem base rate of $761.37 to yield a FY 2018 Federal per diem base rate of $771.35. Similarly, applying the adjusted market basket update of 1.25 percent and the wage index budget neutrality factor of 1.0006 to the FY 2017 ECT payment per treatment of $327.78 yields an ECT payment per treatment of $332.08 for FY 2018.

Inpatient Psychiatric Facilities Quality Reporting Program (IPFQR)

Section 1886(s)(4) of the Act requires the establishment of a quality data reporting program for the IPF PPS beginning in FY 2014. CMS finalized new requirements for quality reporting for IPFs in the “Hospital Inpatient Prospective Payment System for Acute Care Hospitals and the Long Term Care Hospital.

“Prospective Payment System and Fiscal Year 2013 Rates”, Final Rule (August 31, 2012) (77 FR 53258, 53644 through 53360). Section 1886(s)(4)(A)(i) of the Act requires that, for FY 2014 and each subsequent FY, the Secretary will reduce any annual update to a standard Federal rate for discharges occurring during the FY by two percentage points for any IPF that does not comply with the quality data submission requirements with respect to an applicable year. Therefore, a two percentage point reduction is applied to the Federal per diem base rate and the ECT payment per treatment as follows:
• For IPFs that fail to submit quality reporting data under the IPFQR program, a -0.75 percent annual update (an update consisting of 1.25 percent annual update (that is, the adjusted market basket update) reduced by 2.0 percentage points in accordance with Section 1886(s)(4)(A)(ii) of the Act) and the wage index budget neutrality factor of 1.0006 are applied to the FY 2017 Federal per diem base rate of $761.37, yielding a Federal per diem base rate of $756.11 for FY 2018.

• Similarly, a -0.75 percent annual update and the 1.0006 wage index budget neutrality factor are applied to the FY 2017 ECT payment per treatment of $327.78, yielding an ECT payment per treatment of $325.52 for FY 2018.

PRICER Updates: IPF PPS Fiscal Year 2018 (October 1, 2017 – September 30, 2018)

• The Federal per diem base rate is $771.35 for IPFs that complied with quality data submission requirements.

• The Federal per diem base rate is $756.11 when applying the two percentage point reduction, for IPFs that failed to comply with quality data submission requirements.

• The fixed dollar loss threshold amount is $11,425.

• The IPF PPS wage index is based on the FY 2017 pre-floor, pre-reclassified acute care hospital wage index.

• The labor-related share is 75.0 percent.

• The non-labor related share is 25.0 percent.

• The ECT payment per treatment is $332.08 for IPFs that complied with quality data submission requirements.

• The ECT payment per treatment is $325.52 when applying the two percentage point reduction, for IPFs that failed to comply with quality data submission requirements.

<table>
<thead>
<tr>
<th>CCRs</th>
<th>Rural</th>
<th>Urban</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Median CCRs</td>
<td>0.5930</td>
<td>0.4420</td>
</tr>
<tr>
<td>National Ceiling CCRs</td>
<td>1.9634</td>
<td>1.7071</td>
</tr>
</tbody>
</table>

The National Urban and Rural Cost to Charge Ratios for the IPF PPS Fiscal Year 2018

CMS is applying the national Cost-to-Charge Ratios (CCRs) to the following situations:

• For new IPF facilities that have not submitted their first Medicare cost report, CMS is using these national ratios until the facility's actual CCR can be computed using the first tentatively settled or final settled cost report, which will then be used for the subsequent cost report period.
- The IPFs whose operating or capital CCR is in excess of 3 standard deviations above the corresponding national geometric mean (that is, above the ceiling).

- Other IPFs for whom the fiscal intermediary obtains inaccurate or incomplete data with which to calculate either an operating or capital CCR or both.

**International Classification of Diseases, Tenth Revision Clinical Modifications/Procedural Classification System (ICD-10-CM/PCS) Updates**

The adjustment factors are unchanged for the FY 2018 IPF PPS. However, CMS updated the ICD-10-CM/PCS code set as of October 1, 2017. These updates affect the ICD-10-CM/PCS codes which underlie the IPF PPS MS-DRG categories, the IPF PPS comorbidity categories and the IPF PPS code first list. The updated FY 2018 MS-DRG code lists are available on the IPPS website at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html), and the updated FY 2018 IPF PPS comorbidity categories, and IPF PPS code first list are available at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/tools.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/tools.html).

**FY 2018 IPF PPS Wage Index**

The FY 2018 final IPF PPS wage index is available online at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/WageIndex.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/WageIndex.html). This FY 2018 IPF PPS final wage index adopts minor OMB changes to a few statistical area delineations.

**Cost of Living Adjustment (COLA) Adjustment**

The IPF PPS COLA factors list were updated for FY 2018. See Table 1 and 2 below:

**Table 1: Alaska COLAs for IPF Prospective Payment System Fiscal Year 2018**

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<thead>
<tr>
<th>Alaska:</th>
<th>Cost of Living Adjustment Factor</th>
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<tr>
<td>City of Anchorage and 80-kilometer (50-mile) radius by road</td>
<td>1.25</td>
</tr>
<tr>
<td>City of Fairbanks and 80-kilometer (50-mile) radius by road</td>
<td>1.25</td>
</tr>
<tr>
<td>City of Juneau and 80-kilometer (50-mile) radius by road</td>
<td>1.25</td>
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<tr>
<td>Rest of Alaska</td>
<td>1.25</td>
</tr>
</tbody>
</table>
Table 2: Hawaii COLAs for IPF Prospective Payment System Fiscal Year 2018

<table>
<thead>
<tr>
<th>Hawaii</th>
<th>Cost of Living Adjustment Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>City and County of Honolulu</td>
<td>1.25</td>
</tr>
<tr>
<td>County of Hawaii</td>
<td>1.21</td>
</tr>
<tr>
<td>County of Kauai</td>
<td>1.25</td>
</tr>
<tr>
<td>County of Maui and County of Kalawao</td>
<td>1.25</td>
</tr>
</tbody>
</table>

Rural Adjustment

Due to the OMB CBSA changes implemented in FY 2016, several IPFs had their status changed from “rural” to “urban” as of FY 2016. As a result, these rural IPFs were no longer eligible for the 17 percent rural adjustment which is part of the IPF PPS. Rather than ending the adjustment abruptly, CMS phased out the adjustment for these providers over a three year period. In FY 2016, the adjustment for these newly-urban providers was two-thirds of 17 percent, or 11.3 percent. For FY 2017, the adjustment for these providers is one-third of 17 percent, or 5.7 percent. For FY 2018 and subsequent years, no rural adjustment will be given to these providers. There is no rural phase-out for the single provider whose status changed from rural to urban as a result of the July 15, 2015, OMB Bulletin 15-01.

ADDITIONAL INFORMATION


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

DOCUMENT HISTORY

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<th>Date of Change</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>August 7, 2017</td>
<td>Initial article issued</td>
</tr>
</tbody>
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July 2017 Update of the Hospital Outpatient Prospective Payment System (OPPS)

MLN Matters Number: MM10122
Related Change Request (CR) Number: 10122

Related CR Release Date: May 30, 2017
Effective Date: July 1, 2017

Related CR Transmittal Number: R3783CP
Implementation Date: July 3, 2017

PROVIDER TYPES AFFECTED

This MLN Matters® Article is intended for providers and suppliers that submit 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

This article is based on Change Request (CR) 10122 which describes changes to the OPPS to be implemented in the July 2017 update. Make sure your billing staffs are aware of these changes.

BACKGROUND


Key changes to and billing instructions for various payment policies implemented in the July 2017 Outpatient Prospective Payment System (OPPS) updates are as follows:

Category III CPT Codes Effective July 1, 2017

The American Medical Association (AMA) releases Category III Current Procedural Terminology (CPT) codes twice per year: in January, for implementation beginning the following July, and in July, for implementation beginning the following January.
For the July 2017 update, the CMS is implementing 10 Category III CPT codes that the AMA released in January 2017 for implementation on July 1, 2017. The Status Indicators (SI) and APC assignments for these codes are shown below in Table 1. Payment rates for these services are 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 1 — Category III CPT Codes Effective July 1, 2017

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Long Descriptor</th>
<th>July 2017 OPPS SI</th>
<th>July 2017 OPPS APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>0469T</td>
<td>Retinal polarization scan, ocular screening with on-site automated results, bilateral</td>
<td>E1</td>
<td>N/A</td>
</tr>
<tr>
<td>0470T</td>
<td>Optical coherence tomography (OCT) for microstructural and morphological imaging of skin, image acquisition, interpretation, and report; first lesion</td>
<td>M</td>
<td>N/A</td>
</tr>
<tr>
<td>0471T</td>
<td>Optical coherence tomography (OCT) for microstructural and morphological imaging of skin, image acquisition, interpretation, and report; each additional lesion (List separately in addition to code for primary procedure)</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>0472T</td>
<td>Device evaluation, interrogation, and initial programming of intra-ocular retinal electrode array (eg, retinal prosthesis), in person, with iterative adjustment of the implantable device to test functionality, select optimal permanent programmed values with analysis, including visual training, with review and report by a qualified health care professional</td>
<td>Q1</td>
<td>5743</td>
</tr>
<tr>
<td>0473T</td>
<td>Device evaluation and interrogation of intra-ocular retinal electrode array (eg, retinal prosthesis), in person, including reprogramming and visual training, when performed, with review and report by a qualified health care professional</td>
<td>Q1</td>
<td>5742</td>
</tr>
<tr>
<td>CPT Code</td>
<td>Long Descriptor</td>
<td>July 2017 OPPS SI</td>
<td>July 2017 OPPS APC</td>
</tr>
<tr>
<td>----------</td>
<td>----------------------------------------------------------------------------------</td>
<td>------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>0474T*</td>
<td>Insertion of anterior segment aqueous drainage device, with creation of intraocular reservoir, internal approach, into the supraciliary space</td>
<td>J1</td>
<td>5492</td>
</tr>
<tr>
<td>0475T</td>
<td>Recording of fetal magnetic cardiac signal using at least 3 channels; patient recording and storage, data scanning with signal extraction, technical analysis and result, as well as supervision, review, and interpretation of report by a physician or other qualified health care professional</td>
<td>M</td>
<td>N/A</td>
</tr>
<tr>
<td>0476T</td>
<td>Recording of fetal magnetic cardiac signal using at least 3 channels; patient recording, data scanning, with raw electronic signal transfer of data and storage</td>
<td>Q1</td>
<td>5734</td>
</tr>
<tr>
<td>0477T</td>
<td>Recording of fetal magnetic cardiac signal using at least 3 channels; signal extraction, technical analysis, and result</td>
<td>Q1</td>
<td>5734</td>
</tr>
<tr>
<td>0478T</td>
<td>Recording of fetal magnetic cardiac signal using at least 3 channels; review, interpretation, report by physician or other qualified health care professional</td>
<td>M</td>
<td>N/A</td>
</tr>
</tbody>
</table>

*For the device offset amount associated with this CPT code, refer to the discussion on device offset.

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

The AMA CPT Editorial Panel established two additional PLA CPT codes, specifically, CPT codes 0004U and 0005U effective May 1, 2017. The long descriptors for the codes are listed below in Table 2. Because the codes were effective May 1, 2017, they were not included in the April 2017 OPPS Update and are instead being including in the July Update with an effective date of May 1, 2017.

Under the hospital OPPS, CPT code 0004U is assigned to status indicator “A” and CPT code 0005U to status indicator “Q4” (Conditionally packaged laboratory tests). For more information
on OPPS SI “A” and “Q4”, refer to OPPS Addendum D1 of the CY 2017 OPPS/ASC final rule for the latest definitions to the OPPS status indicators for CY 2017.

CPT codes 0004U and 0005U have been added to the July 2017 I/OCE with an effective date of May 1, 2017. These codes, along with their short descriptors and status indicators, are in the July 2017 Addendum B at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html.

### Table 2 — Proprietary Laboratory Analyses (PLA) CPT Codes Effective May 1, 2017

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Long Descriptor</th>
<th>OPPS SI</th>
</tr>
</thead>
<tbody>
<tr>
<td>0004U</td>
<td>Infectious disease (bacterial), DNA, 27 resistance genes, PCR amplification and probe hybridization in microarray format (molecular detection and identification of AmpC, carbapenemase and ESBL coding genes), bacterial culture colonies, report of genes detected or not detected, per isolate</td>
<td>A</td>
</tr>
<tr>
<td>0005U</td>
<td>Oncology (prostate) gene expression profile by real-time RT-PCR of 3 genes (ERG, PCA3, and SPDEF), urine, algorithm reported as risk score</td>
<td>Q4</td>
</tr>
</tbody>
</table>

**New Separately Payable Procedure Codes**

Effective July 1, 2017, three new HCPCS codes, C9745, C9746, and C9747 have been created as described in the Table 3.

### Table 3 — New Separately Payable Procedure Codes Effective July 1, 2017

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>C9745</td>
<td>Nasal endo balloon dil</td>
<td>Nasal endoscopy, surgical; balloon dilation of eustachian tube</td>
<td>J1</td>
<td>5165</td>
<td>J8</td>
</tr>
</tbody>
</table>
### New Procedures Requiring the Insertion of a Device

As described in the CY 2017 OPPS/ASC final rule with comment period, effective January 1, 2017, all new procedures requiring the insertion of an implantable medical device will generally be assigned a default device offset percentage of 41 percent and assigned device intensive status, until claims data become available. In certain rare instances, CMS may temporarily assign a higher offset percentage if warranted by additional information. In accordance with this policy, the following new code(s) requiring the insertion of a device (listed Table 4) will be assigned device intensive status.

#### Table 4 — New Device Intensive Procedures Effective July 1, 2017

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
<th>Effective Date</th>
<th>July 2017 OPPS SI</th>
<th>July 2017 OPPS APC</th>
<th>CY 2017 OPPS Payment Rate</th>
<th>CY 2017 Device Offset</th>
</tr>
</thead>
<tbody>
<tr>
<td>0474T</td>
<td>Insertion of anterior segment aqueous drainage device, with creation of intraocular reservoir, internal approach, into the suprachial space</td>
<td>7-01-2017</td>
<td>J1</td>
<td>5492</td>
<td>$3,418.76</td>
<td>$1,401.69</td>
</tr>
<tr>
<td>HCPCS Code</td>
<td>Long Descriptor</td>
<td>Effective Date</td>
<td>July 2017 OPPS SI</td>
<td>July 2017 OPPS APC</td>
<td>CY 2017 OPPS Payment Rate</td>
<td>CY 2017 Device Offset</td>
</tr>
<tr>
<td>------------</td>
<td>----------------------------------------------------------------------------------</td>
<td>----------------</td>
<td>-------------------</td>
<td>-------------------</td>
<td>----------------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td>C9745</td>
<td>Nasal endoscopy, surgical; balloon dilation of eustachian tube</td>
<td>7-01-2017</td>
<td>J1</td>
<td>5165</td>
<td>$4,130.94</td>
<td>$1,693.69</td>
</tr>
<tr>
<td>C9746</td>
<td>Transperineal implantation of permanent adjustable balloon continence device, with cystourethroscopy, when performed</td>
<td>7-01-2017</td>
<td>J1</td>
<td>5377</td>
<td>$14,363.61</td>
<td>$5,889.08</td>
</tr>
</tbody>
</table>

**New HCPCS Code for Pathogen Testing for Blood Platelets**

For the July 2017 update, the HCPCS Workgroup inactivated HCPCS P9072 for Medicare reporting and replaced the code with two new HCPCS codes effective July 1, 2017. Specifically, to report either of the services described by HCPCS P9072 based on the code descriptor in effect for January 1, 2017 – June 30, 2017, providers must instead report either HCPCS code Q9988 (Platelets, pathogen reduced, each unit) or Q9987 (Pathogen(s) test for platelets) effective July 1, 2017. CMS notes that HCPCS code Q9987 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. The coding changes associated with these codes are available at [https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update.html](https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update.html) effective July 2017. The payment rates for HCPCS codes Q9987 and Q9988 are 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). Also, see Table 5 below.
Table 5 – Blood Platelet Coding Changes Effective July 1, 2017

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>July 2017 OPPS SI</th>
<th>July 2017 OPPS APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>P9072</td>
<td>Plate path red/rapid bacter tes</td>
<td>Platelets, pheresis, pathogen reduced or rapid bacterial tested, each unit</td>
<td>E1</td>
<td>N/A</td>
</tr>
<tr>
<td>Q9987</td>
<td>Pathogen test for platelets</td>
<td>Pathogen(s) test for platelets</td>
<td>S</td>
<td>1493</td>
</tr>
<tr>
<td>Q9988</td>
<td>Platelets, pathogen reduced</td>
<td>Platelets, pathogen reduced, each unit</td>
<td>R</td>
<td>9536</td>
</tr>
</tbody>
</table>

**Drugs, Biologicals, and Radiopharmaceuticals**

a. **Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective July 1, 2017**
   For CY 2017, payment for non-pass-through drugs, biologicals and therapeutic radiopharmaceuticals is made at a single rate of ASP + 6 percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical. In CY 2017, a single payment of ASP + 6 percent for pass-through drugs, biologicals and radiopharmaceuticals is made to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items. Payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. Updated payment rates effective July 1, 2017 are available at [http://www.cms.gov/HospitalOutpatientPPS/](http://www.cms.gov/HospitalOutpatientPPS/).

b. **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 at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/OPPS-Restated-Payment-Rates.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/OPPS-Restated-Payment-Rates.html) on the first date of the quarter. Providers may resubmit claims that were impacted by adjustments to previous quarter’s payment files.

c. **Drugs and Biologicals with OPPS Pass-Through Status Effective July 1, 2017**
   Two drugs and biologicals have been granted OPPS pass-through status effective July 1, 2017. These items, along with their descriptors and APC assignments, are in Table 6 below.
Table 6 — Drugs and Biologicals with OPPS Pass-Through Status Effective July 1, 2017

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
<th>APC</th>
<th>Status Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9489</td>
<td>Injection, nusinersen, 0.1 mg</td>
<td>9489</td>
<td>G</td>
</tr>
<tr>
<td>C9490</td>
<td>Injection, bezlotoxumab, 10 mg</td>
<td>9490</td>
<td>G</td>
</tr>
</tbody>
</table>

d. New Drug HCPCS Codes Effective July 1, 2017
Effective July 1, 2017, three 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 7.

Table 7 — New Drug HCPCS Codes Effective July 1, 2017

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
<th>Status Indicator</th>
<th>APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q9984</td>
<td>Levonorgestrel-releasing intrauterine contraceptive system (Kyleena), 19.5 mg</td>
<td>E1</td>
<td>N/A</td>
</tr>
<tr>
<td>Q9985</td>
<td>Injection, hydroxyprogesterone caproate, not otherwise specified, 10 mg</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>Q9986</td>
<td>Injection, hydroxyprogesterone caproate (Makena), 10 mg</td>
<td>K</td>
<td>9074</td>
</tr>
</tbody>
</table>

e. Changes to Status Indicator for CPT Code 90682
The influenza vaccine associated with CPT code 90682 (Influenza virus vaccine, quadrivalent (riv4), derived from recombinant DNA, hemagglutinin (ha) protein only, preservative and antibiotic free, for intramuscular use) is approved for use in the 2017-2018 flu season. (This is per CR9876; see related MLN Matters Article MM9876 at [https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9876.pdf](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9876.pdf).) CPT code 90682 was added to the January 2017 I/OCE with an effective date of January 1, 2017 and assigned status indicator “L” (Not paid under OPPS. Paid at reasonable cost; not subject to deductible or coinsurance). Because this code is not payable until the start of the 2017 flu season, the status indicator will be retroactively corrected from SI=L to SI=E1 (Not paid by Medicare when submitted on outpatient claims (any outpatient bill type)) effective January 1, 2017, through June 30, 2017. Effective July 1, 2017, CPT code 90682 is assigned SI=L. Table 8, below, describes the status indicator change and effective date.
Table 8 — Changes to Status Indicator for HCPCS Code 90682

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Long Descriptor</th>
<th>Status Indicator</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>90682</td>
<td>(Influenza virus vaccine, quadrivalent (riv4), derived from recombinant dna, hemagglutinin (ha) protein only, preservative and antibiotic free, for intramuscular use)</td>
<td>E1</td>
<td>January 1, 2017 – June 30, 2017</td>
</tr>
<tr>
<td>90682</td>
<td>(Influenza virus vaccine, quadrivalent (riv4), derived from recombinant dna, hemagglutinin (ha) protein only, preservative and antibiotic free, for intramuscular use)</td>
<td>L</td>
<td>July 1, 2017</td>
</tr>
</tbody>
</table>

f. Revised Status Indicator for HCPCS Code J1725
For the July 2017 update, the HCPCS Workgroup inactivated HCPCS code J1725 for Medicare reporting and replaced it with HCPCS code Q9986. Therefore, effective July 1, 2017, the status indicator for HCPCS code J1725 (Injection, hydroxyprogesterone caproate, 1 mg) will change from SI=K (Paid under OPPS; separate APC payment) to SI=E1 (Not paid by Medicare when submitted on outpatient claims [any outpatient bill type]). Table 9, below, describes the status indicator change and effective date for HCPCS code J1725. The payment rates for HCPCS codes Q9986 are 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 — Revised Status Indicator for HCPCS Code J1725

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Long Descriptor</th>
<th>Status Indicator</th>
<th>Effective Date</th>
<th>Termination Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>J1725</td>
<td>Injection, hydroxyprogesterone caproate, 1 mg</td>
<td>K</td>
<td>01/01/2012</td>
<td>06/30/2017</td>
</tr>
<tr>
<td>J1725</td>
<td>Injection, hydroxyprogesterone caproate, 1 mg</td>
<td>E1</td>
<td>07/01/2017</td>
<td></td>
</tr>
</tbody>
</table>

g. Other Changes to CY 2017 HCPCS Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals
Effective July 1, 2017, HCPCS code Q9989 (Ustekinumab, for Intravenous Injection, 1 mg) will replace HCPCS code C9487 (Ustekinumab, for Intravenous Injection, 1 mg). The status
indicator will remain G, “Pass-Through Drugs and Biologicals”. Table 10 describes the HCPCS code change and effective date.

**Table 10 — Other Changes to CY 2017 HCPCS Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals Effective July 1, 2017**

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
<th>Status Indicator</th>
<th>APC</th>
<th>Effective Date</th>
<th>Termination Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9487</td>
<td>Ustekinumab, for Intravenous Injection, 1 mg</td>
<td>G</td>
<td>9487</td>
<td>04/01/2017</td>
<td>06/30/2017</td>
</tr>
<tr>
<td>Q9989</td>
<td>Ustekinumab, for Intravenous Injection, 1 mg</td>
<td>G</td>
<td>9487</td>
<td>07/01/2017</td>
<td></td>
</tr>
</tbody>
</table>

**Application of Co-insurance and Deductible for HCPCS Code G0404**

For CY 2017 HCPCS code G0404 (Electrocardiogram, routine ECG with 12 leads; tracing only, without interpretation and report, performed as a screening for the Initial Preventive Physical Examination (IPPE)) was inadvertently assigned a waiver of coinsurance and deductible. Beginning July 1, 2017, CMS will apply coinsurance and deductible to HCPCS code G0404. This change will be retroactive back to January 1, 2017.

**Changes to OPPS Pricer Logic**

a. Effective January 1, 2017, for outliers for Community Mental Health Centers (CMHCs) (bill type 76x), updated logic to cap CMHC claims' outlier payments at 8% of payments based on the current claim’s OPPS Pricer calculations.

b. Effective January 1, 2017, added Payment Method Flag (PMF) '9' to valid list to bypass the outlier cap logic.

c. Effective for CY’s 2016 and 2017, changed the location of the device credit selection logic to ensure that providers with a special payment indicator of ‘1’ or ‘2’ in the Outpatient Provider Specific File receive the device credit.

d. Effective July 1, 2017, added line item Denial/Rejection (D/R) Flag ‘3’ to valid list for FISS informational use.

**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>
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<tr>
<th>Date of Change</th>
<th>Description</th>
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<tbody>
<tr>
<td>May 30, 2017</td>
<td>Initial Article Released</td>
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</table>

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

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

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

PROVIDER TYPE AFFECTED

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

PROVIDER ACTION NEEDED

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

BACKGROUND

The DMEPOS fee schedules are updated on a quarterly basis, when necessary, in order to implement fee schedule amounts for new and existing codes, as applicable, and apply changes in payment policies. The quarterly update process for the DMEPOS fee schedule is located in the Medicare Claims Processing Manual, Chapter 23, Section 60 at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf.

Also, payment on a fee schedule basis is a regulatory requirement at 42 Code of Federal Regulations (CFR) §414.102 for parenteral and enteral nutrition (PEN), splints and casts and intraocular lenses (IOLs) inserted in a physician's office.

Additionally, Section 1834 of the Act mandates adjustments to the fee schedule amounts for certain items furnished on or after January 1, 2016, in areas that are not competitive bid areas (CBAs), based on information from competitive bidding programs (CBPs) for DME. The Social Security Act (§1842(s)(3)(B)) provides authority for making adjustments to the fee schedule amount for enteral nutrients, equipment and supplies (enteral nutrition) based on information from CBPs. Also, the adjusted fees apply a rural payment rule. The DMEPOS and PEN fee schedule files contain HCPCS codes that are subject to the adjustments as well as codes that are not subject to the fee schedule adjustments. Additional information on adjustments to the fee schedule amounts based on information from CBPs is available in CR 9642 (Transmittal 3551, dated June 23, 2016).

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

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

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

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

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

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


ADDITIONAL INFORMATION


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

DOCUMENT HISTORY

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<td>August 2, 2017</td>
<td>The article was revised on August 3, 2017, to reflect an updated CR. That CR updated the policy section on complex rehabilitative power wheelchair accessories &amp; seat and back cushions (page 2 of this article). The CR release date, transmittal number and link to the CR were also changed.</td>
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Medicare Part A Skilled Nursing Facility (SNF) Prospective Payment System (PPS) Pricer Update FY 2018

MLN Matters Number: MM10118  Related Change Request (CR) Number: CR10118
Related CR Release Date: June 16, 2017  Effective Date: October 1, 2017
Related CR Transmittal Number: R3796CP  Implementation Date: October 2, 2017

PROVIDER TYPES AFFECTED

This MLN Matters® Article is intended for Skilled Nursing Facilities (SNFs) submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries paid under the Skilled Nursing Facility (SNF) Prospective Payment System (PPS).

PROVIDER ACTION NEEDED

Change Request (CR) 10118 informs MACs about the updates to the payment rates under the PPS for SNFs, for FY 2018, as required by statute. Make sure that your billing staffs are aware of these changes.

BACKGROUND

Annual updates to PPS rates are required by Section1888(e) of the Social Security Act, as amended by the Medicare, Medicaid, and State Children’s Health Insurance Plan (SCHIP) Balanced Budget Refinement Act of 1999 (the BBRA), the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (the BIPA), and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (the MMA), relating to Medicare payments and consolidated billing for SNFs.

Each July, the Centers for Medicare & Medicaid Services (CMS) publishes the SNF payment rates for the upcoming Fiscal Year (FY) (that is, October 1, 2017, through September 30, 2018) in the Federal Register, available online at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/List-of-SNF-Federal-Regulations.html. The update methodology is similar to that used in the previous year, which includes a forecast error adjustment whenever the difference between the forecasted and actual change in the SNF market basket exceeds a 0.5 percentage point. The statute mandates an update to the Federal rates using the latest SNF full market basket adjusted for productivity. However, for FY 2018, the SNF payment increase factor is 1.0 percent, as required by Section 411(a) of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The payment rates will be effective October 1, 2017.
ADDITIONAL INFORMATION


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

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October 2017 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions To Prior Quarterly Pricing Files

MLN Matters Number: MM10187
Related Change Request (CR) Number: 10187
Related CR Release Date: July 21, 2017
Effective Date: October 1, 2017
Related CR Transmittal Number: R3809CP
Implementation Date: October 2, 2017

PROVIDER TYPES AFFECTED

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

WHAT YOU NEED TO KNOW

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

BACKGROUND

The ASP methodology is based on quarterly data submitted to the CMS by manufacturers. CMS will supply contractors with the ASP and not otherwise classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the Outpatient Prospective Payment System (OPPS) are incorporated into the Outpatient Code Editor (OCE) through separate instructions available in Chapter 4, section 50 of the Medicare Claims Processing Manual, at https://www.cms.gov/regulations-and-Guidance/Guidance/Manuals.downloads/clm104c04.pdf.

- File: October 2017 ASP and ASP NOC -- Effective Dates of Service: October 1, 2017, through December 31, 2017
File: July 2017 ASP and ASP NOC -- Effective Dates of Service: July 1, 2017, through September 30, 2017
File: April 2017 ASP and ASP NOC -- Effective Dates of Service: April 1, 2017, through June 30, 2017
File: January 2017 ASP and ASP NOC -- Effective Dates of Service: January 1, 2017, through March 31, 2017
File: October 2016 ASP and ASP NOC -- Effective Dates of Service: October 1, 2016, through December 31, 2016

For any drug or biological not listed in the ASP or NOC drug-pricing files, MACs will determine the payment allowance limits in accordance with the policy described in the “Medicare Claims Processing Manual,” Chapter 17, Section 20.1.3, which is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c17.pdf. For any drug or biological not listed in the ASP or NOC drug-pricing files that is billed with the KD modifier, contractors shall determine the payment allowance limits in accordance with instructions for pricing and payment changes for infusion drugs furnished through an item of Durable Medical Equipment (DME) on or after January 1, 2017, associated with the passage of the 21st Century Cures Act.

ADDITIONAL INFORMATION


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

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Provider-Based Determination

MLN Matters Number: MM10095
Related Change Request (CR) Number: CR10095
Related CR Release Date: August 4, 2017
Effective Date: November 6, 2017
Related CR Transmittal Number: R1891OTN
Implementation Date: November 6, 2017

PROVIDER TYPES AFFECTED

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

WHAT YOU NEED TO KNOW

Change Request (CR) 10095 advises MACs to use a uniform electronic Provider-Based (PB) checklist to perform uniform reviews of PB applications.

BACKGROUND

Prior to September 2014, the Centers for Medicare & Medicaid Services (CMS) had been receiving discrete, PB checklists from each of the MACs and found that each one was significantly different from the next. Some checklists were incomplete and did not cover all the required information from the PB regulations. Some checklists did not include sufficient information. CR 10095 instructs MACs to use the comprehensive electronic PB checklist when reviewing PB attestations.

CR 10095 does not make any policy revisions to the review of PB applications. Some checklists were incomplete, did not cover all the required information from the PB regulations, and/or did not include sufficient information.

ADDITIONAL INFORMATION

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

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Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - July CY 2017 Update

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

PROVIDER TYPE AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 10104 informs MACs about the release of payment files based upon the calendar year (CY) 2017 Medicare Physician Fee Schedule (MPFS) Final Rule. Make sure that your billing staffs are aware of these changes.

BACKGROUND

Payment files were issued to the MACs based upon the CY 2017 MPFS Final Rule, published in the Federal Register on November 15, 2016, to be effective for services furnished between January 1, 2017, and December 31, 2017. Section 1848(c)(4) of the Social Security Act authorizes the Secretary to establish ancillary policies necessary to implement relative values for physicians’ services.

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

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

<table>
<thead>
<tr>
<th>CPT/HCPCS</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>20245</td>
<td>Global Days = 000</td>
</tr>
<tr>
<td>52441</td>
<td>Endo Base = 52000</td>
</tr>
<tr>
<td>64897</td>
<td>Co-Surgery = 1</td>
</tr>
<tr>
<td>64902</td>
<td>Co-Surgery = 1</td>
</tr>
<tr>
<td>J1725</td>
<td>Status = I, effective for DOS on or after July 1, 2017</td>
</tr>
<tr>
<td>P9072</td>
<td>Status = I, effective for DOS on or after July 1, 2017</td>
</tr>
</tbody>
</table>
The following new codes have been added to the HCPCS file effective May 1, 2017. The HCPCS file coverage code is C (carrier judgment) for these new codes. Coverage and payment will be determined by the MAC (they are not part of the MPFS).

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

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

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

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


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The Supplemental Security Income (SSI)/Medicare Beneficiary Data for Fiscal Year 2015 for Inpatient Prospective Payment System (IPPS) Hospitals, Inpatient Rehabilitation Facilities (IRFs), and Long Term Care Hospitals (LTCH)

MLN Matters Number: MM10026
Related Change Request (CR) Number: CR10026
Related CR Release Date: June 30, 2017
Effective Date: July 31, 2017
Related CR Transmittal Number: R1863OTN
Implementation Date: July 31, 2017

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 10026 informs MACs about updated data for determining the disproportionate share adjustment for Inpatient Prospective Payment System (IPPS) hospitals and the low income patient (LIP) adjustment for IRFs as well as payments as applicable for Long Term Care Hospitals (LTCH) discharges (for example, discharges paid the IPPS comparable amount under the short-stay outlier payment adjustment). Make sure that your billing staffs are aware of these changes.

BACKGROUND

The SSI/Medicare beneficiary data for hospitals are available electronically and contains the name of the hospital, Centers for Medicare & Medicaid Services (CMS) certification number, Supplemental Security Income (SSI) days, total Medicare days, and the ratio of days for patients entitled to Medicare Part A attributable to SSI recipients. The files are available at the following as follows:
The data are used for settlement purposes for IPPS hospitals and IRFs with cost reporting periods beginning during fiscal year (FY) 2015 (cost reporting periods beginning on or after October 1, 2014, and before October 1, 2015), except as explicitly directed otherwise by the Centers for Medicare & Medicaid Services (CMS).

These instructions also provide guidance for accepting FY 2015 amended cost reports from hospitals requesting to revise Worksheet S-10 (cost reports starting on or after October 1, 2014 and prior to October 1, 2015) in light of CMS’s proposal to begin using Worksheet S-10 data to determine uncompensated care payments starting in FY 2019. For revisions to be considered, hospitals must submit their amended cost report containing the revised Worksheet S-10 (or a completed Worksheet S-10 if no data had been included on the previously submitted cost report) no later than September 30, 2017. CMS notes that the amended cost report must be received by the MAC by September 30, 2017. Submissions received on or after October 1, 2017 will not be accepted.

Providers should follow the current requirements for electronic submission of cost reports found at 42 CFR §413.24(f)(4), which specify "a provider must submit a hard copy of a settlement summary, a statement of certain worksheet totals found within the electronic file, and a statement signed by its administrator or chief financial officer certifying the accuracy of the electronic file or the manually prepared cost report." (See 42 CFR §413.24(f)(4)(iv).) This instruction applies only to Worksheet S-10 of FY 2015 cost reports for IPPS hospitals. Revisions to Worksheet S-10 from other fiscal years, revisions to other worksheets of the FY 2015 cost reports, or revisions to Worksheet S-10 by non-IPPS hospitals are not subject to this instruction.

If ab IPPS hospital whose FY 2015 cost report has been final settled requests to revise Worksheet S-10 for that FY 2015 cost report and the request is received by the MAC on or before September 30, 2017, MACs will issue a notice of Reopening in order to accept the revisions to or newly submitted Worksheet S-10 and issue a revised notice of program reimbursement on or before October 31, 2017.

Section 9105 of the Consolidated Omnibus Budget Reconciliation Act of 1985 provides that for discharges occurring on or after May 1, 1986, an additional payment must be made to IPPS hospitals serving a disproportionate share of low income patients. The additional payment is determined by multiplying the federal portion of the Diagnosis-Related Group (DRG) payment by the Disproportionate Share Hospital (DSH) adjustment factor, and beginning for discharges occurring on or after October 1, 2014, the additional payment is determined by multiplying the
DRG payment by the DSH adjustment factor reduced by 75 percent. (See 42 CFR 412.106.) Under the IRF prospective payment system (PPS), IRFs receive an additional payment amount to account for the cost of furnishing care to low income patients. The additional payment is determined by multiplying the federal prospective payment by the LIP adjustment formula. (See 42 CFR 412.624(e)(2).)

Under the LTCH PPS, the payment adjustment for short-stay outlier (SSO) cases at 42 CFR 412.529 requires the calculation of an amount comparable to the amount that would otherwise be paid under the IPPS (that is, the "IPPS comparable amount."). This calculation includes an "IPPS Comparable" DSH adjustment, where applicable, that is determined using the best available SSI data at the time of claim payment (See 42 CFR 412.529(d)(4)).

ADDITIONAL INFORMATION


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

DOCUMENT HISTORY

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<td>July 3, 2017</td>
<td>Initial Article Released</td>
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WPS GHA PROVIDER SERVICES

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