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

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DOLLAR AMOUNT IN CONTROVERSY REQUIRED TO SUSTAIN APPEAL RIGHTS

CMS has announced the dollar amount that must remain in controversy to sustain appeal rights beginning January 1, 2018. The amount that must remain in controversy for ALJ hearing requests filed on or before December 31, 2017, is $160. This amount will remain at $160 for ALJ hearing requests filed on or after January 1, 2018. The amount that must remain in controversy for reviews in Federal District Court requested on or before December 31, 2017, is $1,560. This amount will increase to $1,600 for appeals to Federal District Court filed on or after January 1, 2018.
2018 Annual Update of Healthcare Common Procedure Coding System (HCPCS) Codes for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Update

MLN Matters Number: MM10262
Related CR Release Date: September 8, 2017
Related CR Transmittal Number: R3857CP

Related Change Request (CR) Number: 10262
Effective Date: January 1, 2018
Implementation Date: January 2, 2018

PROVIDER TYPES AFFECTED

This MLN Matters® Article is intended for physicians, other providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs), including Home Health & Hospice (HH&H) MACs and Durable Medical Equipment (DME) MACs, for services provided to Medicare beneficiaries who are in a Part A covered Skilled Nursing Facility (SNF) stay.

PROVIDER ACTION NEEDED

Change Request (CR) 10262 makes changes to Healthcare Common Procedure Coding System (HCPCS) codes and Medicare Physician Fee Schedule designations that will be used to revise Common Working File (CWF) edits to allow A/B MACs to make appropriate payments in accordance with policy for SNF CB in Chapter 6, Section 110.4.1 and Chapter 6, Section 20.6 in the "Medicare Claims Processing Manual."

BACKGROUND

The Common Working File (CWF) currently has edits in place for claims received for beneficiaries in a Part A covered SNF stay as well as for beneficiaries in a non-covered stay. These edits allow only those services that are excluded from consolidated billing to be separately paid. Barring any delay in the Medicare Physician Fee Schedule, the new code files will be provided to CWF by November 1, 2017.

By the first week in December 2017, new code files will be posted at http://www.cms.gov/SNFConsolidatedBilling/. The files will be applicable to claims with dates of service on or after January 1, 2018, through December 31, 2018. It is important and necessary for the provider/contractor community to view the "General Explanation of the Major
Categories” file located at the bottom of each year’s update in order to understand the Major Categories including additional exclusions not driven by HCPCS codes.

**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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Annual Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement

MLN Matters Number: MM10308
Related Change Request (CR) Number: 10308
Related CR Release Date: October 6, 2017
Effective Date: January 1, 2018
Related CR Transmittal Number: R3877CP
Implementation Date: January 2, 2018

PROVIDER TYPES AFFECTED

This MLN Matters® Article is intended for Home Health Agencies (HHAs) and other providers submitting claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries in a home health period of coverage.

PROVIDER ACTION NEEDED

Change Request (CR) 10308 provides the 2018 annual update to the list of Healthcare Common Procedure Coding System (HCPCS) codes used by Medicare systems to enforce consolidated billing of home health services. Make sure your billing staffs are aware of these updates.

BACKGROUND

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

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

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

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

The recurring updates in CR10308 provide annual HH consolidated billing updates effective January 1, 2018. The following HCPCS codes are added to the HH consolidated billing therapy code list:

- 97763 – Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes
  - This code replaces 97762.
- G0515 – Development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct (one-on-one) patient contact, each 15 minutes
  - This code replaces 97532.

**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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Care Coordination Services and Payment for Rural Health Clinics (RHCs) and Federally-Qualified Health Centers (FQHCs)

MLN Matters Number: MM10175 Revised  Related Change Request (CR) Number: 10175
Related CR Release Date: August 11, 2017  Effective Date: January 1, 2018
Related CR Transmittal Number: R1899OTN  Implementation Date: January 2, 2018

Note: This article was revised on November 13, 2017, to correct statements on page 2 (in bold). All other information is unchanged.

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 10175 provides instructions for payment to Rural Health Clinics (RHCs) billing under the all-inclusive rate (AIR), and Federally Qualified Health Centers (FQHCs) billing under the prospective payment system (PPS), for care coordination services for dates of service on or after January 1, 2018.

BACKGROUND

As authorized by §1861(aa) of the Social Security Act, RHCs and FQHCs are paid for physician services and services and supplies incident to physician services. Care coordination services are RHC and FQHC services, but payment for the additional costs associated with certain care coordination services are not included in the RHC AIR or the FQHC PPS rate. In the CY 2016 Medicare Physician Fee Schedule (PFS) final rule (80 FR 71080), Centers for Medicare & Medicaid Services (CMS) finalized requirements and a payment methodology for Chronic Care Management (CCM) services furnished by RHCs and FQHCs. Effective January 1, 2016, CCM payment to RHCs and FQHCs is based on the Medicare PFS national non-facility payment rate when CPT code 99490 is billed alone or with other payable services on a RHC or FQHC claim. The rate is updated annually and there is no geographic adjustment. Revisions to the CCM requirements for
RHCs and FQHCs were in the CY 2017 PFS final rule (81 FR 80256) for services furnished on or after January 1, 2017.

In the CY 2017 PFS final rule (81 FR 80225), CMS established separate payment, beginning January 1, 2017, for practitioners billing under the PFS, for complex CCM services, General Behavioral Health Integration (BHI) services, and a psychiatric collaborative care model (CoCM). To allow payment to RHCs and FQHCs for these new services, CMS finalized in the CY 2018 Physician Fee Schedule Final Rule to revise payment for care coordination services in RHCS and FQHCs by establishing 2 new G codes for use by RHCs and FQHCs, effective January 1, 2018. **The first new G code will be a General Care Management code for RHCs and FQHCs with the payment amount set at the average of the 3 national non-facility PFS payment rates for the CCM and general BHI codes. The second new G code for RHCs and FQHCs will be a Psychiatric CoCM code with the payment amount set at the average of the 2 national non-facility PFS payment rates for psychiatric CoCM services. RHC or FQHC claims submitted using CPT 99490 for dates of service on or after January 1, 2018, will be denied.**

Effective for dates of service on or after January 1, 2018, RHCs and FQHCs will be paid for General Care Management services when G0511 is billed alone or with other payable services on a RHC or FQHC claim. Payment for G0511 is set at the average of the 3 national non-facility PFS payment rates for the CCM (CPT code 99490 and CPT code 99487) and general BHI (CPT code 99484). The rate is updated annually based on the PFS amounts and coinsurance applies. This code could only be billed once per month per beneficiary, and could not be billed if other care management services are billed for the same time period.

Effective for dates of service on or after January 1, 2018, RHCs and FQHCs will be paid for Psychiatric CoCM services when G0512 is billed alone or with other payable services on an RHC or FQHC claim. Payment for G0512 is set at the average of the 2 national non-facility PFS payment rates for CoCM (CPT code 99492 and CPT code 99493). The rate is updated annually based on the PFS amounts and coinsurance applies. This code could only be billed once per month per beneficiary, and could not be billed if other care management services are billed for the same time period.

**General Care Management (G0511) Requirements:** RHCs and FQHCs can bill the new General Care Management G code when the following requirements are met:

1. Initiating Visit: An Evaluation Management (E/M), Annual Wellness Visit (AWV), or Initial Preventive Physical Examination (IPPE) visit furnished by a physician, Nurse Practitioner (NP), Physician Assistants (PA), or Certified Nurse-Midwives (CNM) has occurred no more than one-year prior to commencing care coordination services. This would be billed as an RHC or FQHC visit.

2. Beneficiary Consent: Has been obtained during or after the initiating visit and before provision of care coordination services by RHC or FQHC practitioner or clinical staff;
can be written or verbal, must be documented in the medical record and includes information:

- On the availability of care coordination services and applicable cost-sharing
- That only one practitioner can furnish and be paid for care coordination services during a calendar month
- On the right to stop care coordination services at any time (effective at the end of the calendar month)
- Permission to consult with relevant specialists.

3. Billing Requirements: At least 20 minutes of care coordination services has been furnished in the calendar month furnished a) under the direction of the RHC or FQHC physician, NP, PA, or CNM, and b) by an RHC or FQHC practitioner, or by clinical personnel under general supervision.

4. Patient Eligibility: Patient must have:

- Option A: Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, and place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, OR
- Option B: Any behavioral health or psychiatric condition being treated by the RHC or FQHC practitioner, including substance use disorders, that, in the clinical judgment of the RHC or FQHC practitioner, warrants BHI services.

5. Requirement Service Elements

For patients meeting the eligibility requirements of Option A, the RHC or FQHC must meet all of the following requirements:

- Structured recording of patient health information using Certified EHR Technology and includes demographics, problems, medications, and medication allergies that inform the care plan, care coordination, and ongoing clinical care
- 24/7 access to physicians or other qualified health care professionals or clinical staff including providing patients/caregivers with a means to make contact with health care professionals in the practice to address urgent needs regardless of the time of day or day of week, and continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments
- Comprehensive care management including systematic assessment of the patient’s medical, functional, and psychosocial needs; system-based approaches to ensure timely receipt of all recommended preventive care services; medication reconciliation with review of adherence and potential interactions; and oversight of patient self-management of medications
• Comprehensive care plan including the creation, revision, and/or monitoring of an electronic care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment and an inventory of resources and supports; a comprehensive care plan for all health issues with particular focus on the chronic conditions being managed

• Care plan information made available electronically (including fax) in a timely manner within and outside the RHC or FQHC as appropriate and a copy of the plan of care given to the patient and/or caregiver

• Management of care transitions between and among health care providers and settings, including referrals to other clinicians; follow-up after an emergency department visit; and follow-up after discharges from hospitals, skilled nursing facilities, or other health care facilities; timely creation and exchange/transmit continuity of care document(s) with other practitioners and providers;

• Coordination with home- and community-based clinical service providers, and documentation of communication to and from home- and community-based providers regarding the patient’s psychosocial needs and functional deficits in the patient’s medical record

• Enhanced opportunities for the patient and any caregiver to communicate with the practitioner regarding the patient’s care through not only telephone access, but also through the use of secure messaging, Internet, or other asynchronous non-face-to-face consultation methods.

For patients meeting the eligibility requirements of Option B, the RHC or FQHC must meet all of the following requirements:

• Initial assessment or follow-up monitoring, including the use of applicable validated rating scales

• Behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes

• Facilitating and coordinating treatment (such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation)

• Continuity of care with a designated member of the care team.

**Psychiatric CoCM (G0512) Requirements: RHCs and FQHCs can bill the Psychiatric CoCM G code when the following requirements are met:**

1. Initiating Visit: An E/M, AWV, or IPPE visit furnished by a physician, NP, PA, or CNM has occurred no more than one-year prior to commencing psychiatric CoCM services. This would be billed as an RHC or FQHC visit.
2. Beneficiary Consent: Has been obtained during or after the initiating visit and before provision of care coordination services by RHC or FQHC practitioner or clinical staff; can be written or verbal, must be documented in the medical record and include:

- Information on the availability of care coordination services and applicable cost-sharing
- That only one practitioner can furnish and be paid for care coordination services during a calendar month
- That the patient has the right to stop care coordination services at any time (effective at the end of the calendar month)
- The patient is giving permission to consult with relevant specialists

3. Billing Requirements: At least 70 minutes in the first calendar month, and at least 60 minutes in subsequent calendar months of psychiatric CoCM services, furnished a) under the direction of the RHC or FQHC practitioner, and b) by an RHC or FQHC practitioner or Behavioral Health Care Manager under general supervision.

4. Patient Eligibility: Patient must have a behavioral health or psychiatric condition that is being treated by the RHC or FQHC practitioner, including substance use disorders, that, in the clinical judgment of the RHC or FQHC practitioner, warrants psychiatric CoCM services.

5. Requirement Service Elements: Psychiatric CoCM requires a team that includes the following:

RHC or FQHC Practitioner (physician, NP, PA, or CNM) who:

- Directs the behavioral health care manager or clinical staff
- Oversees the beneficiary’s care, including prescribing medications, providing treatments for medical conditions, and making referrals to specialty care when needed
- Remains involved through ongoing oversight, management, collaboration and reassessment

Behavioral Health Care Manager who:

- Provides assessment and care management services, including the administration of validated rating scales; behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes; provision of brief psychosocial interventions; ongoing collaboration with the RHC or FQHC practitioner; maintenance of the registry;
acting in consultation with the psychiatric consultant

- Is available to provide services face-to-face with the beneficiary; has a continuous relationship with the patient and a collaborative, integrated relationship with the rest of the care team

- Is available to contact the patient outside of regular RHC or FQHC hours as necessary to conduct the behavioral health care manager’s duties

Psychiatric Consultant who:

- Participates in regular reviews of the clinical status of patients receiving CoCM services;

- Advises the RHC or FQHC practitioner regarding diagnosis, options for resolving issues with beneficiary adherence and tolerance of behavioral health treatment; making adjustments to behavioral health treatment for beneficiaries who are not progressing; managing any negative interactions between beneficiaries’ behavioral health and medical treatments

- Facilitate referral for direct provision of psychiatric care when clinically indicated

MACs will apply coinsurance and deductible to HCPCS codes G0511 and G0512 on FQHC claims.

ADDITIONAL INFORMATION


If you have any questions, please contact your MAC at their toll-free number. That number is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/.
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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 Revised
Related Change Request (CR) Number: CR10098
Related CR Release Date: November 9, 2017
Effective Date: January 1, 2018
Related CR Transmittal Number: R1976OTN
Implementation Date: January 2, 2018

Note: This article was revised on November 13, 2017, to reflect a revised CR10098 issued on November 9. In the article, the CR release date, transmittal number, and Web address of CR are revised. All other information remains the same.

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/](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>November 13, 2017</td>
<td>Article revised to reflect a revised CR. In the article, the CR release date, transmittal number, and Web address of CR are revised. All other information remains the same.</td>
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<tr>
<td>July 28, 2017</td>
<td>Initial article released.</td>
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Correction to Prevent Payment on Inpatient Information Only Claims for Beneficiaries Enrolled in Medicare Advantage Plans

MLN Matters Number: MM10238
Related Change Request (CR) Number: 10238

Related CR Release Date: October 27, 2017
Effective Date: April 1, 2015

Related CR Transmittal Number: R3898CP
Implementation Date: April 2, 2018

PROVIDER TYPES AFFECTED

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

WHAT YOU NEED TO KNOW

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

BACKGROUND

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

The Centers for Medicare & Medicaid Services (CMS) uses claims data to calculate a hospital’s percentage of total Medicare days for which Medicare beneficiaries were simultaneously entitled to both SSI and Medicare. In order for MA enrolled inpatient days to be included in this Medicare/SSI fraction, the hospital must submit an informational only bill (Type of Bill (TOB) 11X) which includes Condition Code 04 to their MAC.
CMS was notified that a CWF edit that is required to prevent payment on information only claims for MA beneficiaries for IDE studies and Clinical Studies Approved Under CED, which should be paid by the Medicare Advantage Plan, is bypassed for claims billed with condition code (CC) 30, thereby causing a Medicare Fee-for-Service (FFS) payment in error.

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

ADDITIONAL INFORMATION


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

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

MLN Matters Number: MM10141
Related CR Release Date: August 18, 2017
Related CR Transmittal Number: R3842CP

Related Change Request (CR) # 10141
Effective Date: October 1, 2017
Implementation Date: January 2, 2018

Contractors with capability to do so will implement effective October 1, 2017

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 10141 instructs MACs to obtain the most recent Healthcare Provider Taxonomy Code (HPTC) set and to update their internal HPTC tables and/or reference files.

BACKGROUND

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

You should note that:

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

The HPTC set is maintained by the NUCC for standardized classification of health care providers. The NUCC updates the code set twice a year with changes effective April 1 and October 1. The HPTC list is available for view from the Washington Publishing Company (WPC) website at [www.wpc-edi.com/codes](http://www.wpc-edi.com/codes) and can be downloaded from the NUCC’s website [http://www.nucc.org/index.php/code-sets-mainmenu-41/provider-taxonomy-mainmenu-40](http://www.nucc.org/index.php/code-sets-mainmenu-41/provider-taxonomy-mainmenu-40).

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

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

**ADDITIONAL INFORMATION**


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

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

Note: This article was re-issued on October 3, 2017, to confirm that its content remains valid even though Special Edition Article SE1607 was rescinded.

Provider Types Affected

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

What You Need to Know

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

Background

Partial hospitalization services are intensive outpatient services provided in lieu of inpatient hospitalization for mental health conditions. The regulation at 42 CFR 410.43(c)(1) states...
that PHPs are intended for patients who require a minimum of 20 hours per week of therapeutic services as evidenced in their plan of care. Additionally, the regulation at 42 CFR 410.43(a)(3) requires that PHP services are services that are furnished in accordance with a physician certification and plan of care as specified under 42 CFR 424.24(e).

**Additional Information**


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

**Document History**

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</tr>
<tr>
<td>April 28, 2017</td>
<td>Initial article released.</td>
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Internet Only Manual (IOM) Update to Pub. 100-04, Chapter 15 - Ambulance, to Restore Multiple Patients on One Trip Instructions

MLN Matters Number: MM10245
Related Change Request (CR) Number: 10245
Related CR Release Date: September 1, 2017
Effective Date: October 2, 2017
Implementation Date: October 2, 2017
Related CR Transmittal Number: R3855CP

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

PROVIDER ACTION NEEDED
Change Request (CR) 10245 alerts providers that instructions in Section 30.1.2 of Chapter 15 – Ambulance, concerning “Multiple Patients on One Trip” were inadvertently omitted from the current version of the Medicare Claims Processing Manual. CR10245 restores the missing instructions to Section 30.1.2. Be aware that this CR10245 contains no policy changes but does update the manual section.

BACKGROUND
The omitted language that is being added back into the manual is as follows:

Ambulance suppliers submitting a claim using the ASC X12 professional format or the CMS-1500 paper form for an ambulance transport with more than one Medicare patient onboard must use the “GM” modifier (“Multiple Patients on One Ambulance Trip”) for each service line item. In addition, suppliers are required to submit documentation to A/B MACs (Part B) to specify the particulars of a multiple patient transport. The documentation must include the total number of patients transported in the vehicle at the same time and the health insurance claim numbers (HICN) for each Medicare beneficiary.

Ambulance claims submitted on or after January 1, 2011 in version 5010 of the ASC X12 837 professional claim format require the presence of a diagnosis code and the absence of diagnosis code will cause the ambulance claim to not be accepted into the claims processing system. The presence of a diagnosis code on an ambulance claim is not required as a condition of ambulance payment policy. The adjudicative process does not take into account the
presence (or absence) of a diagnosis code but a diagnosis code is required on the ASC X12 837 professional claim format.

**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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New Positron Emission Tomography (PET) Radiopharmaceutical/Tracer Unclassified Codes

MLN Matters Number: MM10319
Related Change Request (CR) Number: 10319
Related CR Release Date: November 9, 2017
Effective Date: January 1, 2018
Related CR Transmittal Number: R3911CP
Implementation Date: December 11, 2017 – MACs; April 2, 2018 - FISS, 2018

PROVIDER TYPES AFFECTED

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

WHAT YOU NEED TO KNOW

Positron Emission Tomography (PET) is a nuclear medicine imaging study used to detect normal and abnormal tissues. All PET scan services are billed using PET or PET/Computed Tomography (CT) Current Procedural Terminology (CPT) codes 78459, 78491, 78492, 78608, and 78811 through 78816. Each of these CPT codes always requires the use of a radiopharmaceutical code, also known as a tracer code. Therefore, an applicable tracer code, along with an applicable CPT code, is necessary for claims processing of any PET scan services.

While there are a number of PET tracers already billable for a diverse number of medical indications, there have been, and may be in the future, additional PET indications that might require a new PET tracer. Under those circumstances, the process to request/approve/implement a new code could be time-intensive.

To help alleviate inordinate spans of time between when a coverage determination is made and when it can be fully implemented via valid claims processing, the Centers for Medicare & Medicaid Services (CMS) has created two new PET radiopharmaceutical unclassified tracer codes that can be used temporarily pending the creation/approval/implementation of permanent CPT codes that would later specifically define their function.

Effective January 1, 2017, with the January 2017 quarterly Healthcare Common Procedure Coding System (HCPCS) update, the two temporary PET HCPCS codes are:

- A9597 - Positron emission tomography radiopharmaceutical, diagnostic, for tumor identification, not otherwise classified


• A9598 - Positron emission tomography radiopharmaceutical, diagnostic, for non-tumor identification, not otherwise classified

Make sure that your billing staffs are aware of these changes.

NOTE: HCPCS codes A9597 and A9598 are NOT to be reported for any CMS approved PET indication where a dedicated PET radiopharmaceutical is already assigned. In other words, HCPCS A9597 and A9598 are not replacements for currently approved PET radiopharmaceuticals A9515, A9526, A9552, A9555, A9580, A9586, A9587, or A9588.

**BACKGROUND**

Effective with dates of service on or after January 1, 2018, the above two HCPCS codes shall be used ONLY AS NECESSARY FOR AN INTERIM PERIOD OF TIME under the circumstances explained below:

1. After U.S. Food and Drug Administration (FDA) approval of a PET oncologic indication, or,
2. After CMS approves coverage of a new PET indication, BUT,

ONLY IF either of the above situations requires the use of a dedicated PET radiopharmaceutical/tracer that is currently non-existent.

Once permanent replacement codes are implemented via a subsequent CMS CR, that subsequent CR will also discontinue use of the temporary code for that PET particular indication.

Effective for claims with dates of service on and after January 1, 2018, MACs will ensure when PET tracer code A9597 or A9598 are present on a claim, that claim must also include:

• An appropriate PET HCPCS code, either 78459, 78491, 78492, 78608, 78811, 78812, 78813, 78814, 78815, or 78816
• If tumor-related, either the -PI or -PS modifier as appropriate
• If clinical trial-, registry-, or study-related outside of NCD220.6.17 PET for solid tumors, clinical trial modifier -Q0
• If Part A outpatient and study-related outside of NCD220.6.17 PET for solid tumors, also include condition code 30 and ICD-10 diagnosis Z00.6
• If clinical trial-, registry-, or study-related, all claims require the 8-digit clinical trial number

Effective for claims with dates of service on and after January 1, 2018, MACs for Part A shall line-item deny and MACs for Part B shall line-item reject, PET claims for A9597 or A9598 that do not include the above elements, as appropriate. When denying or rejecting line items, MACs will use the following remittance messages:
• Remittance Advice Remark Code (RARC) N386
• Claim Adjustment Reason Code (CARC) 50, 96, 16, and/or 119
• Group Code CO (Contractual Obligation) assigning financial liability to the provider

MACs will not search for and adjust previously processed claims but will adjust such claims that you bring to their attention.

ADDITIONAL INFORMATION


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

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October 2017 Integrated Outpatient Code Editor (I/OCE) Specifications Version 18.3

MLN Matters Number: MM10230 Revised Related Change Request (CR) Number: 10230
Related CR Release Date: November 3, 2017 Effective Date: October 1, 2017
Related CR Transmittal Number: R3907CP Implementation Date: October 2, 2017

Note: This article was revised on November 3, 2017, to reflect the revised CR10230 issued on that same date. In the article, the modification table was updated to include the revisions to several age and gender edits (row 1 of the table) and to add reference to the conditional bilateral list in row 10 of the table. Also, the CR release date, transmittal number and the Web address for accessing the CR are revised. All other information remains the same.

PROVIDER TYPE AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 10230 provides the Integrated Outpatient Code Editor (I/OCE) instructions and specifications that will be used under the Outpatient Prospective Payment System (OPPS) and Non-OPPS for hospital outpatient departments, community mental health centers, all non-OPPS providers, and for limited services when provided in a Home Health Agency (HHA) not under the Home Health PPS or to a hospice patient for the treatment of a non-terminal illness. This update relates to Chapter 4, Section 40.1 of the "Medicare Claims Processing Manual" (Pub. 100-04). Make sure your billing staffs are aware of these updates.

BACKGROUND

CR10230 informs MACs, as well as the Fiscal Intermediary Shared System (FISS) maintainer that the I/OCE is being updated for October 1, 2017. The I/OCE routes all institutional outpatient claims (which includes non-OPPS hospital claims) through a single integrated OCE.

The I/OCE specifications will be posted at http://www.cms.gov/OutpatientCodeEdit/.
The following table summarizes the modifications of the I/OCE for the October 2017 v18.3 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.

**Note:** Some I/OCE modifications in the update may be retroactively added to prior releases. If so, the retroactive date appears in the “Effective Date” column.

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<td>2,3</td>
<td>Revisions to several age and gender edits (details in Summary of Data Changes of CR10230).</td>
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<tr>
<td>10/1/2017</td>
<td>1, 2, 3, 5, 86</td>
<td>Updated diagnosis code editing for validity, age, gender and manifestation based on the FY 2018 ICD-10-CM code revisions to the Medicare Code Editor (MCE).</td>
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<td>10/1/2017</td>
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<td>Updated the mental health diagnosis list based on the FY 2018 ICD-10-CM code revisions.</td>
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<td>10/1/2017</td>
<td>95</td>
<td>Modify the effective date for edit 95 to 10/1/2017.</td>
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<td>4/1/2017</td>
<td>30, 95</td>
<td>Update the list of add-on procedure codes that are not counted towards the daily and weekly requirements for number of Partial Hospitalization Program (PHP) services. Procedure codes 90833, 90836 and 90838 are removed from the list; 90785 remains (see special processing logic, Appendix C-a Flowchart and Appendix O of CR10230).</td>
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<td>7/1/2017</td>
<td>22</td>
<td>Add ZC (Merck/ Samsung Bioepis) to the list of valid modifiers.</td>
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<td>7/1/2017</td>
<td>94</td>
<td>Add modifier ZC as a biosimilar manufacturer modifier applicable for HCPCS Q5102.</td>
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<td>10/1/2016</td>
<td>99</td>
<td>Add HCPCS J2505 (Injection, pegfilgrastim 6mg) to the list of HCPCS excepted from requiring an OPPS procedure on the same claim (see special processing logic).</td>
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<td>7/1/2017</td>
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<td>Add new revenue code 1006 to the list of valid revenue codes and to the list of revenue codes not recognized by Medicare.</td>
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<td>Update the following lists for the release (see quarterly data files):</td>
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<td>• Conditional bilateral list (R1 – code added to list)</td>
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<td>• Edit 99 exclusion list (add new codes to exception list)</td>
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<td>• Comprehensive Ambulatory Payment Classification (APC) ranking</td>
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<td></td>
<td>• Comprehensive APC Code Pairs (correction to two APC Pairs missing complexity-adjusted APC assignment retroactive for 2016 service dates)</td>
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<td>• New data file report for Comprehensive APCs (includes list of procedures, rank and flag for eligibility of complexity-adjusted APC)</td>
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<td>• Device-procedure list (edit 92)</td>
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<td>• Terminated device-procedures for device credit (Device offset amount corrections; updated code list)</td>
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--- | --- | ---
5/25/2017 | 68 | Implement NCD mid-quarter effective editing for procedure code 93668.
4/3/2017 | 68 | Implement NCD mid-quarter effective editing for HCPCS A4575 and E0446.
10/1/2017 | 68 | Make all HCPCS/APC/SI changes as specified by CMS (quarterly data files).
10/1/2017 | 20, 40 | Implement version 23.3 of the NCCI (as modified for applicable outpatient institutional providers).

### ADDITIONAL INFORMATION


If you have any questions, please contact your MAC at their toll-free number. That number is available at [https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/](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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<tbody>
<tr>
<td>November 3, 2017</td>
<td>This article was revised to reflect the revised CR10230 issued on that same date. In the article, the modification table was updated to include the revisions to several age and gender edits (row 1 of the table) and to add reference to the conditional bilateral list in row 10 of the table. Also, the CR release date, transmittal number and the Web address for accessing the CR are revised. All other information remains the same.</td>
</tr>
<tr>
<td>August 29, 2017</td>
<td>Initial article released</td>
</tr>
</tbody>
</table>

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The article was revised on September 15, 2017, to reflect an updated Change Request (CR) that updated the policy section (added Transurethral Waterjet Prostate Ablation Procedure) that also includes information on the revised OPPS status indicator and APC for CPT code 0421T. It also corrected an error to the OPPS status indicator for Q5102 in Table 5. In addition, a new Table 7 was added. All other information remains the same.

**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**

Change Request (CR) 10236 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**

This Recurring Update Notification describes changes to and billing instructions for various payment policies implemented in the October 2017 OPPS update. The October 2017 Integrated Outpatient Code Editor (I/OCE) will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in CR 10236. This Recurring Update Notification applies to Chapter 4, section 10.9.

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

*Proprietary Laboratory Analyses (PLA) CPT Codes 0006U through 0017U Effective August 1, 2017*

The American Medical Association CPT Editorial Panel established 12 new PLA CPT codes,
specifically, CPT codes 0006U through 0017U effective August 1, 2017. Because the codes will be effective August 1, 2017, they were not included in the July 2017 OPPS Update and are instead being including in the October 2017 Update with an effective date of August 1, 2017.

Table 1 lists the long descriptors and status indicators for CPT codes 0006U through 0017U. For more information on OPPS status indicators “A” and “Q4”, refer to OPPS Addendum D1 of the CY 2017 OPPS/ASC final rule for the latest definitions.

Table 1 — Proprietary Laboratory Analyses (PLA) CPT Codes Effective August 1, 2017

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Long Descriptor</th>
<th>OPPS SI</th>
<th>OPSS APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>0006U</td>
<td>Prescription drug monitoring, 120 or more drugs and substances, definitive tandem mass spectrometry with chromatography, urine, qualitative report of presence (including quantitative levels, when detected) or absence of each drug or substance with description and severity of potential interactions, with identified substances, per date of service</td>
<td>Q4</td>
<td>N/A</td>
</tr>
<tr>
<td>0007U</td>
<td>Drug test(s), presumptive, with definitive confirmation of positive results, any number of drug classes, urine, includes specimen verification including DNA authentication in comparison to buccal DNA, per date of service</td>
<td>Q4</td>
<td>N/A</td>
</tr>
<tr>
<td>0008U</td>
<td>Helicobacter pylori detection and antibiotic resistance, DNA, 16S and 23S rRNA, gyrA, pbp1, rdxA and rpoB, next generation sequencing, formalin-fixed paraffin embedded or fresh tissue, predictive, reported as positive or negative for resistance to clarithromycin, fluoroquinolones, metronidazole, amoxicillin, tetracycline and rifabutin</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>0009U</td>
<td>Oncology (breast cancer), ERBB2 (HER2) copy number by FISH, tumor cells from formalin fixed paraffin embedded tissue isolated using image-based dielectrophoresis (DEP) sorting, reported as ERBB2 gene amplified or non-amplified</td>
<td>Q4</td>
<td>N/A</td>
</tr>
<tr>
<td>0010U</td>
<td>Infectious disease (bacterial), strain typing by whole genome sequencing, phylogenetic-based report of strain relatedness, per submitted isolate</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>CPT Code</td>
<td>Long Descriptor</td>
<td>OPPS SI</td>
<td>OPPS APC</td>
</tr>
<tr>
<td>----------</td>
<td>---------------------------------------------------------------------------------</td>
<td>---------</td>
<td>----------</td>
</tr>
<tr>
<td>0011U</td>
<td>Prescription drug monitoring, evaluation of drugs present by LCMS/MS, using oral fluid, reported as a comparison to an estimated steady-state range, per date of service including all drug compounds and metabolites</td>
<td>Q4</td>
<td>N/A</td>
</tr>
<tr>
<td>0012U</td>
<td>Germline disorders, gene rearrangement detection by whole genome next-generation sequencing, DNA, whole blood, report of specific gene rearrangement(s)</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>0013U</td>
<td>Oncology (solid organ neoplasia), gene rearrangement detection by whole genome next-generation sequencing, DNA, fresh or frozen tissue or cells, report of specific gene rearrangement(s)</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>0014U</td>
<td>Hematology (hematolymphoid neoplasia), gene rearrangement detection by whole genome next-generation sequencing, DNA, whole blood or bone marrow, report of specific gene rearrangement(s)</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>0015U</td>
<td>Drug metabolism (adverse drug reactions), DNA, 22 drug metabolism and transporter genes, real-time PCR, blood or buccal swab, genotype and metabolizer status for therapeutic decision support</td>
<td>Q4</td>
<td>N/A</td>
</tr>
<tr>
<td>0016U</td>
<td>Oncology (hematolymphoid neoplasia), RNA, BCR/ABL1 major and minor breakpoint fusion transcripts, quantitative PCR amplification, blood or bone marrow, report of fusion not detected or detected with quantitation</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>0017U</td>
<td>Oncology (hematolymphoid neoplasia), JAK2 mutation, DNA, PCR amplification of exons 12-14 and sequence analysis, blood or bone marrow, report of JAK2 mutation not detected or detected</td>
<td>A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

CPT codes 0006U through 0017U have been added to the October 2017 I/OCE with an effective date of August 1, 2017. These codes, along with their short descriptors and status indicators, are also listed in the October 2017 OPPS Addendum B.
Billing for Peripheral Artery Disease (PAD) Rehabilitation

Effective May 25, 2017, the Centers for Medicare & Medicaid Services (CMS) will pay for supervised exercise therapy (SET) for beneficiaries with intermittent claudication for the treatment of symptomatic peripheral artery disease. To implement this National Coverage Determination (NCD), CMS will pay separately for CPT code 93668 under the hospital OPPS.

For purposes of Medicare coverage, services must meet all of the following eligibility criteria:

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

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

1. MACs have the discretion to cover SET beyond 36 sessions over 12 weeks and may cover an additional 36 sessions over an extended period of time. A second referral is required for these additional sessions.
2. SET is non-covered for beneficiaries with absolute contraindications to exercise as determined by their primary physician.

For more information on this recent NCD, refer to the “Decision Memo on Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) (CAG-00449N),” which is available at https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=287.

Table 2 lists the long descriptor, status indicator, and APC assignment for CPT code 93668. The payment amount for CPT code 93668 is available in the October 2017 OPPS Addendum B.

### Table 2 — Peripheral Artery Disease (PAD) Rehabilitation

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Long Descriptor</th>
<th>OPPS SI</th>
<th>OPPS APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>93668</td>
<td>Peripheral arterial disease (pad) rehabilitation, per session</td>
<td>S</td>
<td>5733</td>
</tr>
</tbody>
</table>

New Procedures Requiring the Insertion of a Device

Since January 1, 2017, all new procedures requiring the insertion of an implantable medical
device will be assigned a default device offset percentage of at least 41%, and thereby assigned device intensive status, until claims data is available. In certain rare instances, CMS may temporarily assign a higher offset percentage if warranted by additional information. In accordance with current Medicare policy, the following code requiring the insertion of a device (listed in Table 3) will be assigned device intensive status effective October 1, 2017. CMS notes that although HCPCS code C9747, was effective under the OPPS as of July 1, 2017, its device intensive designation is not effective until October 1, 2017.

Table 3 — New Procedures Requiring the Insertion of a Device

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
<th>Effective Date</th>
<th>October 2017 OPPS SI</th>
<th>October 2017 OPPS APC</th>
<th>CY 2017 OPPS Payment Rate</th>
<th>CY 2017 Device Offset</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9747</td>
<td>Ablation of prostate, transrectal, high intensity focused ultrasound (HIFU), including imaging guidance</td>
<td>10-01-2017</td>
<td>J1</td>
<td>5376</td>
<td>$7,452.66</td>
<td>$3,055.60</td>
</tr>
</tbody>
</table>

 Drugs, Biologics, and Radiopharmaceuticals

a. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective October 1, 2017

Payment for separately payable non pass-through drugs, biologicals and therapeutic radiopharmaceuticals (status indicator “K”) 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 addition, a single payment of ASP + 6 percent for pass-through drugs, biologicals and radiopharmaceuticals (status indicator “G”) 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 ASP submissions become available. Updated payment rates effective October 1, 2017 and drug price restatements are available in the October 2017 update of the OPPS Addendum A and Addendum B 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 paid based on the ASP methodology will have payment rates that are corrected retroactively. These retroactive corrections typically occur on a quarterly basis. The list of drugs and biologicals with corrected payments rates will be accessible on the first date of the quarter at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/OPPS-Restated-Payment-Rates.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/OPPS-Restated-Payment-Rates.html).

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

c. Drugs and Biologicals with OPPS Pass-Through Status Effective October 1, 2017

Four drugs and biologicals have been granted OPPS pass-through status effective October 1, 2017. These items, along with their descriptors and APC assignments, are identified in Table 4.

Table 4 – Drugs and Biologicals with OPPS Pass-Through Status Effective October 1, 2017

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Description</th>
<th>Long Description</th>
<th>Oct 2017 OPPS SI</th>
<th>Oct 2017 OPPS APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9491</td>
<td>Injection, avelumab</td>
<td>Injection, avelumab, 10 mg</td>
<td>G</td>
<td>9491</td>
</tr>
<tr>
<td>C9492</td>
<td>Injection, durvalumab</td>
<td>Injection, durvalumab, 10 mg</td>
<td>G</td>
<td>9492</td>
</tr>
<tr>
<td>C9493</td>
<td>Injection, edaravone</td>
<td>Injection, edaravone, 1 mg</td>
<td>G</td>
<td>9493</td>
</tr>
<tr>
<td>C9494</td>
<td>Injection, ocrelizumab</td>
<td>Injection, ocrelizumab, 1 mg</td>
<td>G</td>
<td>9494</td>
</tr>
</tbody>
</table>

d. New Modifier for Biosimilar Biological Product

Q5102 can be reported with either the existing modifier ZB or new modifier ZC effective July 1, 2017, see table 5. **CMS is also instructing MACs that the ZC modifier will become effective, that is, valid for claims submitted beginning October 1, 2017, and applies retroactively to dates of service on or after July 24, 2017.**

Table 5 – Biosimilar Biological Product Payment and Required Modifiers

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>SI</th>
<th>APC</th>
<th>HCPCS Code Effective Date</th>
<th>Modifier</th>
<th>Modifier Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5102</td>
<td>Injection, infliximab biosimilar</td>
<td>Injection, Infliximab, Bio similar, 10 mg</td>
<td>G</td>
<td>1847</td>
<td>04/05/2016</td>
<td>ZB – Pfizer/Hospira</td>
<td>04/01/2016</td>
</tr>
</tbody>
</table>
e. New Flu Vaccine

The existing influenza vaccine CPT code 90674 (Cciiv4 vaccine, no preservative, 0.5 ml, intramuscular) with trade name Flucelvax Quadrivalent was effective January 1, 2017 and is a preservative-free and antibiotic-free vaccine. A new preservative, antibiotic-free influenza vaccine CPT code with the same trade name, Flucelvax Quadrivalent, will be effective on January 1, 2018. For the period between August 1, 2017 and December 31, 2017, Flucelvax Quadrivalent Preservative can be reported as Q2039. The permanent CPT code for the Flucelvax Quadrivalent preservative influenza vaccine will be released on a later date, see Table 6.

Table 6 – Billing for Preservative and Preservative-Free Flucelvax Quadrivalent Influenza Vaccine

<table>
<thead>
<tr>
<th>Vaccine Type</th>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>OPPS SI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flucelvax Quadrivalent Preservative-Free and Antibiotic-Free Flu Vaccine</td>
<td>90674</td>
<td>Cciiv4 vaccine, no preservative, 0.5 ml, intramuscular</td>
<td>Influenza virus vaccine, quadrivalent (cCIIV4), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use</td>
<td>L</td>
</tr>
<tr>
<td>Flucelvax Quadrivalent Preservative Flu Vaccine</td>
<td>Q2039</td>
<td>Cciiv4 vaccine, nos, intramuscular</td>
<td>Influenza virus vaccine, not otherwise specified</td>
<td>L</td>
</tr>
</tbody>
</table>

**Upper Eyelid Blepharoplasty and Blepharoptosis Repair**

As indicated in Chapter VIII of the CY 2017 National Correct Coding Initiative (NCCI) Policy Manual for Medicare Services, CMS payment policy does not allow separate payments for a blepharoptosis procedure (CPT code 67901-67908) and a blepharoplasty procedure (CPT
codes 15822-15823) on the ipsilateral upper eyelid. Under this policy, any removal of upper eyelid skin in the context of an upper eyelid blepharoptosis surgery was considered a part of the blepharoptosis surgery. This instruction was clarified in the July 2016 Hospital OPPS Update Change Request (Transmittal 3557, Change Request 9658 dated July 1, 2016) and the July 2016 OPPS MLN Matters Article MM9658, available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9658.pdf.

However, effective October 1, 2017, CMS is revising this policy to allow either cosmetic or medically necessary blepharoplasty to be performed in conjunction with a medically necessary upper eyelid blepharoptosis surgery. Specifically, physicians may receive payment for a medically necessary upper eyelid blepharoptosis from Medicare even when performed with (non-covered) cosmetic blepharoplasty on the same eye during the same visit. Since cosmetic procedures are not covered by Medicare, advance beneficiary notice of noncoverage (ABN) instructions would apply for cosmetic blepharoplasty. However, medically necessary blepharoplasty will continue to be bundled into the payment for blepharoptosis when performed with and as a part of a blepharoptosis surgery.

Other aspects of the July 2016 OPPS Update CR and MLN guidance on upper eyelid blepharoplasty and blepharoptosis remain unchanged. Specifically, CMS notes that Medicare does not allow separate payment for the following:

- Operating on the left and right eyes on different days when the standard of care is bilateral eyelid surgery
- Charging the beneficiary an additional amount for removing orbital fat when a blepharoplasty or a blepharoptosis repair is performed
- Performing a blepharoplasty on a different date of service than the blepharoptosis procedure for the purpose of unbundling the blepharoplasty
- Performing blepharoplasty as a staged procedure, either by one or more surgeons (note that under certain circumstances a blepharoptosis procedure could be a staged procedure)
- Billing for two procedures when two surgeons divide the work of a blepharoplasty performed with a blepharoptosis repair
- Using modifier 59 to unbundle the blepharoplasty from the ptosis repair on the claim form; this applies to both physicians and facilities.
- Treating medically necessary surgery as cosmetic for the purpose of charging the beneficiary for a cosmetic surgery
- In the rare event that a blepharoplasty is performed on one eye and a blepharoptosis repair is performed on the other eye, the services must each be billed with the appropriate RT or LT modifier.

Transurethral Waterjet Prostate Ablation Procedure

On June 5, 2017, the Investigational Device Exemption (IDE) study associated with the “Waterjet Ablation Therapy for Endoscopic Resection of Prostate Tissue II” met CMS’s standards for coverage. The procedure associated with this study is currently described by CPT code 0421T. Based on the recent Medicare coverage of the IDE study, CMS is revising the
OPPS status indicator (SI) for CPT code 0421T from “E1” (Not paid by Medicare when submitted on outpatient claims (any outpatient bill type)) to “J1” (Hospital Part B services paid through a comprehensive APC) and assigning the code to APC 5374 (Level 4 Urology and Related Services).

The SI and APC revision will be added to the January 2018 IOCE release with an effective date of June 5, 2017, which is the date of the Medicare approval for coverage of the IDE study.

Table 7 (below) lists the long descriptor, status indicator, and APC assignment for CPT code 0421T. The October 2017 national payment rate for APC 5374 is $2,542.56. However, as previously stated, payment for claims involving CPT code 0421T will not begin to be processed until January 1, 2018.

For more information on this approved Medicare IDE study, refer to study title “Waterjet Ablation Therapy for Endoscopic Resection of Prostate Tissue II” which can be found on the CMS IDE Studies website at: https://www.cms.gov/Medicare/Coverage/IDE/Approved-IDE-Studies.html.

For more information on Medicare’s coverage related to IDE studies, refer to this CMS website: https://www.cms.gov/Medicare/Coverage/IDE/index.html.

Table 7 - Transurethral Waterjet Prostate Ablation Procedure

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Long Description</th>
<th>OPPS SI</th>
<th>OPPS APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>0421T</td>
<td>Transurethral waterjet ablation of prostate, including control of post-operative bleeding, including ultrasound guidance, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included when performed)</td>
<td>J1</td>
<td>5374</td>
</tr>
</tbody>
</table>

Coverage Determinations

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


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

DOCUMENT HISTORY

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>September 15, 2017</td>
<td>The article was revised to reflect an updated Change Request (CR) that updated the policy section (added Transurethral Waterjet Prostate Ablation Procedure) that also includes information on the revised OPPS status indicator and APC for CPT code 0421T. It also corrected an error to the OPPS status indicator for Q5102 in Table 5. In addition, a new Table 7 was added.</td>
</tr>
<tr>
<td>August 29, 2017</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>
Pulmonary Rehabilitation (PR) Services Addition to Chapter 19, Indian Health Services (IHS)

MLN Matters Number: MM10276
Related Change Request (CR) Number: 10276
Related CR Release Date: October 27, 2017
Effective Date: For dates of service on or after January 1, 2010
Related CR Transmittal Number: R3897CP
Implementation Date: April 2, 2018

PROVIDER TYPE AFFECTED

This MLN Matters Article is intended for physicians and other providers billing Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries in the Indian Health Service (IHS).

PROVIDER ACTION NEEDED

Effective January 1, 2010, MACs will pay medically necessary IHS claims containing Healthcare Common Procedure Coding System (HCPCS) code G0424 (Pulmonary rehabilitation, including exercise (includes monitoring), one hour, per session, up to two sessions per day) when billing for Pulmonary Rehabilitation (PR) services, including exercise and monitoring.

BACKGROUND

PR is a multi-disciplinary program of care for patients with chronic respiratory impairment. It is an evidence-based, multidisciplinary, and comprehensive intervention for patients with chronic respiratory diseases who are symptomatic and often have decreased daily life activities; and is individually tailored and designed to optimize physical and social performance and autonomy.

The Medicare Improvements for Providers and Patients Act of 2008 (MIPPA) added payment and coverage improvements for patients with chronic obstructive pulmonary disease and other conditions, and now provides a covered benefit for a comprehensive PR program under Medicare Part B effective January 1, 2010. This law provides a single PR program, which was codified in the Medicare Physician Fee Schedule (MPFS) final rule at 42 Code of Federal Regulation (CFR) 410.47, which you can find at https://www.gpo.gov/fdsys/granule/CFR-2010-title42-vol2/CFR-2010-title42-vol2-sec410-47.

CR10276 provides that, effective January 1, 2010, MIPPA provisions added a physician–
supervised, comprehensive PR program, which includes the following mandatory components:

1. Physician-prescribed exercise
2. Education or training
3. Psychosocial assessment
4. Outcomes assessment
5. An individualized treatment plan

As specified at 42 CFR 410.47(f), pulmonary rehabilitation program sessions are limited to a maximum of two (2) one (1)-hour sessions per day for up to 36 sessions, with the option for an additional 36 sessions if medically necessary.

Effective January 1, 2010, IHS providers are paid, for PR services, separately from the All Inclusive Rate (AIR). Your MACs will pay IHS claims for PR services containing HCPCS code G0424 and revenue code 0948 (Pulmonary Rehabilitation Services) on Types of Bill (TOB) 12X (Hospital Inpatient Part B) and 13X (Hospital Outpatient) under the Medicare Physician Fee Schedule (MPFS), and TOB 85X (Critical Access Hospital Outpatient) based on reasonable cost. These services are paid separately from the All Inclusive Rate.

MACs will accept the inclusion of the KX modifier on the IHS claim lines as an attestation that further treatment beyond the 36 sessions is medically necessary up to a total of 72 sessions for a beneficiary. PR services may be billed on IHS claims with or without a clinic visit. MACs will deny your PR claims that exceed 72 sessions.

ADDITIONAL INFORMATION

The official instruction, CR10276, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3897CP.pdf. You will find the revised “Medicare Claims Processing Manual,” Chapter 19 (Indian Health Services), Sections 100.11 as an attachment to the CR.

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>Initial article released.</td>
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Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes - October 2017 Update

MLN Matters Number: MM10234  Related Change Request (CR) Number: 10234
Related CR Release Date: August 25, 2017  Effective Date: July 24, 2017
Related CR Transmittal Number: R3850CP  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.

WHAT YOU NEED TO KNOW

The Healthcare Common Procedure Coding System (HCPCS) code set is updated on a quarterly basis. The October 2017 HCPCS file includes a new HCPCS modifier. CR10234 informs MACs about the new modifier, ZC, Merck/Samsung Bioepis. The ZC modifier will become effective for claims submitted beginning October 1, 2017, and applies retroactively to dates of service on or after July 24, 2017.

MACs shall add the following modifier to the required modifiers that must be used when HCPCS code Q5102 is billed on a claim:

- HCPCS Modifier: ZC
- Short Description: Merck/Samsung Bioepis
- Long Description: Merck/Samsung Bioepis

A second biosimilar version of infliximab was marketed on July 24, 2017, creating a situation where products from two manufacturers may appear on claims. To allow the identification of the manufacturer of the specific biosimilar biological product that was administered to a patient, either existing HCPCS modifier ZB, or new modifier ZC is required when HCPCS code Q5102 is billed on a claim that is submitted after 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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Revision of PWK (Paperwork) Fax/Mail Cover Sheets

MLN Matters Number: MM10124  Related Change Request (CR) Number: 10124
Related CR Release Date: November 9, 2017  Effective Date: April 1, 2018
Related CR Transmittal Number: R1974OTN  Implementation Date: April 2, 2018

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 10124 alerts providers that their MAC will provide revised fax/mail cover sheets via hardcopy and/or electronic download. These revised documents are attached to CR10124. There are three paperwork (PWK) attachments to CR10124: (1) Medicare Part A Fax/Mail Cover Sheet (2) Medicare Part B Fax/Mail Cover Sheet and (3) Medicare DME MAC Fax/Mail Cover Sheet.

BACKGROUND

CR10124 revises the three PWK Fax/Mail Cover Sheets to remove Health Insurance Claim Number (HICN) from the forms and replace it with Medicare ID. HICN is being removed from the forms as part of the Medicare Access and CHIP Re-authorization Act (MACRA) of 2015, which requires removal of the Social Security Number-based HICN from Medicare cards within 4 years of enactment. These Fax/Mail Cover sheets are used so that providers are able to continue to submit electronic claims, which require additional documentation.

ADDITIONAL INFORMATION


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

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Screening for the Human Immunodeficiency Virus (HIV) Infection

Note: This article was revised on August 17, 2017, to reflect a revised CR9980 issued on August 16. In the article, the CR release date, transmittal number, and the Web address for accessing CR9980 are revised. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9980 informs MACs that they shall recognize the specified HCPCS codes for services related to the Screening for the Human Immunodeficiency Virus (HIV) Infection. Make sure that your billing staffs are aware of these codes.

Background

The Centers for Medicare & Medicaid Services (CMS) issued CR9403 (transmittal 3461), effective April 13, 2015, for screening for HIV infection. The guidelines are based on strong recommendations by the U.S. Preventive Services Task Force published in April 2013. The recommendations provide guidelines for screening various age groups based on risk of infection as well as for pregnant women.

Effective for claims with dates of service on or after April 13, 2015, MACs will recognize the following Healthcare Common Procedure Coding System (HCPCS) codes for claims related to the Screening for the Human Immunodeficiency Virus (HIV) Infection:

- CPT Code 0098T
- CPT Code 0099T
- CPT Code 0100T

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<tr>
<td>G0432</td>
<td>Infectious agent antibody detection by enzyme Immune assay (EIA) technique, qualitative or Semi-quantitative, multiple-step method, HIV-1 or HIV-2, screening</td>
</tr>
<tr>
<td>G0433</td>
<td>Infectious agent antibody detection by enzyme-linked immunosorbent assay (ELISA) technique, antibody, HIV-1 or HIV-2, screening.</td>
</tr>
<tr>
<td>G0435</td>
<td>Infectious agent antibody detection by rapid antibody test of oral mucosa transudate, HIV-1 or HIV-2, screening.</td>
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**Billing Requirements**

Your MAC will calculate the next eligible date for HIV Screening to include HCPCS codes G0432, G0433, and G0435 to be included with G0475 and based on effective date of April 13, 2015.

The next eligible date will be displayed on all of Medicare’s Common Working File (CWF) provider query screens (HUQA, HIQA, HIQH, ELGA, ELGH, and PRVN). This includes MBD and NGD extract records.

When there is no next eligible date, the CWF provider query screens will display this information in the date field to indicate why there is not a next eligible date.

When the incoming HUOP or HUBC claim line having the HIV screening HCPCS code G0475, G0432, G0433, or G0435 is submitted without the required HIV Primary Diagnosis Codes of Z11.4, **OR**

When the incoming HUOP or HUBC claim line having the HIV screening HCPCS 80081 is submitted with one of the following secondary diagnosis codes denoting pregnancy, but the required HIV primary diagnosis code of Z11.4 is not present:

- Z34.00, Z34.01, Z34.02, Z34.03, Z34.04, Z34.05, Z34.80, Z34.81, Z34.82, Z34.83, Z34.90, Z34.91, Z34.92, Z34.93, O09.90, O09.91, O09.92, O09.93

The claim line item will be denied. In denying the line, MACs will use either:

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

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MLN Matters® Number: MM9980

- CARC 11 - This diagnosis is inconsistent with the procedure. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- Remittance Advice Remarks Code (RARC) N386 - This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at http://www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.
- Group Code CO (Contractual Obligation)

Medicare will create a new consistency edit to deny when the incoming HUOP or HUBC claim line having either the HIV HCPCS codes G0475, G0432, G0433, G0435, or the CPT HCPCS code 80081 is submitted with one of the pregnancy secondary diagnosis codes, but the Sex Code on the claim indicates ‘Male.’ The secondary diagnosis codes indicating pregnancy are:

- Z34.00, Z34.01, Z34.02, Z34.03, Z34.08, Z34.1, Z34.12, Z34.13, Z34.90, Z34.91, Z34.92, Z34.93, O09.90, O09.91, O09.92, O09.93

In denying a line for this reason, MACs will use:
- CARC 7 - The procedure/revenue code is inconsistent with the patient’s gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- Group Code CO

Medicare systems will create a consistency edit to not allow Place of Service (POS) other than 11 (Office) or 81 (Independent Lab for the HIV screenings HCPCS G0475, G0432, G0433, and ‘G0435’ effective with dates of service on or after April 13, 2015. If a POS other than 11 or 81 is on the claim, the MAC will deny the line item, using:

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

Medicare systems will create a consistency edit to not allow Type of Bill (TOB) other than 12X, 13X, 14X, 22X, 23X, and 85x for the HIV screening HCPCS G0475, G0432, G0433, and G0435.

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Additional Information


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

Document History

- June 6, 2017 – Initial article released.
- August 17, 2017 – Article revised to reflect revised CR9980. In the article, the CR release date, transmittal number, and the Web address for accessing CR9980 are revised. All other information remains the same.
Therapy Cap Values for Calendar Year (CY) 2018

MLN Matters Number: MM10341       Related Change Request (CR) Number: 10341
Related CR Release Date: November 9, 2017    Effective Date: January 1, 2018
Related CR Transmittal Number: R3918CP    Implementation Date: January 2, 2018

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 10341 provides the amounts for outpatient therapy caps for Calendar Year (CY) 2018. For physical therapy and speech-language pathology combined, the CY 2018 cap is $2,010. For occupational therapy, the CY 2018 cap is $2,010. Make sure that your billing staffs are aware of these therapy cap value updates.

BACKGROUND

The Balanced Budget Act of 1997, P.L. 105-33, Section 4541(c) applies, per beneficiary, annual financial limitations on expenses considered incurred for outpatient therapy services under Medicare Part B, commonly referred to as “therapy caps.” The therapy caps are updated each year based on the Medicare Economic Index.

Section 5107 of the Deficit Reduction Act of 2005 required an exceptions process to the therapy caps for reasonable and medically necessary services. The exceptions process for the therapy caps has been continuously extended several times through subsequent legislation. Most recently, Section 202 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) extended the therapy caps exceptions process through December 31, 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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Transitional Drug Add-on Payment Adjustment (TDAPA) for Patients with Acute Kidney Injury (AKI)

MLN Matters Number: MM10281
Related Change Request (CR) Number: 10281
Related CR Release Date: October 27, 2017
Effective Date: April 1, 2018
Related CR Transmittal Number: R1941OTN
Implementation Date: April 1, 2018

PROVIDER TYPE AFFECTED

This MLN Matters Article is intended for dialysis facilities submitting claims to Medicare Administrative Contractors (MACs) provided to Medicare beneficiaries with Acute Kidney Injury (AKI).

PROVIDER ACTION NEEDED

This article is based on Change Request (CR) 10281, which updates the AKI payment policy regarding Transitional Drug Add-on Payment Adjustments (TDAPA). Please make sure your billing staffs are aware of these updates.

BACKGROUND

On June 29, 2015, the Trade Preferences Extension Act of 2015 (TPEA) (Pub. L. 114-27) was enacted. Section 808(a) of the TPEA amended Section 1861(s)(2)(F) of the Social Security Act (the Act) to provide coverage for renal dialysis services furnished on or after January 1, 2017, by a renal dialysis facility or a provider of services paid under Section 1881(b)(14) of the Act to an individual with AKI.

Section 808(b) of the TPEA amended Section 1834 of the Act by adding a new Subsection r that provides for payment for renal dialysis services furnished by renal dialysis facilities or providers of services paid under Section 1881(b)(14) of the Act to individuals with AKI at the End Stage Renal Disease (ESRD) Prospective Payment System (PPS) base rate, beginning January 1, 2017. Thus, beginning January 1, 2017, ESRD facilities can furnish dialysis to AKI patients. The AKI provision is available at https://www.congress.gov/bill/114th-congress/house-bill/1295/text#tocHEE69B51CC87340E2B2AB6A4FA73D2A82.

The provision provides Medicare payment to hospital-based and freestanding ESRD facilities,
for renal dialysis services furnished to pediatric and adult beneficiaries with AKI. Medicare will pay ESRD facilities for the dialysis treatment using the ESRD PPS base rate adjusted by the applicable geographic adjustment factor, that is, the ESRD PPS wage index. In addition to the actual dialysis treatment, the ESRD PPS base rate includes payment for other 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, are also considered renal dialysis services for patients with AKI. As such, 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.

Other items and services that are furnished to beneficiaries with AKI that are not considered to be renal dialysis services but are related to their dialysis as a result of their AKI, would be separately payable. This includes drugs, biologicals, laboratory services, and supplies that ESRD facilities are certified to furnish and that would otherwise be furnished to a beneficiary with AKI in a hospital outpatient setting.

The Centers for Medicare & Medicaid Services (CMS) implemented the initial payment policy decisions related to AKI in CR9598. A related article, MM9598, is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9598.pdf. These policies include:

- The identification of services considered to be AKI using revenue codes, HCPCS codes, and CPT codes
- Treatment settings
- Treatment limits
- Rules for separately billable items and services

CR9814 excluded AKI claims from receiving the ESRD network fee reduction, while CR9987 updated the claims submission policies for Erythropoietin Stimulating Agents (ESAs) for AKI patients. MLN Matters article MM9814 is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9814.pdf.

Under the ESRD PPS drug designation process, CMS provides payment using a TDAPA for new injectable or intravenous drugs and biologicals that qualify under 42 CFR 413.234(c)(1). TDAPA is a payment policy under the ESRD PPS and is only applicable for ESRD beneficiaries. TDAPA is not applicable to the per treatment payment amount that is paid to ESRD facilities for furnishing dialysis to individuals with AKI.

Effective January 1, 2018, TDAPA (as outlined in CR10065, see related MLN Matters article at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10065.pdf) will make payment to ESRD facilities for furnishing calcimimetics, that is, J0604 - Cinacalcet, oral, 1 mg, (for ESRD on dialysis) and J0606 - Injection, etelcalcetide, 0.1 mg to ESRD beneficiaries, ESRD facilities will not be responsible for furnishing calcimimetics to individuals with AKI. Sensipar (HCPCS code J0604)
remains payable under part D for AKI beneficiaries until the utilization is rolled into the bundle at which point it will transition to the bundled payment amount. With regards to Parsabiv (HCPCS code J0606), this drug is not indicated for AKI and therefore no bills should be submitted for Parsabiv in the AKI population.

Note that MACs will Return to the Provider (RTP) any AKI claim billed with modifier AX on type of bill 72x (AKI) with condition code 84, CPT code G0491 and one of the following ICD-10 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, MACs will RTP AKI claims billed HCPCS J0604 or J0606.

ADDITIONAL INFORMATION


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**Coverage - General**

**MEDI CARE BENEFI CIAR IES I N STATE OR LOCAL CUSTODY**

Effective April 1, 2003, Medicare denies claims for beneficiaries who are in the custody of a State or local government under the authority of a penal statute at the time the provider rendered the service. Using Social Security records showing health insurance claim (HIC) numbers and incarceration dates, Medicare identifies and rejects these claims.

Under Sections 1862(a)(2) and (3) of the Social Security Act (the Act), the Medicare program does not pay for services if the beneficiary has no legal obligation to pay for the services and if the services are paid for directly or indirectly by a governmental entity. These provisions are implemented by regulations 42 CFR 411.4(a) and 411.4 (b),

Regulations at 42 CFR 411.4(b) (http://www.gpo.gov/fdsys/pkg/CFR-2012-title42-vol2/pdf/CFR-2012-title42-vol2-sec411-4.pdf) state: "Payment may be made for services furnished to individuals or groups of individuals who are in the custody of the police or other penal authorities or in the custody of a government agency under a penal statute only if the following conditions are met:
(1) State or local law requires those individuals or groups of individuals to repay the cost of medical services they receive while in custody.
(2) The State or local government entity enforces the requirement to pay by billing all such individuals, whether or not covered by Medicare or any other health insurance, and by pursuing the collection of the amounts they owe in the same way and with the same vigor that it pursues the collection of other debts."

**Exclusion from Coverage**

Medicare excludes from coverage items and services furnished to beneficiaries in state or local government custody under a penal statute, unless it is determined that the state or local government enforces a legal requirement that all prisoners/patients repay the cost of all healthcare items and services rendered while in such custody and also pursues collection efforts against such individuals in the same way, and with the same vigor, as it pursues other debts. CMS presumes that a state or local government that has custody of a Medicare beneficiary under a penal statute has a financial obligation to pay for the cost of healthcare items and services. Therefore, Medicare denies payment for items and services furnished to beneficiaries in state or local government custody.

**Claims Processing Procedures**

Providers and suppliers rendering services or items to a prisoner or patient in a jurisdiction that meets the conditions of 42 CFR 411.4(b) (http://www.gpo.gov/fdsys/pkg/CFR-2012-title42-vol2/pdf/CFR-2012-title42-vol2-sec411-4.pdf) should indicate this fact with the use of the QJ modifier, Services/items provided to a prisoner or patient in State or local custody, however, the State or local government, as applicable, meets the requirements in 42 CFR 411.4(b). This modifier indicates the state or local government agency requesting the healthcare items or services provided to the patient has notified the provider that the prisoner or patient is
responsible to repay the cost of Medical services. Furthermore, the agency will pursue the collection of debts for furnishing such items and services with the same vigor and in the same manner as any other debt.

Carriers must deny claims identified by the Common Working File (CWF) as non-covered under 42 CFR 411.4(a) and 411.4(b) using Reason Code 96 Non-covered charges. The following Remark Code will also be used:

<table>
<thead>
<tr>
<th>Remark Code</th>
<th>Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>N103</td>
<td>Social Security records indicate that this beneficiary was in the custody of a state or local government when the service was rendered. Medicare does not cover items and services furnished to beneficiaries while they are in state or local government custody under a penal authority, unless under state or local law, the beneficiary is personally liable for the cost of his or her health care while in such custody and the State or local government pursues such debt in the same way and with the same vigor as any other debt.</td>
</tr>
</tbody>
</table>

**Appeals**

A party to a claim denied in whole or in part under this policy may appeal the initial determination on the basis that, on the date of service, (1) The conditions of 42 CFR 411.4(b) were met, or (2) The beneficiary was not, in fact, in the custody of a State or local government under authority of a penal statute.
Changes to the Laboratory National Coverage Determination (NCD) Edit Software for January 2018

MLN Matters Number: MM10309 Related Change Request (CR) Number: CR10309
Related CR Release Date: October 6, 2017 Effective Date: October 1, 2017
Related CR Transmittal Number: R3872CP Implementation Date: January 2, 2018

PROVIDER TYPE AFFECTED

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

WHAT YOU NEED TO KNOW

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

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

BACKGROUND

CR10309 announces the changes that will be included in the January 2018 quarterly release of the edit module for clinical diagnostic laboratory services. NCDs for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee, and the final rule was published on November 23, 2001. Nationally uniform software was developed and incorporated in the Medicare shared systems so that laboratory claims subject to one of the 23 NCDs (Publication 100-03, Sections 190.12 - 190.34) were processed uniformly throughout the nation effective April 1, 2003.

In accordance with Chapter 16, Section 120.2, Publication 100-04, the laboratory edit module is updated quarterly as necessary to reflect ministerial coding updates and substantive changes to the NCDs developed through the NCD process. The changes are a result of coding analysis decisions developed under the procedures for maintenance of codes in the negotiated NCDs and biannual updates of the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes. CR 10309 communicates requirements to Shared System
Maintainers (SSMs) and contractors, notifying them of changes to the laboratory edit module to update it for changes in laboratory NCD code lists for January 2018. Please access the link below for the NCD spreadsheets included with CR10309:

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

ADDITIONAL INFORMATION


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

DOCUMENT HISTORY

<table>
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<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 12, 2017</td>
<td>Initial article released.</td>
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</tbody>
</table>

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Screening for Hepatitis B Virus (HBV) Infection

Note: This article was revised on August 8, 2017, to reflect an updated Change Request (CR) 9859. In the article, the CR release date, transmittal numbers, and the Web address of the CR are revised. Also, a clarification was made on page 3 to denote that HBV is not separately payable for ESRD TOB 72X unless reported with modifier AY. Another bullet point was added on page 3 to show that contractor pricing applies to G0499 with dates of service September 28, 2016 through December 31, 2017. All other information is unchanged.

Provider Types Affected

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

Provider Action Needed

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

Background

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

1. Reasonable and necessary for the prevention or early detection of illness or
disability.

2. Recommended with a grade of A or B by the United States Preventive Services Task Force (USPSTF).

3. Appropriate for individuals entitled to benefits under Part A or enrolled under Part B.

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

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

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

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

For the purposes of CR9859:

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

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

Key Points of CR9859

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

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

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

- Outpatient hospitals - TOB 13X (payment based on Outpatient Prospective Payment System)
- Non-patient laboratory specimen - TOB 14X (payment based on laboratory fee schedule)
- Critical Access Hospitals (CAHs) - TOB 85X, (payment based on reasonable cost when the revenue code is not 096X, 097X, and 098X)
- End Stage Renal Disease (ESRD) - TOB 72X (payment based on ESRD Prospective Payment System when submitting code G0499 with diagnosis code N18.6. HBV is not separately payable for ESRD TOB 72X unless reported with modifier AY.)
- Contractor pricing applies to G0499 with dates of service September 28, 2016 through December 31, 2017.

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

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

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

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

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

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

**Diagnosis Code Reporting Requirements**

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

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

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

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

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

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

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

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z34.00</td>
<td>Encounter for supervision of normal first pregnancy, unspecified trimester</td>
</tr>
<tr>
<td>Z34.01</td>
<td>Encounter for supervision of normal first pregnancy, first trimester</td>
</tr>
<tr>
<td>Z34.02</td>
<td>Encounter for supervision of normal first pregnancy, second trimester</td>
</tr>
<tr>
<td>Z34.03</td>
<td>Encounter for supervision of normal first pregnancy, third trimester</td>
</tr>
<tr>
<td>Z34.80</td>
<td>Encounter for supervision of other normal pregnancy, unspecified trimester</td>
</tr>
<tr>
<td>Z34.81</td>
<td>Encounter for supervision of other normal pregnancy, first trimester</td>
</tr>
<tr>
<td>Z34.82</td>
<td>Encounter for supervision of other normal pregnancy, second trimester</td>
</tr>
<tr>
<td>Z34.83</td>
<td>Encounter for supervision of other normal pregnancy, third trimester</td>
</tr>
<tr>
<td>Z34.90</td>
<td>Encounter for supervision of normal pregnancy, unspecified, unspecified trimester</td>
</tr>
<tr>
<td>Z34.91</td>
<td>Encounter for supervision of normal pregnancy, unspecified, first trimester</td>
</tr>
<tr>
<td>Z34.92</td>
<td>Encounter for supervision of normal pregnancy, unspecified, second trimester</td>
</tr>
<tr>
<td>Z34.93</td>
<td>Encounter for supervision of normal pregnancy, unspecified, third trimester</td>
</tr>
<tr>
<td>O09.90</td>
<td>Supervision of high risk pregnancy, unspecified, unspecified trimester</td>
</tr>
<tr>
<td>O09.91</td>
<td>Supervision of high risk pregnancy, unspecified, first trimester</td>
</tr>
<tr>
<td>O09.92</td>
<td>Supervision of high risk pregnancy, unspecified, second trimester</td>
</tr>
<tr>
<td>O09.93</td>
<td>Supervision of high risk pregnancy, unspecified, third trimester</td>
</tr>
</tbody>
</table>

Claim/Service Denial

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

When denying services submitted on a TOB other than 13X, 14X, or 85X, they will use:

- CARC 170 - Payment is denied when performed/billed by this type of provider.
  Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present
- RARC N95 - This provider type/provider specialty may not bill this service
- Group Code CO (Contractual Obligation) - Assigning financial liability to the provider

When denying services when HCPCS G0499 is paid in history for claims with dates of service on and after September 28, 2016, or if the beneficiary’s claim history shows claim lines containing

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CPT codes 86704, 86706, 87340, and 87341 submitted in the previous 11 full months they will use the following messages:

- CARC 119 - “Benefit maximum for this time period or occurrence has been reached.”
- RARC N386 - “This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.”
- Group Code PR (Patient Responsibility) - Assigning financial responsibility to the beneficiary (if a claim is received with occurrence code 32 with or without GA modifier or a claim –line is received with a GA modifier indicating a signed ABN is on file.).
- Group Code CO (Contractual Obligation) - Assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

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

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

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

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

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

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

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

• **CARC 171** - Payment is denied when performed by this type of provider on this type of facility. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

• **RARC N428** - Not covered when performed in certain settings.

• **Group Code CO**

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

• **CARC 184** - The prescribing/ordering provider is not eligible to prescribe/order the service billed. NOTE: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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

• **Group Code PR (Patient Responsibility)** - Assigning financial responsibility to the beneficiary (if a claim is received with a GA modifier indicating a signed ABN is on file).

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

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

• **CARC 119** - “Benefit maximum for this time period or occurrence has been reached.”

• **RARC N362** - “The number of days or units of service exceeds our acceptable maximum.”

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

• **Group Code PR (Patient Responsibility)** - Assigning financial responsibility to the beneficiary (if a claim is received with a GA modifier indicating a signed ABN is on file).

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

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

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

• 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 (Contractual Obligation).

When denying services for HBV screening, HCPCS 86704, 86706, 87340, and 87341 that are billed without the appropriate diagnosis code MACs will use:

• CARC 50 - These are non-covered services because this is not deemed a “medical necessity” by the payer. Note: Refer to the 835 Healthcare Policy identification Segment (loop 2110 Service Payment information REF), if present.

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

• Group Code PR (Patient Responsibility) - Assigning financial responsibility to the beneficiary (if a claim is received with a GA modifier indicating a signed ABN is on file).

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

Additional Notes

• HCPCS code G0499 will appear in the January 1, 2018, Clinical Laboratory Fee Schedule (CLFS), in the January 1, 2017, Integrated Outpatient Code Editor (IOCE), and in the January 1, 2017, Medicare Physician Fee Schedule (MPFS) with indicator ‘X’. HCPCS code G0499 will be effective retroactive to September 28, 2016, in the IOCE.

• Your MAC will not search for claims containing HCPCS G0499 with dates of service on or after September 28, 2016, but may adjust claims that you bring to their attention.

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

• MACs will apply contractor pricing to claim lines with G0499 with dates of service September 28, 2016, through December 31, 2017.

• Deductible and coinsurance do not apply to G0499.
Additional Information


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

Document History

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<th>Date</th>
<th>Description</th>
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<tr>
<td>August 8, 2017</td>
<td>This article was revised to reflect an updated CR9859. In the article, the CR release date, transmittal numbers, and the Web address of the CR are revised. A clarification was made on page 3 to denote that HBV is not separately payable for ESRD TOB 72X unless reported with modifier AY. Another bullet point was added on page 3 to show that contractor pricing applies to G0499 with dates of service September 28, 2016 through December 31, 2017. All other information is unchanged.</td>
</tr>
<tr>
<td>June 30, 2017</td>
<td>This article was revised to reflect an updated CR9859. In the article, the CR release date, transmittal numbers, and the Web address of the CR are revised. All other information is unchanged.</td>
</tr>
<tr>
<td>June 9, 2017</td>
<td>The article was revised to reflect an updated CR that changed the implementation date from January 1, 2018, to January 2, 2018.</td>
</tr>
<tr>
<td>May 4, 2017</td>
<td>Initial article released.</td>
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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/guides-and-resources

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

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

NEW POLICIES

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

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

December 2017 – There are no new Policies/Articles for December 2017

November 2017 – There are no new Policies/Articles for November 2017

October 2017

<table>
<thead>
<tr>
<th>Contract</th>
<th>Policy Title</th>
<th>CMS MCD Policy #</th>
<th>WPS Policy #</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>J5/J8</td>
<td>Immunohistochemistry (IHC) Indications for Gastric Pathology</td>
<td>A55739</td>
<td>NA</td>
<td>11/16/2017</td>
</tr>
<tr>
<td>J5/J8</td>
<td>MolDX: Coding and Billing for Abbott RealTime IDH2 testing for Acute Myeloid Leukemia (AML)</td>
<td>A55738</td>
<td>NA</td>
<td>11/16/2017</td>
</tr>
</tbody>
</table>
RETIRED POLICIES

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

Visit our website at the link below for more information:

December 2017

<table>
<thead>
<tr>
<th>Contract</th>
<th>Policy Title</th>
<th>CMS MCD Policy #</th>
<th>WPS Policy #</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>J5/J8</td>
<td>Zika Virus Testing by PCR and ELISA Methods</td>
<td>A55339</td>
<td>N/A</td>
<td>12/31/2017</td>
</tr>
<tr>
<td>J5/J8</td>
<td>Erythropoiesis Stimulating Agents (ESAs)</td>
<td>L34633</td>
<td>INJ-023</td>
<td>12/31/2017</td>
</tr>
</tbody>
</table>

November 2017

<table>
<thead>
<tr>
<th>Contract</th>
<th>Policy Title</th>
<th>CMS MCD Policy #</th>
<th>WPS Policy #</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>J5/J8</td>
<td>MolDX: Next Generation Sequencing (NGS) and Tier 1 and Tier 2 Coding and Billing Guidelines</td>
<td>A55196</td>
<td>N/A</td>
<td>12/15/2017</td>
</tr>
</tbody>
</table>

This article is being retired and incorporated into A55197 MolDX: Next Generation Sequencing Coding and Billing Guidelines.

October 2017 – There are no retired Policies/Articles for October 2017

REVISED POLICIES

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

Visit our website at the link below for more information:

December 2017

<table>
<thead>
<tr>
<th>Contract</th>
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<th>CMS MCD Policy #</th>
<th>WPS Policy #</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>J5/J8</td>
<td>Drugs and Biologics (Non-chemotherapy)</td>
<td>L34741</td>
<td>INJ-041</td>
<td>12/01/2017</td>
</tr>
</tbody>
</table>

Added to Group 10 Paragraph: J1300 Eculizumab (Soliris™)
• The treatment of adult patients with generalized Myasthenia Gravis (gMG) who are anti-acetylcholine receptor (AchR) antibody positive.
<table>
<thead>
<tr>
<th>Contract</th>
<th>Policy Title</th>
<th>CMS MCD Policy #</th>
<th>WPS Policy #</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Added to Group 10 Codes:</td>
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<td></td>
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<tr>
<td></td>
<td>G70.00: Myasthenia gravis without (acute) exacerbation</td>
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<tr>
<td></td>
<td>G70.01: Myasthenia gravis with (acute) exacerbation</td>
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<td></td>
<td>FDA approval/effective date 10/23/2017.</td>
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<tr>
<td></td>
<td>Revised Documentation Requirements: removed Supervising physician with</td>
<td></td>
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<tr>
<td></td>
<td>appropriate signature and replaced with Name of supervising physician;</td>
<td></td>
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<tr>
<td></td>
<td>removed Medication Administration record with appropriate signature.</td>
<td></td>
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<tr>
<td>J5/J8</td>
<td>MolDX: BRCA1 and BRCA2 Genetic Testing</td>
<td>L36813</td>
<td>MolDx-007</td>
<td>12/16/2017</td>
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<tr>
<td></td>
<td>Added:</td>
<td></td>
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<tr>
<td></td>
<td>&quot;or metastatic&quot; after prostate cancer (Gleason score ≥7). It now reads</td>
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<tr>
<td></td>
<td>(Gleason score ≥7 or metastatic).</td>
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<tr>
<td></td>
<td>Personal history of metastatic prostate cancer (radiographic evidence of or</td>
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<td></td>
<td>biopsy-proven disease)</td>
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<tr>
<td></td>
<td>ICD-10 Codes that Support Medical Necessity</td>
<td></td>
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<tr>
<td></td>
<td>C48.1  Malignant neoplasm of specified parts of peritoneum</td>
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<tr>
<td>J5/J8</td>
<td>Category III Codes</td>
<td>L35490</td>
<td>PHYS-084</td>
<td>12/01/2017</td>
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<tr>
<td></td>
<td>Added the phrase: &quot;For Part B only&quot; to the Group 3 Paragraph of CPT/HCPCS</td>
<td></td>
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<tr>
<td></td>
<td>codes, to the Group 3 Paragraph of diagnosis codes, and to the Utilization</td>
<td></td>
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<tr>
<td></td>
<td>Guidelines for codes 0387T, 0389T, 0390T, and 0391T.</td>
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<tr>
<td>J5/J8</td>
<td>MolDX NSCLC, Comprehensive Genomic Profile Testing</td>
<td>L36803</td>
<td>MolDx-017</td>
<td>12/01/2017</td>
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<tr>
<td></td>
<td>Removed CDD from the title of this LCD. Added lifetime smokers, former</td>
<td></td>
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<tr>
<td></td>
<td>light smokers or smokers who have not been tested and/or immunotherapy to</td>
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<td></td>
<td></td>
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<tr>
<td></td>
<td>the following paragraph:</td>
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<tr>
<td></td>
<td>This policy provides coverage for comprehensive somatic genomic profiling</td>
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<td></td>
<td>on tumor tissue-only (hereafter called CGP) for patients with metastatic</td>
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<td></td>
<td>non-small cell lung cancer (NSCLC) who are lifetime non-smokers, former</td>
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<tr>
<td></td>
<td>light smokers or smokers who have not been tested for genomic alterations</td>
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<tr>
<td></td>
<td>or who have tested negative for epidermal growth factor receptor (EGFR)</td>
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<tr>
<td></td>
<td>mutations, EML4-ALK rearrangements, and ROS1 rearrangements. Alterations</td>
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<tr>
<td></td>
<td>detected by CGP, if positive, may allow individuals to be treated with a</td>
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<tr>
<td></td>
<td>targeted and/or immunotherapy for which they were previously ineligible.</td>
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<tr>
<td></td>
<td>At the current time, CGP for germline (i.e. inheritable) mutations is</td>
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<td></td>
<td>not a Medicare benefit.</td>
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<tr>
<td></td>
<td>Analysis of Evidence</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>(Rationale for Determination)</td>
<td></td>
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<tr>
<td></td>
<td>Level of Evidence: Limited</td>
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<tr>
<td></td>
<td>Strength of Evidence: Moderate</td>
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<tr>
<td></td>
<td>Weight of Evidence: Limited</td>
<td></td>
<td></td>
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<tr>
<td>J5/J8</td>
<td>MolDX: OncoCee™ Billing and Coding Guidelines</td>
<td>A55245</td>
<td>N/A</td>
<td>01/15/2018</td>
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<tr>
<td></td>
<td>The following information has been added to this article:</td>
<td></td>
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</tr>
</tbody>
</table>
To receive a CTC assay service denial, please submit the following claim information:

- Select the appropriate CPT code for the service rendered:
  - 86152-Cell enumeration using immunologic selection and identification in fluid specimen (eg, CTC in blood)
  - 86153-CTC, physician interpretation and report

- Enter DEX Z-Code™ identifier adjacent to each code used to report the service 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

November 2017

Added the following codes to Group 1 of covered CPT/HCPCS codes: 0253T (Insertion of anterior segment aqueous drainage device, without extraocular reservoir, internal approach, into the suprachoroidal space), 0449T (Insertion of aqueous drainage device, without extraocular reservoir internal approach, in to the subconjunctival space, initial device) and 0450T (Insertion of aqueous drainage device, without extraocular reservoir internal approach, in to the subconjunctival space, each additional device).

Added code 0253T to Group 1 Paragraph for use with codes 0191T, 0376T and 0474T to support medical necessity.

Created a Group 4 Paragraph: The following ICD-10 Codes are used to support medical necessity with CPT codes 0449T and 0450T.

Created a Group 4 list of diagnosis codes for 0449T and 0450T:
- H40.10X3  Unspecified open-angle glaucoma, severe stage
- H40.10X4  Unspecified open-angle glaucoma, indeterminate stage
- H40.1113  Primary open-angle glaucoma, right eye, severe stage
- H40.1114  Primary open-angle glaucoma, right eye, indeterminate stage
- H40.1123  Primary open-angle glaucoma, left eye, severe stage
- H40.1124  Primary open-angle glaucoma, left eye, indeterminate stage
- H40.1133  Primary open-angle glaucoma, bilateral, severe stage
- H40.1134  Primary open-angle glaucoma, bilateral, indeterminate stage
- H40.1313  Pigmentary glaucoma, right eye, severe stage
- H40.1314  Pigmentary glaucoma, right eye, indeterminate stage
<table>
<thead>
<tr>
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<th>Effective Date</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>H40.1323 Pigmentary glaucoma, left eye, severe stage</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>H40.1324 Pigmentary glaucoma, left eye, indeterminate stage</td>
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<tr>
<td></td>
<td></td>
<td>H40.1333 Pigmentary glaucoma, bilateral, severe stage</td>
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<tr>
<td></td>
<td></td>
<td>H40.1334 Pigmentary glaucoma, bilateral, indeterminate stage</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>H40.1413 Capsular glaucoma with pseudoexfoliation of lens, right eye, severe stage</td>
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<tr>
<td></td>
<td></td>
<td>H40.1414 Capsular glaucoma with pseudoexfoliation of lens, right eye, indeterminate stage</td>
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<tr>
<td></td>
<td></td>
<td>H40.1423 Capsular glaucoma with pseudoexfoliation of lens, left eye, severe stage</td>
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<tr>
<td></td>
<td></td>
<td>H40.1424 Capsular glaucoma with pseudoexfoliation of lens, left eye, indeterminate stage</td>
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<tr>
<td></td>
<td></td>
<td>H40.1433 Capsular glaucoma with pseudoexfoliation of lens, bilateral, severe stage</td>
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<tr>
<td></td>
<td></td>
<td>H40.1434 Capsular glaucoma with pseudoexfoliation of lens, bilateral, indeterminate stage</td>
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</tr>
<tr>
<td></td>
<td>Added 0253T under Utilization Guidelines to 0191T, 0376T and 0474T for anterior segment aqueous drainage devices.</td>
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<tr>
<td></td>
<td>Added the following paragraph to this LCD under Utilization Guidelines for 0449T and 0450T: Insertion of an aqueous drainage device is indicated for the management of refractory glaucomas, including cases where previous surgical treatment has failed, cases of primary open-angle glaucoma, and pseudoexfoliative or pigmentary glaucoma with open angles that are unresponsive to maximum tolerated medical therapy.</td>
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</tr>
<tr>
<td>J5/J8</td>
<td>Drugs and Biologics (Non-chemotherapy)</td>
<td>L34741</td>
<td>INJ-041</td>
<td>11/01/2017</td>
</tr>
<tr>
<td></td>
<td>Added the following to Group 1 Paragraph: J0129 Abatecept (Orencia™), 10 mg</td>
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<tr>
<td></td>
<td>Adult Rheumatoid Arthritis (RA): moderately to severely active RA in adults. Juvenile Idiopathic Arthritis: moderately to severely active polyarticular juvenile idiopathic arthritis in patients 6 years of age and older. Adult Psoriatic Arthritis (PsA): active PsA in adults. FDA approval/effective date 06/30/2017.</td>
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<tr>
<td></td>
<td>Added the following Group 1 Codes:</td>
<td>L40.50 Arthropathic psoriasis, unspecified</td>
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<tr>
<td></td>
<td>L40.51 Distal interphalangeal psoriatic arthropathy</td>
<td></td>
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<tr>
<td></td>
<td>L40.52 Psoriatic arthritis mutilans</td>
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<tr>
<td></td>
<td>L40.53 Psoriatic spondylitis</td>
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<tr>
<td></td>
<td>L40.54 Psoriatic juvenile arthropathy</td>
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<tr>
<td></td>
<td>L40.59 Other psoriatic arthropathy</td>
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<tr>
<td></td>
<td>Added the following to Group 2 Codes J2778 Ranibizumab (Lucentis™): E11.3551 Type 2 diabetes mellitus with stable proliferative diabetic retinopathy, right eye E11.3552 Type 2 diabetes mellitus with stable proliferative diabetic retinopathy, left eye</td>
<td></td>
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</tbody>
</table>
E11.3553 Type 2 diabetes mellitus with stable proliferative diabetic retinopathy, bilateral
FDA approval/effective date 04/15/2017.

Correction to 10/01/2017 revision history.
The following codes in Group 2 J2778 Ranibizumab (Lucentis™): corrected FDA approval/effective date 04/15/2017:
E08.311 Diabetes mellitus due to underlying condition with unspecified diabetic retinopathy with macular edema
E08.319 Diabetes mellitus due to underlying condition with unspecified diabetic retinopathy without macular edema
E08.3291 Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy without macular edema, right eye
E08.3292 Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy without macular edema, left eye
E08.3293 Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy without macular edema, bilateral
E08.3391 Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy without macular edema, right eye
E08.3392 Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy without macular edema, left eye
E08.3393 Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy without macular edema, bilateral
E08.3491 Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy without macular edema, right eye
E08.3492 Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy without macular edema, left eye
E08.3493 Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy without macular edema, bilateral
E08.3521 Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment involving the macula, right eye
E08.3522 Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment involving the macula, left eye
E08.3523 Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment involving the macula, bilateral
E08.3531 Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, right eye
E08.3532 Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, left eye
E08.3533 Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, bilateral
E08.3541 Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, right eye
E08.3542 Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, left eye
<table>
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<th>Policy Title</th>
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<tbody>
<tr>
<td>E08.3543</td>
<td>Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, bilateral</td>
</tr>
<tr>
<td>E08.3551</td>
<td>Diabetes mellitus due to underlying condition with stable proliferative diabetic retinopathy, right eye</td>
</tr>
<tr>
<td>E08.3552</td>
<td>Diabetes mellitus due to underlying condition with stable proliferative diabetic retinopathy, left eye</td>
</tr>
<tr>
<td>E08.3553</td>
<td>Diabetes mellitus due to underlying condition with stable proliferative diabetic retinopathy, bilateral</td>
</tr>
<tr>
<td>E08.3591</td>
<td>Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy without macular edema, right eye</td>
</tr>
<tr>
<td>E08.3592</td>
<td>Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy without macular edema, left eye</td>
</tr>
<tr>
<td>E08.3593</td>
<td>Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy without macular edema, bilateral</td>
</tr>
<tr>
<td>E09.311</td>
<td>Drug or chemical induced diabetes mellitus with unspecified diabetic retinopathy with macular edema</td>
</tr>
<tr>
<td>E09.319</td>
<td>Drug or chemical induced diabetes mellitus with unspecified diabetic retinopathy without macular edema</td>
</tr>
<tr>
<td>E09.3291</td>
<td>Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, right eye</td>
</tr>
<tr>
<td>E09.3292</td>
<td>Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, left eye</td>
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<td>Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, left eye</td>
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<td>E09.3393</td>
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<tr>
<td>E09.3493</td>
<td>Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, bilateral</td>
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<tr>
<td>E09.3521</td>
<td>Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, right eye</td>
</tr>
<tr>
<td>E09.3522</td>
<td>Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, left eye</td>
</tr>
<tr>
<td>E09.3523</td>
<td>Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, bilateral</td>
</tr>
<tr>
<td>E09.3531</td>
<td>Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, right eye</td>
</tr>
<tr>
<td>E09.3532</td>
<td>Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, left eye</td>
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<tr>
<td>Contract</td>
<td>Policy Title</td>
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<td>------------------------------------------------------------------------------</td>
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<tr>
<td>E09.353</td>
<td>Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, bilateral</td>
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<td>E09.354</td>
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Correction to 10/01/2017 revision history.
The following codes in Group 3 J0178 Aflibercept (Eylea): corrected FDA approval/effective date 04/15/2017:
E08.311 Diabetes mellitus due to underlying condition with unspecified diabetic retinopathy with macular edema
E09.311 Drug or chemical induced diabetes mellitus with unspecified diabetic retinopathy with macular edema
E10.311 Type 1 diabetes mellitus with unspecified diabetic retinopathy with macular edema
Contract Policy Title

E11.311 Type 2 diabetes mellitus with unspecified diabetic retinopathy with macular edema
E13.311 Other specified diabetes mellitus with unspecified diabetic retinopathy with macular edema.

Added the following to the CMS National Coverage Policy; CR10236 Transmittal 3864 September 15, 2017: corrected effective date to the OPPS status indicator for Q5102 modifiers: July 01, 2017.

Billing & Coding Guidelines included which contains information regarding HCPCD code Q5102 appropriate modifiers: ZB or ZC.

7. Part B Biosimilar Biological Product Payment and Required Modifiers
The 2016 Physician Fee Schedule Final Rule, updated the regulation text found at 42 CFR 414.904(j) to make clear that effective January 1, 2016, the payment amount for a biosimilar biological drug product is based on the average sales price of all NDCs assigned to the biosimilar biological products included within the same billing and payment code. Modifiers will be used to distinguish between biosimilar products that appear in the same HCPCS code but are made by different manufacturers. CMS will issue HCPCS codes for biosimilar biological products and will issue and assign modifiers to specific biosimilar products in each HCPCS code. Claims for separately paid biosimilar biological products will be required to include a modifier that identifies the manufacturer of the specific product. The use of the modifiers on claims for biosimilar is mandatory.

If a HCPCS code and corresponding biosimilar modifier(s) do not appear on the quarterly update, then a modifier is not required to appear on claims for the code. New biosimilar products that are not adequately described by an existing unique HCPCS code may be billed under a miscellaneous code or “not otherwise classified” code such as J3590. Similarly, a “not otherwise classified” code may also be used in situations where an existing biosimilar HCPCS code is associated with a corresponding modifier that is not yet in effect in the claims processing system. The manufacturer modifier is not required on claims that use a miscellaneous HCPCS code.

J5/J8 MolDX: BRCA1 and BRCA2 Genetic Testing

Clarified the Criteria for Testing section to align with the reformatted NCCN Guidelines:
Criteria for Testing
- Individual with a personal history of ovarian* cancer
- Individual with a breast cancer diagnosis meeting any of the following criteria:
  - A known mutation in a cancer susceptibility gene within the family
  - Diagnosed ≤50 y
  - Triple negative breast cancer (estrogen receptor (ER) negative, progesterone receptor (PR) negative, and human epidermal growth factor receptor 2 (HER2) negative) breast cancer diagnosed ≤ 60 y
  - Two breast cancer primaries in a single individual
- Breast cancer at any age, and
  - ≥1 first, second, or third degree relative with breast cancer ≤50 y, or
  - ≥1 first, second, or third degree relative with invasive ovarian cancer at any age, or
  - ≥2 first, second, or third degree relatives with breast cancer and/or pancreatic cancer at any age, or
  - Pancreatic cancer at any age, or
  - From a population at increased risk due to founder mutations, in which case requirements for inclusion may be modified
- Male breast cancer
  - Individual of Ashkenazi Jewish descent with breast, ovarian, or pancreatic cancer at any age
  - Individual with a personal and family history of three or more of the following:
    - Breast cancer, pancreatic cancer, prostate cancer (Gleason score ≥7), melanoma, sarcoma, adrenocortical carcinoma, brain tumors, leukemia, diffuse gastric cancer, colon cancer, endometrial cancer, thyroid cancer, kidney cancer, dermatologic manifestations, and/or macrocephaly, hamartomatous polyps of gastrointestinal (GI) tract

*Includes fallopian tube and primary peritoneal cancers. BRCA – related ovarian cancers are associated with epithelial, non-mucinous histology.

**NCCN defines blood relative as first- (parents, siblings and children), second- (grandparents, aunts, uncles, nieces and nephews, grandchildren and half-siblings), and third degree-relatives (great-grandparents, great-aunts, great uncles, great grandchildren and first cousins) on same side of family.

J5/J8 MolDX: Next Generation Sequencing Coding and Billing Guidelines

This article has been updated with information from our A55196 - MolDX: Next Generation Sequencing (NGS) and Tier 1 and Tier 2 Coding and Billing Guidelines which will be retiring.

Next Generation Sequencing (NGS)

NGS testing platforms allow identification of somatic and/or germline alterations in multiple genes simultaneously. This guideline focuses on Targeted and Comprehensive Genomic Profile testing for somatic variant detection using tumor tissue only-based panels. Panels involving germline variants, matched tumor-normal, or “liquid biopsies” (including circulating tumor cells (CTCs) or DNA (ctDNA), or cell-free DNA (cfDNA)) will be addressed separately, but should be billed using CPT 81479.

Targeted (aka Hot Spot) Tumor Panels

Targeted NGS panels identify somatic alterations known to occur in certain areas (i.e., “hotspots”) in specific genes of interest. Generally, these NGS panels can detect single nucleotide variants (SNVs or point mutations) and small (typically ≤40 bp) insertions or deletions (indels), but not copy number alterations (CNAs) or structural variants (SVs), such as gene rearrangements, fusions, or translocations.
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<th>WPS Policy #</th>
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<td>Gleason score 9-10/Gleason grade group 5</td>
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|          | Gleason grade group 1 |
|          | Intermediate |
|          | 3+4=7/Gleason grade group 2 OR |
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<td>• IHC for H. pylori, or neuroendocrine markers such as synaptophysin or chromogranin</td>
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October 2017

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<td>Added CR 10236 - October 2017 Update of the Hospital Outpatient Prospective Payment System (OPPS) regarding Upper Eyelid Blepharoplasty and</td>
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</table>
Blepharoptosis Repair to the CMS National Coverage Policy section and its related billing instructions to the Billing and Coding Guideline.

9. Per CR 10236 - October 2017 Update of the Hospital Outpatient Prospective Payment System (OPPS). This Recurring Update Notification describes changes to and billing instructions for various payment policies implemented in the October 2017 OPPS update.

As indicated in Chapter VIII of the CY 2017 National Correct Coding Initiative (NCCI) Policy Manual for Medicare Services, CMS payment policy does not allow separate payments for a blepharoptosis procedure (CPT code 67901-67908) and a blepharoplasty procedure (CPT codes 15822-15823) on the ipsilateral upper eyelid. Under this policy, any removal of upper eyelid skin in the context of an upper eyelid blepharoptosis surgery was considered a part of the blepharoptosis surgery. This instruction was clarified in the July 2016 Hospital Outpatient Prospective Payment System (OPPS) Update Change Request (Transmittal 3557, Change Request 9658 dated July 1, 2016) and the July 2016 OPPS MLN Matters Article MM9658.

However, effective October 1, 2017, CMS is revising this policy to allow either cosmetic or medically necessary blepharoplasty to be performed in conjunction with a medically necessary upper eyelid blepharoptosis surgery. Specifically, physicians may receive payment for a medically necessary upper eyelid blepharoptosis from Medicare even when performed with (non-covered) cosmetic blepharoplasty on the same eye during the same visit. Since cosmetic procedures are not covered by Medicare, advanced beneficiary notice of noncoverage (ABN) instructions would apply for cosmetic blepharoplasty. However, medically necessary blepharoplasty will continue to be bundled into the payment for blepharoptosis when performed with and as a part of a blepharoptosis surgery.

Other aspects of the July 2016 OPPS Update CR and MLN guidance on upper eyelid blepharoplasty and blepharoptosis remain unchanged. Specifically, we note that Medicare does not allow separate payment for the following:

* Operating on the left and right eyes on different days when the standard of care is bilateral eyelid surgery
* Charging the beneficiary an additional amount for removing orbital fat when a blepharoplasty or a blepharoptosis repair is performed
* Performing a medically necessary blepharoplasty on a different date of service than the blepharoptosis procedure for the purpose of unbundling the medically necessary blepharoplasty
* Performing blepharoplasty as a staged procedure, either by one or more surgeons (note that under certain circumstances a blepharoptosis procedure could be a staged procedure)
* Billing for two procedures when two surgeons divide the work of a medically necessary blepharoplasty performed with a blepharoptosis repair
* Using modifier 59 to unbundle a medically necessary blepharoplasty from the ptosis repair on the claim form; this applies to both physicians and facilities.
* Treating medically necessary surgery as cosmetic for the purpose of charging the beneficiary for a cosmetic surgery
### Contract Policy Title

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Added code 0474T (Insertion of anterior segment aqueous drainage device, with insertion of intraocular reservoir, internal approach, into the supraciliary space) to Group 1 of covered CPT/HCPCS codes and to Group 1 Paragraph.

Added the following language to Paragraph 2 to clarify claims processing for NCD 150.13 Percutaneous Image-Guided Lumbar Decompression for Lumbar Spinal Stenosis (PILD for LSS) for code 0275T: Effective for claims with dates of service on or after December 7, 2016, Medicare will cover PILD under CED for beneficiaries with LSS who are enrolled in a CMS-approved prospective longitudinal study PILD procedure using and FDA-approved/cleared device that completed a CMS-approved RCT (randomized controlled trial) that met the criteria listed in the January 2014 NCD (see CR 8757, transmittal #2959, dated May 16, 2014). This is an expansion of coverage for PILD under CED, therefore the current coding and editing instructions remain unchanged.

### J5/J8 Drugs and Biologics (Non-chemotherapy)

| L34741 | INJ-041 | 10/01/2017 |

Please refer to the 2018 ICD-10 Code Update Article/Table.

Codes added to Group 2 due to FDA indication.

Group 2 Paragraph: J2778 Ranibizumab (Lucentis™), 0.1 mg:

- Neovascular (Wet) Age-Related Macular Degeneration
- Diabetic macular edema
- Diabetic retinopathy in patients with or without diabetic macular edema.

Group 2 Codes:

- E08.311 Diabetes mellitus due to underlying condition with unspecified diabetic retinopathy with macular edema
- E08.319 Diabetes mellitus due to underlying condition with unspecified diabetic retinopathy without macular edema
- E08.3291 Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy without macular edema, right eye
- E08.3292 Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy without macular edema, left eye
- E08.3293 Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy without macular edema, bilateral
- E08.3391 Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy without macular edema, right eye
- E08.3392 Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy without macular edema, left eye
- E08.3393 Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy without macular edema, bilateral
- E08.3491 Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy without macular edema, right eye
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<td>H35.81</td>
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Codes added to Group 3 due to FDA indications.

Group 3 Paragraph: J0178 Aflibercept (Eylea), 1mg
Neovascular (wet) Age-Related Macular Degeneration
Diabetic macular edema
Diabetic retinopathy in patients with diabetic macular edema

Group 3 Codes:
E08.311 Diabetes mellitus due to underlying condition with unspecified diabetic retinopathy with macular edema
E09.311 Drug or chemical induced diabetes mellitus with unspecified diabetic retinopathy with macular edema
E10.311 Type 1 diabetes mellitus with unspecified diabetic retinopathy with macular edema
E11.311 Type 2 diabetes mellitus with unspecified diabetic retinopathy with macular edema
E13.311 Other specified diabetes mellitus with unspecified diabetic retinopathy with macular edema.

Group 1 Paragraph

HCPCS code Q5102 must be billed with appropriate modifier to identify the manufacturer for biosimilar drugs:
ZB Pfizer/Hospira. Effective dates of service on or after 04/05/2016 or
ZC Merck/Samsung Bioepis. Effective claims submitted on or after 10/01/2017.
CR10236 October 2017 Update of the Hospital Outpatient Prospective Payment System (OPPS): New Modifier for Biosimilar Biological Product: Q5102 can be reported with either the existing modifier ZB or new modifier ZC effective July 1, 2017.

CR10234 Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes - October 2017 Update: The ZC modifier will become effective, that is, valid for claims submitted beginning October 1, 2017 and applies retroactively to dates of service on or after July 24, 2017.

Group 11 Paragraph: Q5102 Infliximab, Biosimilar

HCPCS code Q5102 must be billed with appropriate modifier to identify the manufacturer for biosimilar drugs:
ZB Pfizer/Hospira. Effective dates of service on or after 04/05/2016 or
ZC Merck/Samsung Bioepis. Effective claims submitted on or after 10/01/2017.
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<td>Medicare Part B Drug Average Sales Price: Part B Biosimilar Biological Product Payment and Required Modifiers: July 2017 Update</td>
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<td>7.</td>
<td>Part B Biosimilar Biological Product Payment and Required Modifiers</td>
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<td>The 2016 Physician Fee Schedule Final Rule, updated the regulation text found at 42 CFR 414.904(j) to make clear that effective January 1, 2016, the payment amount for a biosimilar biological drug product is based on the average sales price of all NDCs assigned to the biosimilar biological products included within the same billing and payment code. Modifiers will be used to distinguish between biosimilar products that appear in the same HCPCS code but are made by different manufacturers. CMS will issue HCPCS codes for biosimilar biological products and will issue and assign modifiers to specific biosimilar products in each HCPCS code. Claims for separately paid biosimilar biological products will be required to include a modifier that identifies the manufacturer of the specific product. The use of the modifiers on claims for biosimilar is mandatory.</td>
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|          | If a HCPCS code and corresponding biosimilar modifier(s) do not appear on the quarterly update, then a modifier is not required to appear on claims for the code. New biosimilar products that are not adequately described by an existing unique HCPCS code may be billed under a miscellaneous code or “not otherwise
classified" code such as J3590. Similarly, a "not otherwise classified" code may also be used in situations where an existing biosimilar HCPCS code is associated with a corresponding modifier that is not yet in effect in the claims processing system. The manufacturer modifier is not required on claims that use a miscellaneous HCPCS code.

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<td>J5/J8</td>
<td>Erythropoiesis Stimulating Agents (ESAs)</td>
<td>L34633</td>
<td>INJ-023</td>
<td>10/01/2017</td>
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</table>

Group 8 Codes: added:
- C93.10 Chronic myelomonocytic leukemia not having achieved remission
- C93.11 Chronic myelomonocytic leukemia, in remission

| J5/J8 | Human Granulocyte/Macrophage Colony Stimulating Factors | L34699 | INJ-019 | 10/01/2017 |

Coverage Indications, Limitations, and/or Medical Necessity

F. Indications for tbo-filgrastim (GRANIX) (J1447) added:
4. Administration may be indicated for patients with Myelodysplastic Syndromes (MDS). Such risk factors should be documented in the patient record.
   a. Consider in combination epoetin alfa or darbepoetin alfa for lower risk disease associated with symptomatic anemia, serum erythropoietin levels less than or equal to 500mU/ml, ring sideroblasts less than 15% and no response to epoetin or darbepoetin alone.
   b. Treatment of lower risk disease associated with symptomatic anemia, no del(5q) with or without other cytogenetic abnormalities, serum erythropoietin levels less than or equal to 500mU/ml, and ring sideroblasts greater than or equal to 15% either:
      • In combination with epoetin alpha or darbepoetin alpha as initial therapy, or
      • In combination with lenalidomide and epoetin alpha or darbepoetin alpha if no response to erythropoietins alone.

Group 6 Codes added:
- C93.10 Chronic myelomonocytic leukemia not having achieved remission
- D46.0 Refractory anemia without ring sideroblasts, so stated
- D46.1 Refractory anemia with ring sideroblasts
- D46.20 Refractory anemia with excess of blasts, unspecified
- D46.21 Refractory anemia with excess of blasts 1
- D46.A Refractory cytopenia with multilineage dysplasia
- D46.B Refractory cytopenia with multilineage dysplasia and ring sideroblasts
- D46.4 Refractory anemia, unspecified
- D46.Z Other myelodysplastic syndromes
- D46.9 Myelopysplastic syndrome, unspecified.

G. Indications for Filgastrim-sndz (ZARXIO) (Q5101) HCPCS code Q5101 must be billed with modifier ZA: effective for dates of service on or after 01/01/2016.

Group 1 Paragraph
HCPCS code Q5101 must be billed with modifier ZA: effective for dates of service on or after 01/01/2016.

Group 7 Paragraph: Q5101
- HCPCS code Q5101 must be billed with modifier ZA: effective for dates of service on or after 01/01/2016.
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<td>MolDX: Molecular Diagnostic Tests (MDT)</td>
<td>L36807</td>
<td>MolDX-004</td>
<td>10/01/2017</td>
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Utilization Guidelines
Change Request 9284: Implementation of Biosimilar Claim Modifiers: HCPCS code Q5101 must be billed with modifier ZA to identify the manufacturer for biosimilar drugs. Effective for dates of service on or after 01/01/2016. HCPCS code Q5101 submitted without modifier ZA will be returned to the provider.

Under Frequency, added the following sentence for clarification: "All time intervals are determined on a rolling basis. For example, the limitation of coverage to six sessions in a year refers to a rolling 12-month period. The year begins with the first session and completes one year later. The next rolling year begins with the first session after completion of the preceding rolling year." Please refer to the combined ICD-10-CM code update article for code changes specific to this policy.

The following information was added under the Summary of Evidence: The clinical expression of AFAP is more variable with adenomas developing at a later age, and some patients with <10 cumulative adenomatous polyps².

Under "Indications and Limitations of Coverage" replaced 81479 with 81219 in the following sentence: "Genetic testing of the CALR gene (81219) (only found in ET and PMF) is medically necessary when the following criteria are met:"

CPT 81219 has been listed in Group 1 of the CPT/HCPC Code Tables 81219 CALR (CALRETICULIN) (EG, MYELOPROLIFERATIVE DISORDERS), GENE ANALYSIS, COMMON VARIANTS IN EXON 9

0004U-0017U have been added to the CPT code section of this LCD.

Effective 05/01/2017 Per Change Request (CR) 10104 & 10122:
0004U Nfct ds dna 27 resist genes
0005U Onco prst8 3 gene ur alg

Effective 08/01/2017 Per Change Request 10222 & 10236:
0006U RX MNTR 120+ DRUGS & SBSTS
0007U RX TEST PRSMV UR W/DEF CONF
0008U HPYLORI DETCJ ABX RSTNC DNA
0009U ONC BRST CA ERBB2 AMP/NONAMP
0010U NFCT DS STRN TYP WHL GEN SEQ
0011U RX MNTR LC-MS/MS ORAL FLUID
0012U GERMLN DO GENE REARGMT DETCJ
0013U ONC SLD ORG NEO GENE REARGMT
0014U HEM HMTLMF NEO GENE REARGMT
0015U RX METAB ADVRS RX RXN DNA
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<td>0016U ONC HMTLMF NEO RNA BCR/ABL1 0017U ONC HMTLMF NEO JAK2 MUT DNA</td>
<td><strong>MoIDx: ResponseDX Tissue of Origin® Coding and Billing Guidelines</strong></td>
<td>A55204</td>
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<td>Diagnosis code D49.7 Chronic myeloproliferative disease was added to Group 1 covered ICD-10 Codes.</td>
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<td>J5/J8 Non-Invasive Cerebrovascular Studies</td>
<td><strong>Non-Invasive Cerebrovascular Studies</strong></td>
<td>L35753</td>
<td>CV-045</td>
<td>10/01/2017</td>
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<td></td>
<td>Please see combined article for ICD-10 Code Updates. Added codes H93.A1 (Pulsatile tinnitus, right ear), H93.A2 (Pulsatile tinnitus, left ear) and H93.A3 (Pulsatile tinnitus, bilateral) to Group 1; deleted codes H93.11 (Tinnitus, right ear), H93.12 (Tinnitus, left ear) and H93.13 (Tinnitus, bilateral) from Group 1; and deleted Group 1 Paragraph instructions to use tinnitus codes to report pulsatile tinnitus. Removed the asterisk in Group 1 for diagnosis code R42 (Dizziness and giddiness) and the associated asterisk explanation at the end of Group 1: Group 1 Medical Necessity ICD-10 Codes Asterisk Explanation: *while diagnostic code R42 is listed as a covered diagnostic code, note that dizziness and giddiness alone are not usual indications unless associated with other localizing signs and symptoms.</td>
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<td>J5/J8 Non-Invasive Peripheral Arterial Vascular Studies</td>
<td><strong>Non-Invasive Peripheral Arterial Vascular Studies</strong></td>
<td>L35761</td>
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<td>Please see combined article for ICD-10 Code Updates. Added the words &quot;claudication and&quot; to the asterisk explanation phrase for &quot;use for claudication and intermittent claudication&quot; at the end of Group 1 for code I73.9 (Peripheral vascular disease, unspecified).</td>
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<td>J5/J8 Non-Invasive Peripheral Venous Vascular and Hemodialysis Access Studies</td>
<td><strong>Non-Invasive Peripheral Venous Vascular and Hemodialysis Access Studies</strong></td>
<td>L35751</td>
<td>CV-047</td>
<td>10/01/2017</td>
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<td>Please see combined article for ICD-10 Code Updates. Added code Z01.810 (Encounter for preprocedural cardiovascular examination) to Group 1 (Peripheral Venous Examinations (93970, and 93971)) and Group 3 (Vessel Mapping for Vessels for Hemodialysis Access (G0365)). Also added to Paragraph 3: Pre-operative examination for potential harvest vein grafts or pre-operative examination of vessel prior to hemodialysis access surgery (Z01.810 or Z01.818).</td>
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Claim Status Category and Claim Status Codes Update

MLN Matters Number: MM10132
Related Change Request (CR) Number: 10132
Related CR Release Date: August 18, 2017
Effective Date: January 1, 2018
Related CR Transmittal Number: R3839CP
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) 10132 updates, 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 your billing staffs are aware of these updates.

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.

The National Code Maintenance Committee meets at the beginning of each ASC X12 trimester meeting, held each year in January or February, June, and in September or October. At these meetings, the Committee 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.

added, changed, or deleted.

All code changes approved during the September/October 2017 Committee meeting shall be posted on the above websites on or about November 1, 2017.

The Centers for Medicare & Medicaid Services (CMS) will issue instructions to the MACs who then must update their claims systems to ensure that the current version of these codes is used in their claim status responses.

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 CR10132. References in CR10132 to “277 responses,” and “claim status responses,” encompass both the ASC X12 277 Health Care Claim Status Response and the ASC X12 277 Healthcare Claim Acknowledgment transactions.

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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Claim Status Category Codes and Claim Status Codes Update

MLN Matters Number: MM10271
Related Change Request (CR) Number: 10271

Related CR Release Date: November 9, 2017
Effective Date: April 1, 2018

Related CR Transmittal Number: R3916CP
Implementation Date: April 2, 2018

**PROVIDER TYPE AFFECTED**

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

**PROVIDER ACTION NEEDED**

Change Request (CR) 10271 informs MACs about system changes to update, as needed, the Claim Status Codes 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 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.

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 National Code Maintenance Committee has decided to allow the industry 6 months for implementation of newly added or changed 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 January 2018 committee meeting will be posted on these sites on or about February 1, 2018.

The Centers for Medicare & Medicaid Services (CMS) will issue notifications regarding the need
for future updates to these codes. When instructed, MACs must update their claims systems to ensure that the current version of these codes is used in their claim status responses. MAC 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 Change Request (CR) 10271.

Note: References in CR 10271 to “277 responses” and "claim status responses" encompass both the ASC X12 277 Health Care Claim Status Response and the ASC X12 277 Healthcare Claim Acknowledgment transactions.

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: MM10140 Related Change Request (CR) Number: CR10140
Related CR Release Date: August 18, 2017 Effective Date: January 1, 2018
Related CR Transmittal Number: R3841CP 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), including Durable Medical Equipment (DME) MACs and Home Health & Hospice MACs for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

Change Request (CR) 10140 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 are based on the CORE Code Combination List to be published on or about October 1, 2017.

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 Affordable Care Act. The Health Insurance Portability and Accountability Act (HIPAA) amended the Act by adding Part C—Administrative Simplification—to Title XI of the Social Security Act, requiring the Secretary of DHHS to adopt standards for certain transactions to enable health information to be exchanged more efficiently and to achieve greater uniformity in the
transmission of health information. Through the Affordable Care Act, Congress sought to promote implementation of electronic transactions and achieve cost reduction and efficiency improvements by creating more uniformity in the implementation of standard transactions. This was done by mandating the adoption of a set of operating rules for each of the HIPAA transactions. The Affordable Care Act defines operating rules and specifies the role of operating rules in relation to the standards.

CAQH CORE will publish the next version of the Code Combination List on or about October 1, 2017. This update is based on the CARC and RARC updates as posted at the Washington Publishing Company (WPC) website on or about July 1, 2017. This will also include updates based on Market Based Review that CAQH CORE conducts once a year to accommodate code combinations that are currently being used by Health Plans including Medicare as the industry needs them. See http://www.wpc-edi.com/reference for CARC and RARC updates and http://www.caqh.org/CORECodeCombinations.php for CAQH CORE defined code combination updates.

Note: The Affordable Care Act 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


If you have any questions, please contact your MAC at their toll-free number. That number is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/监测-项目/医疗保险-FFS-合规-项目/审查-承包商-目录-互动-地图/.

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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: MM10268 Related Change Request (CR) Number: 10268
Related CR Release Date: November 9, 2017 Effective Date: April 1, 2018
Related CR Transmittal Number: R3915CP Implementation Date: April 2, 2018

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 10268 instructs MACs and Shared System Maintainers (SSMs) to update systems based on the CORE 360 Uniform Use of Claims Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC), and Claim Adjustment Group Code (CAGC) Rule publication. These system updates are based on the Committee on Operating Rules for Information Exchange (CORE) Code Combination List to be published on or about February 1, 2018. Make sure that your billing staff is aware of these changes.

BACKGROUND

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

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. CR10268 deals with the regular update in CAQH CORE defined code combinations per Operating Rule 360 - Uniform Use of CARC and RARC (835) Rule.

CAQH CORE will publish the next version of the Code Combination List on or about February 1, 2018. This update is based on the CARC and RARC updates as posted at the Washington Publishing Company (WPC) website on or about November 1, 2017. This will also include updates based on Market Based Review that CAQH CORE conducts once a year to accommodate code combinations that are currently being used by Health Plans including Medicare as the industry needs them. You can find CARC and RARC updates at http://www.wpc-edi.com/reference and CAQH CORE defined code combination updates at http://www.caqh.org/CORECodeCombinations.php.

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 CR10268, 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 (CR10140).

Per the Affordable Care Act 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 four Business Scenarios. Medicare can use any code combination if the business scenario is not one of the four CORE defined business scenarios. With the four CORE defined business scenarios, Medicare must use the code combinations from the lists published by CAQH CORE.

**ADDITIONAL INFORMATION**


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

MLN Matters Number: MM10095 Revised 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

Note: This article was revised on September 7, 2017, to remove a reference to checklists that should not have been included. All other information remains the same.

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. 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.

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

MLN Matters Number: MM10270  Related Change Request (CR) Number: 10270
Related CR Release Date: November 9, 2017  Effective Date: April 1, 2018
Related CR Transmittal Number: R3910CP  Implementation Date: April 2, 2018

PROVIDER TYPES AFFECTED

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

WHAT YOU NEED TO KNOW

Change Request (CR) 10270 updates the Remittance Advice Remark Codes (RARC) and Claims Adjustment Reason Code (CARC) lists and instructs Medicare Shared System Maintainers (SSMs) to update Medicare Remit Easy Print (MREP) and PC Print. Be sure your 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 of 1986 (HIPAA) instructs health plans to be able to conduct standard electronic transactions adopted under HIPAA using valid standard codes. Medicare policy states that CARCs and RARCs, as appropriate, which provide either supplemental explanation for a monetary adjustment or policy information that generally applies to the monetary adjustment, are required in the remittance advice and coordination of benefits transactions.

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

SSMs have the responsibility to implement code deactivation, making sure that any deactivated code is not used in original business messages and allowing the deactivated code in derivative messages. SSMs must make sure that Medicare does not report any deactivated code on or
after the effective date for deactivation as posted on the Washington Publishing Company (WPC) website. If any new or modified code has an effective date later than the implementation date specified in CR10270, MACs must implement on the date specified on the WPC website, available at: 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.

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

PROVIDER EDUCATION

WPS GHA Learning Center

WPS GHA Provider Outreach & Education (POE) has numerous educational opportunities in our learning portal at http://wpsgha.litmos.com. This will take you to the first screen that provides information for first time users. You can also access https://wpsgha.litmos.com/account/login to see how to access our list of educational offerings, how to register as a user, and set up a profile. We offer on-demand learning courses that allow you to access the education at your convenience. We offer education on many subjects, and in different formats. To see our most current list, please visit the WPS GHA Learning Center at http://wpsgha.litmos.com/online-courses. Most of our education offers Certificates of Achievement identifying the time of the education. These certificates can be used with your accrediting organization (without an index number) to receive Continuing Education Units (CEUs).

Continue to watch our Wednesday eNews to see the latest offerings. During the late fall and winter months, we provide more offerings by teleconference, webinar, and On-Demand training. In any of our educational offerings we will provide the handout electronically and the attendee, whether in-person, teleconference, webinar, or On-Demand, will be responsible for accessing the material. To access, choose the Additional References tab in the individual course on our Learning Center.
Below are just some of the offerings we currently have available.

**Teleconferences**

**Incident to Guidelines**

12/07/2017 – 9:30 AM – 11:00 AM CT

This program will cover the CMS instructions on incident to billing for evaluation and management (E/M) services, other services such as injections, chemotherapy, and procedures provided in an office setting. This allows for billing services under the physician/non-physician practitioner’s (NPP) provider number even when someone else provided the service. This will also include services provided incident to in a Rural Health Clinic, Federally Qualified Health Clinic, and Critical Access Hospital (CAH) Method II. We will have a presentation along with time for questions and answers.

**New to Medicare – Know the Contractors**

01/09/2018 — 9:00 AM – 10:00 AM CT

The New to Medicare series is designed for those working with Medicare for less than 1 year or with questions on the basics of the Medicare program. This teleconference will address information needed by anyone who is beginning to learn the Medicare program. The agenda will include:

- Identifying Medicare contractors
- Identifying what the contractors do for Medicare
- Providing resources for contacting the contractors
- And more

**Understanding Percutaneous Image – Guided Breast Biopsy Requirements**

01/10/2018 — 10:30 AM – 11:30 AM CT

During this program, we will specifically focus on the NCD 220.13, by defining percutaneous image-guided biopsy documentation requirements and reviewing the Breast Imaging Reporting and Data System (BI-RADS Score). There will also be review of covered diagnosis codes and correct billing related to NCD 220.13.

**Ambulance Question and Answer Teleconference**

01/11/2018 — 9:00 AM – 10:00 AM CT

The teleconference will give ambulance suppliers an opportunity to ask questions related to the Medicare ambulance benefit. The teleconference will not have a formal presentation only brief Medicare updates will be provided. If no questions are asked, the teleconference will end early.

**Understanding the Targeted Probe and Educate Ask-the-Contractor Teleconference**

01/17/2018 — 11:30 AM – 1:00 PM CT
In this teleconference, representatives from Medical Review and Provider Outreach and Education will discuss the new process flow called Targeted Probe and Educate (TPE). We will explain how this affects you, review how the transition has been, give current TPE updates, and host an open question and answer session for providers seeking additional clarification.

**Inhalation Treatment for Acute Airway Obstruction**

01/24/2018 — 10:30 AM – 11:30 AM CT

Do you ever wonder what is required when billing for CPT code 94640? This program will specifically discuss the requirements for billing pressurized and non-pressurized inhalation for acute airway obstruction.

**Webinars**

**Physician’s Role in Establishing Home Health Eligibility**

12/14/2017 — 9:00 AM – 10:30 AM CT  
12/14/2017 — 1:30 PM – 3:00 PM CT

An A/B MAC and HHH MAC Collaboration webinar. The Home Health & Hospice Collaborative Workgroup, WPS GHA, Palmetto GBA, CGS, and NGS invites all physicians who refer or certify Medicare beneficiaries for home health services to attend this education. We will highlight how the physician’s documentation affects the reimbursement or recoupment of Home Health Agency payment. Learn what documentation and medical record requirements support covered home health services. We will discuss physician billing for Home Health Certification, Recertification and Care Plan Oversight. There are two opportunities to attend.

**Understanding the Impact of the Integrated/Outpatient Code Editor**

12/07/2017 — 1:00 PM – 2:30 PM CT

The Integrated Outpatient Code Editor (I/OCE) is a major tool used to determine if and how outpatient claims can be processed and paid. Learn how the I/OCE examines claim information, and how it adjudicates claims. Resources to help understand various errors will also be presented during this live webinar. This information can assist you in reducing denials, appeals and phone calls.

**National Correct Coding Initiative (NCCI) – What is it and how do I use it?**

01/30/2018 — 9:00 AM – 11:00 AM CT

During this webinar, attendees will gain a better understanding of NCCI rules, exceptions, modifier usage, edits, medically unlikely edits, add-on codes and more! Avoid denials, appeals and inquiries based on incorrect billing by joining us to learn about NCCI and to improve your billing practices.
On Demand Training Available

Appeal Tips to Avoid Decision Dismissals and Duplicate Requests

At the end of this course providers will be able to:

- Identify why dismissal decisions occur
- Appropriately file appeal request
- Understand the CMS guidelines for rendering appeal decisions

Introductions to Medicare Secondary Payer (MSP)

The purpose of this course is two-fold. First, to introduce participants to the MSP program, giving them a broad overview of MSP regulation. Second, this course requires participants to review MSP resources on the Centers for Medicare and Medicaid Services (CMS) website, helping them become adept at locating information and resources.

Ambulance and Skilled Nursing Consolidated Billing

Are you confused by how Skilled Nursing Facility (SNF) Consolidated Billing (CB) affects billing for ambulance suppliers? Do you know where to find the resources to help determine who to bill when SNF CB applies? During this course, we will show ambulance suppliers the many CMS website resources to help with SNF CB.

This course is designed for Part A and Part B outpatient mental health coders, billers, providers, office, and compliance staff.

New You Need to Know: Big Changes in Medical Review Question and Answer Session Recording

The teleconference recording was an open question and answer session on the new Targeted Probe and Educate process being implemented by Medical Review. In this teleconference, representatives from Medical Review and Provider Outreach and Education discussed the new process flow called Targeted Probe and Educate (TPE), explained how this will affect providers and facilities.

QUARTERLY PROVIDER UPDATE

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

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

- Regulations and major policies completed or cancelled.
- New/Revised manual instructions

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

2018 Annual Update for the Health Professional Shortage Area (HPSA) Bonus Payments

MLN Matters Number: MM10317
Related Change Request (CR) Number: 10317
Related CR Release Date: September 29, 2017
Effective Date: January 1, 2018
Related CR Transmittal Number: R3870CP
Implementation Date: January 2, 2018

PROVIDER TYPE AFFECTED

This MLN Matters® Article is intended for physicians submitting claims to Medicare Administrative Contractors (MACs) for services provided in Health Professional Shortage Areas (HPSAs) to Medicare beneficiaries.

PROVIDER ACTION NEEDED

Change Request (CR) 10317 alerts you that the Centers for Medicare & Medicaid Services (CMS) will make the annual HPSA bonus payment file for 2018 available to your MAC to use for HPSA bonus payments on applicable claims with dates of service on or after January 1, 2018, through December 31, 2018. You should review the Physician Bonuses webpage at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HPSAPSAPhysicianBonuses/ each year to determine whether you need to add modifier AQ to your claim in order to receive the bonus payment, or to see if the ZIP code in which you rendered services will automatically receive the HPSA bonus payment. Make sure that your billing staffs are aware of these changes.

BACKGROUND

Section 413(b) of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 mandated an annual update to the automated HPSA bonus payment file. The HPSA ZIP code file is populated using the latest designations as close as possible to November 1 of each year. The HPSA ZIP code file shall be made available to your MAC in early December of each year. MACs will implement the HPSA ZIP code file and for claims with dates of service January 1 to December 31 of the following year, shall make automatic HPSA bonus payments to physicians providing eligible services in a ZIP code contained on the file.
# 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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Ambulance Inflation Factor for CY 2018 and Productivity Adjustment

MLN Matters Number: MM10323 Related Change Request (CR) Number: CR 10323
Related CR Release Date: October 27, 2017 Effective Date: January 1, 2018
Related CR Transmittal Number: R3893CP Implementation Date: January 2, 2018

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 10323 furnishes the Calendar Year (CY) 2018 Ambulance Inflation Factor (AIF) for determining the payment limit for ambulance services. The AIF for CY 2018 is 1.1 percent. Make sure that your billing staffs are aware of this change.

BACKGROUND

CR10323 furnishes the Calendar Year (CY) 2018 Ambulance Inflation Factor (AIF) for determining the payment limit for ambulance services required by Section 1834(l)(3)(B)) of the Social Security Act (the Act) which is available at https://www.ssa.gov/OP_Home/ssact/title18/1834.htm.

Section 1834(l)(3)(B) of the Act provides the basis for an update to the payment limits for ambulance services that is equal to the percentage increase in the Consumer Price Index for all Urban Consumers (CPI-U) for the 12-month period ending with June of the previous year. Section 3401 of the Affordable Care Act amended Section 1834(l)(3)) of the Act to apply a productivity adjustment to this update equal to the 10-year moving average of changes in economy-wide private nonfarm business Multi-Factor Productivity (MFP) beginning January 1, 2011. The resulting update percentage is referred to as the AIF.

The MFP for Calendar Year (CY) 2018 is 0.5 percent and the CPI-U for 2018 is 1.6 percent. According to the Affordable Care Act, the CPI-U is reduced by the MFP, even if this reduction results in a negative AIF update. Therefore, the AIF for CY 2018 is 1.1 percent.
Part B coinsurance and deductible requirements apply to payments under the ambulance fee schedule.

**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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Annual Clotting Factor Furnishing Fee Update 2018

MLN Matters Number: MM10254
Related Change Request (CR) Number: CR10254
Related CR Release Date: September 15, 2017
Effective Date: January 1, 2018
Related CR Transmittal Number: R3862CP
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 related to the administration of clotting factors provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

Change Request (CR) 10254 announces the clotting factor furnishing fee for 2018 is $0.215 per unit. Make sure that your billing staffs are aware of this update to the annual clotting factor furnishing fee for 2018.

BACKGROUND

The Centers for Medicare and Medicaid Services (CMS) includes the clotting factor furnishing fee in the published national payment limits for clotting factor billing codes. When the national payment limit for a clotting factor is not included on the Average Sales Price (ASP) Medicare Part B Drug Pricing File or the Not Otherwise Classified (NOC) Pricing File, the MACs make payment for the clotting factor as well as payment for the furnishing fee. For dates of service from January 1, 2018, through December 31, 2018, the clotting factor furnishing fee of $0.215 per unit is added to the payment limit for the clotting factor.

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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Calculating Interim Rates for Graduate Medical Education (GME) Payments to New Teaching Hospitals

MLN Matters Number: MM10240 Revised  Related Change Request (CR) Number: N/A
Related CR Release Date: October 27, 2017  Effective Date: October 23, 2017
Related CR Transmittal Number: R1952OTN  Implementation Date: October 23, 2017

Note: This article was revised on October 30, 2017, to reflect the revised CR10240 issued on October 27. The CR was re-issued to revise several policy statements and to address how to handle certain impacted claims.

PROVIDER TYPE AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 10240 provides instructions to the MACS on calculating interim rates for Graduate Medical Education (GME) payments to new teaching hospitals. Make sure your billing staffs are aware of this notification.

BACKGROUND

Section 1886(h) of the Social Security Act (the Act), currently implemented in the regulations at 42 Code of Federal Regulation (CFR) 413.75 through 413.83, establishes a methodology for determining payments to hospitals for the direct costs of approved GME programs. In general, Medicare direct GME payments are calculated by multiplying the hospital's updated Per Resident Amount (PRA) by the weighted number of Full-Time Equivalent (FTE) residents working in all areas of the hospital complex (and at nonprovider sites, when applicable), and the hospital's ratio of Medicare inpatient days to total inpatient days.

Section 1886(d)(5)(B) of the Act, as implemented at 42 CFR 412.105, provides for a payment adjustment known as the Indirect Medical Education (IME) adjustment under the hospital Inpatient Prospective Payment System (IPPS) for hospitals that have residents in an approved GME program, in order to account for the higher indirect patient care costs of teaching hospitals relative to nonteaching hospitals. The hospital's IME adjustment applied to the Diagnosis Related Group (DRG) payments is calculated based on the ratio of the hospital's number of FTE
residents training in the inpatient and outpatient departments of the IPPS hospital (and at nonprovider sites, when applicable), to the number of inpatient hospital beds. This ratio is referred to as the IME Intern-and-Resident-to-Bed (IRB) ratio.

Under section 1886(h)(4)(F) of the Act, for cost reporting periods beginning on or after October 1, 1997, a hospital's unweighted FTE count of residents for purposes of direct GME may not exceed the hospital's unweighted FTE count for direct GME in its most recent cost reporting period ending on or before December 31, 1996. Under section 1886(d)(5)(B)(v) of the Act, a similar limit based on the FTE count for IME during that cost reporting period is applied effective for discharges occurring on or after October 1, 1997. Dental and podiatric residents are not included in this statutory cap.

Section 1886(h)(4)(H)(i) of the Act requires the Secretary to establish rules for calculating the direct GME caps for new teaching hospitals that are training residents in new medical residency training programs established on or after January 1, 1995. Under section 1886(d)(5)(B)(viii) of the Act, such rules also apply to the establishment of a hospital's IME cap on the number of FTE residents training in new programs. The Centers for Medicare & Medicaid Services (CMS) implemented these statutory requirements in rules published in the following Federal Registers - August 29, 1997 (62 FR 46002 through 46008), May 12, 1998 (63 FR 26323 through 26325 and 26327 through 26336), and August 27, 2009 (74 FR 43908 through 43919).

Current Regulations on New Program Caps

Generally, under existing regulations at 42 CFR 413.79(e)(1) (for direct GME) and 42 CFR 412.105(f)(1)(vii) (for IME), if a hospital did not train any allopathic or osteopathic residents in its most recent cost reporting period ending on or before December 31, 1996, and it begins to participate in training residents in a new medical residency training program (allopathic or osteopathic) on or after January 1, 1995, the hospital's unweighted FTE resident cap (which would otherwise be zero) may be adjusted based on the sum of the product of the highest number of FTE residents in any program year during the fifth year of the first new program's existence at all of the hospitals to which the residents rotate, the minimum accredited length for each type of program, and the ratio of the number FTE residents in the new program that trained at the hospital over the entire 5-year period to the total number of FTE residents in the program that trained at all hospitals over the entire 5-year period. The number of FTE resident cap slots that a teaching hospital receives for each new program may not exceed the number of accredited slots that are available for each new program. See the August 31, 2012 Federal Register (77 FR 53416) for details on how the cap calculation is made. Similar regulations apply for IME at 42 CFR 412.105(f)(1)(vii). In the August 22, 2014, Federal Register (79 FR 50104 through 50111), CMS again revised the regulations at 42 CFR 413.79(e)(1) for direct GME and 42 CFR 412.105(f)(1)(v)(D) for IME, to state that if a hospital begins training residents in a new program on or after October 1, 2012, the hospital's FTE caps will take effect with the beginning of the hospital's cost reporting period that coincides with or follows the start of the sixth program year of the first new program started. Also, under 42 CFR 413.79(d)(5) for direct GME and 42 CFR 412.105(f)(1)(v) and 412.105(a)(1)(ii) for IME, FTE residents in new programs are exempt from the application of the 3-year rolling average and the IME intern-and-resident-to-bed (IRB) ratio cap. For programs started after October 1, 2012, these exemptions are applicable during the cost reporting periods prior to the beginning of the cost reporting period.
that coincides with or follows the start of the sixth program year of the first new program started, in which the FTE cap is established.

Establishment of a Direct GME (DGME) Per Resident Amount (PRA)

Under section 1886(h)(3) of the Act, and implemented at 42 CFR §413.77(e)(1), if a hospital did not previously have a PRA established, but begins training in a cost reporting period beginning on or after July 1, 1985, the MAC establishes a PRA effective with the hospital’s first cost reporting period in which it participates in Medicare and has residents on duty during the first month of that cost reporting period. Effective for cost reporting periods beginning on or after October 1, 2006, if a hospital did not have residents on duty during the first month of that period, the MAC establishes a PRA using the information from the first cost reporting period immediately following the cost reporting period during which the hospital participates in Medicare and residents began training at the hospital.

As 42 CFR §413.77(e)(1) states, any GME costs incurred by the hospital in the cost reporting period prior to the PRA base period are reimbursed on a reasonable cost basis. For example, a hospital with a January 1 to December 31 cost reporting period starts to train residents in an approved residency program for the first time on July 1, 2017. The residents continue to train at the hospital in January 2018 and after. The hospital’s PRA would be established from and effective for direct GME payment during the January 2018 through December 2018 cost report, and the hospital would be paid based on Medicare’s share of the reasonable GME costs in the January 2017 through December 2017 cost report.

In order for a PRA to be established, the residents need not be in a newly approved residency program, nor must the hospital be the sponsor, nor incur costs. Rather, a hospital counts the respective share of the FTE resident that trains in its hospital, whether it employs the resident or not. (See the September 4, 1990 Federal Register, 55 FR 36064-5, which explains that regardless of who employs the resident, each hospital would count the proportion of FTE time spent at its facility, both for the direct GME PRA base year, and in the payment years, while the hospital that incurs the costs of the resident in any year would claim those costs on its cost report). The MAC shall calculate and finalize the hospital’s final PRA as part of the settlement of the base year cost report. See below for instructions for establishing an interim rate PRA for purposes of paying the hospital an interim direct GME payment amount from approximately the time it starts to train residents in an approved program.

Resources for determining weighted average PRA include: –67 FR 50067 through 50069 (August 1, 2002); Determining hospital cost per FTE -- 54 FR 40286 (September 29, 1989), 55 FR 36063 through 36065 (September 4, 1990), HCFA Memorandum, BPO-F12, November 8, 1990, Questions and Answers Pertaining to Graduate Medical Education.

When to Establish Interim Rates for a New Teaching Hospital Participating in a New Program(s)

When a hospital that does not have FTE caps and/or a PRA approaches its MAC and requests in writing (email is sufficient) IME and DGME payments due to training residents for the first time
in a new approved GME residency program, the MAC shall, in accordance with the regulations governing interim rate reviews at 42 CFR §412.116(c) and 42 CFR §413.60 and 42 CFR §413.64(a) through (e)

- Use the policy guidance in CR10240 to verify that the hospital does not already have a PRA and/or FTE resident caps established, and the hospital is actually training residents in a new approved program. (Refer to the August 27, 2009 FR, page 43908, to determine if an approved program meets the “new” criteria).

- Establish interim IME and DGME payment rates for the hospital at the earliest scheduled rate review after the hospital submits a written request for payment. MACs need not perform a special rate review exclusively for establishing interim IME and DGME rates; rather, MACs may choose to wait until the next regularly scheduled rate review following receipt of the written request from the hospital, and establish interim rates for IME and DGME payments at that time.

Alternatively, if the hospital is training residents for the first time but the residents are in an existing program, and the new teaching hospital has received IME and/or DGME cap slots from another hospital under a Medicare GME affiliation agreement (under 42 CFR 413.79(f)), if the hospital requests in writing (email is sufficient) IME and DGME payments, the MAC shall

- Establish interim IME and DGME rates for the hospital in accordance with the regulations governing interim rate reviews at 42 CFR §412.116(c) and 42 CFR §413.60 and 42 CFR §413.64(a) through (e).

- A hospital must provide the necessary documentation (discussed below) in order for the MAC to establish the interim rates.

Documentation Required for Calculating Interim IME and DGME Rates for a New Teaching Hospital

If a hospital requests in writing (email is sufficient) that a MAC establish interim IME and DGME rates due to training residents for the first time in either new or existing approved program(s), the MAC shall request the following documentation from the hospital:

For IME and DGME:

- Formal accreditation letter or proof of accreditation of the applicable program(s) by the relevant accrediting body.

- Number of accredited positions being trained in the program for the relevant cost reporting year for which interim rates are being established

- Rotation schedules, or similar documentation, indicating where the residents are training, from which to develop estimated FTE counts applicable to the requesting hospital. For IME,
FTE residents training in locations specified in the regulations at 42 CFR §412.105(f)(1)(ii) (A)—(E) may be counted. For DGME, FTE residents training in accordance with the regulations at 42 CFR §413.78 may be counted. The MAC shall ensure that the number of FTE residents based on which the hospital is paid in a year does not exceed the number of accredited slots available to the hospital for the particular program year.

- If applicable, a copy of the Medicare GME Affiliation Agreement under 42 CFR §413.79(f).

For IME:

- Available bed count from the most recently submitted cost report, but modified if appropriate as part of the current interim rate review. Determine the available bed count in accordance with the instructions on the Medicare cost report, CMS Form 2552-10, Worksheet E, Part A, line 4.

- Timely submission of claims for receipt of IME payments on behalf of inpatient services provided to Medicare Fee for Service and Medicare Advantage beneficiaries, in accordance with 42 CFR 424.30 and 424.44.

For DGME:

- Medicare utilization – Determine the hospital’s Medicare utilization rate (or ratio of Medicare inpatient days to total inpatient days) in accordance with the instructions on the Medicare cost report, CMS Form 2552-10, Worksheet E-4, lines 26, 27, and 28, columns 1 and 2 for Part A and Part C, using the hospital’s most recently submitted cost report (but modified as appropriate as part of the current interim rate review).

- Timely submission of claims for receipt of IME payments on behalf of inpatient services provided to Medicare Fee for Service and Medicare Advantage beneficiaries, in accordance with 42 CFR 424.30 and 424.44.

- For the PRA, see below.

**Calculating an Interim Rate PRA**

Under 42 CFR §413.77(e)(1)(i) and (ii), a new PRA is equal to the lower of the hospital’s actual cost per resident incurred in the base period, or the weighted mean average PRA of all of the other existing teaching hospitals located in the same core-based statistical area (CBSA) as the new teaching hospital. Under 42 CFR §413.77(e)(1)(iii), if under §413.77(e)(1)(ii)(A) or (B) there are less than 3 existing teaching hospitals with PRAs located in the same CBSA as the new teaching hospital with PRAs that can be used for the weighted average PRA calculation, the census region PRA is used (updated for inflation to the new teaching hospital’s base year cost reporting period).

Since the hospital’s actual cost per FTE resident information would not be available until the hospital files its base year cost report, and since determination of the weighted average PRA for the CBSA can be labor intensive, the MAC shall use the latest available census region PRA
issued by CMS for the census region in which the new teaching hospital is located, updated for inflation to the base period of the new teaching hospital, for the purpose of calculating and paying DGME interim rates. However, once the hospital submits its base year cost report, the MAC shall calculate and assign the appropriate PRA to the new teaching hospital (as part of the normal cost report settlement process for the new teaching hospital). The MAC shall calculate the interim rate subsequently using the hospital’s permanently assigned PRA, updated with inflation.

The MAC shall update the IME field in its file and establish a direct GME pass-through payment to reflect the appropriate interim payments to the hospital. MACs may enter the IME intern and resident to bed (IRB) ratio effective with the date that the residents in the approved program began training at the hospital, and may either reprocess claims for any retroactive period, or may work with the hospital to hold claims until an IRB ratio is entered into its file, and then claims may be processed prospectively. Alternatively, MACs may enter a current or prospective effective date for the IRB ratio in its file and may manually compute and issue a lump sum interim payment for any retroactive period.

### ADDITIONAL INFORMATION


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<tr>
<th>Date of Change</th>
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<tr>
<td>October 30, 2017</td>
<td>Article revised to reflect a re-issued CR, which revised several policy statements and addressed how to handle certain impacted claims.</td>
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<tr>
<td>September 26, 2017</td>
<td>Initial article released.</td>
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Correcting Payment of Inpatient Prospective Payment System (IPPS) Transfer Claims Assigned to Medicare Severity-Diagnosis Related Group (MS DRG) 385

MLN Matters Number: MM10145 Revised
Related CR Release Date: September 13, 2017
Related CR Transmittal Number: R1918OTN

Note: This article was revised on September 13, 2017, to reflect a revised CR. That CR removed a business requirement to the MACs. The CR release date, transmittal number, and link to the transmittal also changed. All other information is unchanged.

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 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**


### DOCUMENT HISTORY

<table>
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<tr>
<td>September 13, 2017</td>
<td>The article was revised to reflect a revised CR. That CR removed a business requirement to the MACs. The CR release date, transmittal number, and link to the transmittal also changed.</td>
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<tr>
<td>July 28, 2017</td>
<td>Initial Article Released</td>
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Fiscal Year (FY) 2018 Inpatient Prospective Payment System (IPPS) and Long Term Care Hospital (LTCH) PPS Changes

MLN Matters Number: MM10273       Related Change Request (CR) Number: 10273
Related CR Release Date: October 17, 2017       Effective Date: October 1, 2017
Related CR Transmittal Number: R3885CP       Implementation Date: October 2, 2017

Note: This article was revised on October 18, 2017, to reflect a revised CR10273 issued on October 17. The CR was revised to update the factor 3 denominator for hospitals treated as new, the fixed-loss amount for LTCH standard Federal payment rate cases, reference to the Grouper software version, applicable tables and files available on the CMS website, and to clarify the list of ICD-10 codes eligible for the GORE IBE device system new technology add-on payment. In addition, updating the assignment of the wage index for Indian Health Service or Tribal Hospitals of the Pricer in the attachment to the CR. The article was updated accordingly. 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

Change Request (CR) 10273 implements policy changes for the Fiscal Year (FY) 2018 Inpatient Prospective Payment System (IPPS) and LTCH Prospective Payment System (PPS). Failure to adhere to these new policies could affect payment of Medicare claims.

BACKGROUND

The Social Security Amendments of 1983 (P.L. 98-21) provided for establishment of a 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.
IPPS FY 2018 Update

The following policy changes for FY 2018 were displayed in the Federal Register on August 2, 2017, with a publication date of August 14, 2017. All items covered in CR10273 are effective for hospital discharges occurring on or after October 1, 2017, through September 30, 2018, unless otherwise noted.

New IPPS and LTCH PPS Pricer software packages will be released prior to October 1, 2017, that will include updated rates that are effective for claims with discharges occurring on or after October 1, 2017, through September 30, 2018.

Files for download listed throughout the CR are available on the Centers for Medicare & Medicaid Services (CMS) website. The key links are:


Alternatively, the files on the webpages listed above are also available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html. Click on the link on the left side of the screen titled, “FY 2018 IPPS Final Rule Home Page” or the link titled “Acute Inpatient—Files for Download” (and select ‘Files for FY 2018 Final Rule and Correction Notice’).

IPPS FY 2018 Update

A. FY 2018 IPPS Rates and Factors

For the Operating Rates/Standardized Amounts and the Federal Capital Rate, refer to Tables 1A-C and Table 1D, respectively, of the FY 2018 IPPS/LTCH PPS Final Rule, available on the FY 2018 Final Rule Tables webpage. For other IPPS factors, including applicable percentage increase, budget neutrality factors, high cost outlier (HCO) threshold, and cost-of-living adjustment (COLA) factors, refer to the MAC Implementation Files 1 available on the FY 2018 MAC Implementation Files webpage.

B. Medicare Severity - Diagnosis Release Group (MS-DRG) Grouper and Medicare Code Editor (MCE) Changes
The Grouper Contractor, 3M Health Information Systems (3M-HIS), developed the new International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10) MS-DRG Grouper, Version 35.0, software package effective for discharges on or after October 1, 2017. The GROUPER assigns each case into a MS-DRG on the basis of the reported diagnosis and procedure codes and demographic information (that is age, sex, and discharge status). The ICD-10 MCE Version 35.0 which is also developed by 3M-HIS, uses edits for the ICD-10 codes reported to validate correct coding on claims for discharges on or after October 1, 2017.

For discharges occurring on or after October 1, 2017, the Fiscal Intermediary Shared System (FISS) calls the appropriate GROUPER based on discharge date. For discharges occurring on or after October 1, 2017, the MCE selects the proper internal code edit tables based on discharge date.

For the October update, CMS has:

- Reduced the number of MS-DRGs from 757 to 754 for FY 2018. CMS is not implementing any new MS-DRGs for FY 2018. In addition, CMS is deleting MS-DRGs 984, 985 and 986.
- Revised the title to MS-DRG 023 to Craniotomy with Major Device Implant or Acute Complex Central Nervous System (CNS) Principal Diagnosis (PDX) with MCC or Chemotherapy Implant or Epilepsy with Neurostimulator.
- Modified the titles for MS-DRGs 061, 062, and 063 to Ischemic Stroke, Precerebral Occlusion or Transient Ischemia with Thrombolytic Agent w MCC, CC and without CC/MCC, respectively, and retitled MS-DRG 069 to Transient Ischemia without Thrombolytic.
- Revised the titles for MS-DRGs 246 and 248 to state “arteries” instead of “vessels” to better reflect the I-10 terminology in the classification. The revised titles for MS-DRGs 246 and 248 are Percutaneous cardiovascular procedures with drug-eluting stent with MCC or 4+ arteries or stents and Percutaneous cardiovascular procedures with non-drug-eluting stent with MCC or 4+ arteries or stents, respectively.
- Modified the title for MS-DRGs 469 and 470 to Major Hip and Knee Joint Replacement or Reattachment of Lower Extremity with MCC or Total Ankle Replacement and Major Hip and Knee Joint Replacement or Reattachment of Lower Extremity without MCC, respectively.
- Revised the titles for MS-DRGs 823, 824 and 825 to Lymphoma and Non-Acute Leukemia with Other Procedure with MCC, with CC and without CC/MCC, respectively.
• Revised the titles for MS-DRGs 829 and 830 to Myeloproliferative Disorders or Poorly Differentiated Neoplasms with Other Procedure with CC/MCC and without CC/MCC, respectively.

C. Post-acute Transfer and Special Payment Policy

The changes to MS-DRGs for FY 2018 have been evaluated against the general post-acute care transfer policy criteria using the FY 2016 MedPAR data according to the regulations under Sec. 412.4 (c). As a result of this review, no new MS-DRGs will be added to the list of MS-DRGs subject to the post-acute care transfer policy; however MS-DRGs 987, 988 and 989 (Non-Extensive O.R. Procedure Unrelated To Principal Diagnosis with major complication or comorbidity (MCC), with complication or comorbidity (CC), without CC/MCC, respectively) were added to the special payment policy list. See Table 5 of the FY 2018 IPPS/LTCH PPS Final Rule for a listing of all Post-acute and Special Post-acute MS-DRGs available on the FY 2018 Final Rule Tables webpage.

D. New Technology Add-On

The following items will continue to be eligible for new-technology add-on payments in FY 2018:

1. 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 or XW04392

2. 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; 04VC3EZ; 04VC4EZ; 04VD0EZ; 04VD3EZ or 04VD4EZ (CMS notes ICD-10-PCS procedure codes 04VC0FZ; 04VC3FZ; 04VC4FZ; 04VD0FZ; 04VD3FZ; and 04VD4FZ are no longer valid effective October 1, 2017)

3. 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

4. Name of Approved New Technology: Vistogard™
• Maximum Add-on Payment: $40,130 (Note: The maximum payment has changed from FY 2018)

• Identify and make new technology add-on payments with any of the following ICD-10 clinical modification (ICD-10-CM) diagnosis codes T45.1x1A, T45.1x1D, T45.1x1S, T45.1x5A, T45.1x5D, or T45.1x5S in combination with (ICD-10-PCS procedure code XW0DX82)

The following items are eligible for new-technology add-on payments in FY 2018:

5. Name of Approved New Technology: ZINPLAVA™
   • Maximum Add-on Payment: $1,900
   • Identify and make new technology add-on payments with ICD-10-PCS procedure codes XW033A3 or XW043A3.

6. Name of Approved New Technology: Stelara®
   • Maximum Add-on Payment: $2,400
   • Identify and make new technology add-on payments with ICD-10-PCS procedure code XW033F3.

7. Name of Approved New Technology: EDWARDS INTUITY Elite™ Valve System (INTUITY) and LivaNova Perceval Valve (Perceval)
   • Maximum Add-on Payment: $6,110.23
   • Identify and make new technology add-on payments with ICD-10-PCS code X2RF032.

E. Cost of Living Adjustment (COLA) Update for IPPS PPS

The IPPS incorporates a COLA for hospitals located in Alaska and Hawaii. CMS has updated the COLAs for FY 2018, and the COLAs for the qualifying counties in all of Alaska and in Hawaii is 1.25, except for the county of Hawaii which is 1.21. For reference, a table showing the applicable COLAs that are effective for discharges occurring on or after October 1, 2017, are available in the FY 2018 IPPS/LTCH PPS final rule and in MAC Implementation File 1 available on the FY 2018 MAC Implementation Files webpage.

F. FY 2017 Wage Index Changes and Issues

1. Transitional Wage Indexes

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.

For hospitals that were located in an urban county prior to October 1, 2014, that became rural effective October 1, 2014, 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 for FY 2015, 2016 and 2017. These hold harmless wage indexes have expired for FY 2018. MACs will ensure hospitals that were eligible for transitional wage indexes in FY 2017 no longer receive a transitional wage index for FY 2018.

2. Adoption of Federal Information Processing Standard (FIPS) County Codes

Core Based Statistical Areas (CBSAs) are made up of one or more constituent counties. Each CBSA and constituent county has its own unique identifying codes. There are two different lists of codes associated with counties: Social Security Administration (SSA) codes and FIPS codes. Historically, CMS has listed and used SSA and FIPS county codes to identify and crosswalk counties to CBSA codes for purposes of the hospital wage index. CMS has learned that SSA county codes are no longer being maintained and updated. However, the FIPS codes continue to be maintained by the U.S. Census Bureau. The Census Bureau’s most current statistical area information is derived from ongoing census data received since 2010; the most recent data are from 2015. For the purposes of crosswalking counties to CBSAs, in the FY 2018 IPPS/LTCH PPS final rule, CMS finalized that it would discontinue the use of SSA county codes and begin using only the FIPS county codes beginning in FY 2018.

Based on information included in the Census Bureau’s website, since 2010, the Census Bureau has made the following updates to the FIPS codes for counties or county equivalent entities:

- Petersburg Borough, AK (FIPS State County Code 02-195), CBSA 02, was created from part of former Petersburg Census Area (02-195) and part of Hoonah-Angoon Census Area (02-105). The CBSA code remains 02.

- The name of La Salle Parish, LA (FIPS State County Code 22-059), CBSA 14, is now LaSalle Parish, LA (FIPS State County Code 22-059). The CBSA code remains as 14.

- The name of Shannon County, SD (FIPS State County Code 46-113), CBSA 43, is now Oglala Lakota County, SD (FIPS State County Code 46-102). The CBSA code remains as 43.

CMS adopted the implementation of these FIPS code updates, effective October 1, 2017, beginning with the FY 2018 wage indexes. A County to CBSA Crosswalk File is available on the FY 2018 Final Rule Data Files webpage.

Note: The county update changes listed above changed the county names. However, the CBSAs to which these counties map did not change from the prior counties. Therefore, there is no payment impact or change to hospitals in these counties; they continue to be considered rural for the hospital wage index under these changes.
3. Treatment of Certain Providers Redesignated Under Section 1886(d)(8)(B) of the Act

42 CFR 412.64(b)(3)(ii) implements section 1886(d)(8)(B) of the 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. The following is a list of hospitals that have waived LUGAR status for FY 2018: 010164, 070004, 070011, 140167, 250117, 390008, 390031, 390150 and 520102.

4. Section 505 Hospital (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 section 1886(d)(8)(B) of the Act.

G. Treatment of Certain Urban Hospitals Reclassified as Rural Hospitals Under § 412.103 and Hospitals reclassified under the 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 Disproportionate Share Hospital (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 reclassification under the MGCRB. Also, the regulations did not allow a Lugar hospital to keep its Lugar status if it was approved for an urban to rural reclassification under § 412.103. Effective April 21, 2016, hospitals nationwide that have an MGCRB reclassification or Lugar status during FY 2016 and subsequent years can simultaneously seek urban to rural reclassification under § 412.103 for IPPS payment and other purposes, and keep their existing MGCRB reclassification or Lugar status.

H. 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 multicampus 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. Therefore, if a hospital has a campus or campuses in different CBSAs, the MAC adds a suffix to the CMS Certification Number (CCN) of the hospital in the Provider Specific File (PSF), to identify and denote a subcampus in a different CBSA, so that the appropriate wage index associated with
each campus’s geographic location can be assigned and used for payment for Medicare discharges from each respective campus. Also note that, under certain circumstances, it is permissible for individual campuses to have reclassifications to another CBSA, in which case, the appropriate reclassified CBSA and wage index needs to be noted in the PSF.

I. Updating the PSF for Wage Index, Reclassifications and Redesignations

MACs will update the PSF by following the steps, in order, in Attachment 1 of CR10273 to determine the appropriate wage index based on policies mentioned above.

J. Expiration of Medicare-Dependent, Small Rural Hospital (MDH) Program

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. Under current law, beginning in October 1, 2017, all previously qualifying hospitals will no longer have MDH status and will be paid based solely on the Federal rate. (Note that, the SCH policy at § 412.92(b) allows MDHs to apply for SCH status and be paid as such under certain conditions, following the expiration of the MDH program.) Provider Types 14 and 15 will no longer be valid beginning October 1, 2017.

K. Hospital Specific (HSP) Rate Factors for Sole Community Hospitals (SCHs)

For FY 2018, the HSP amount in the PSF for SCHs (and MDHs as applicable) 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 and apply all of the updates and DRG budget neutrality factors to the HSP amount for FY 2013 and beyond.

Note: 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 2014) are not applied to the HSP update for FY 2018.

L. Low-Volume Hospitals – Criteria and Payment Adjustments for FY2018

The temporary changes to the low-volume hospital payment adjustment originally provided by the Affordable Care Act, and extended by subsequent legislation, which expanded the definition of a low-volume hospital and modified the methodology for determining the payment adjustment for hospitals meeting that definition, is currently effective through September 30, 2017, as provided by section 204 of the Medicare Access and CHIP Reauthorization Act of 2015. Under current law, beginning in October 1, 2017, the low-volume hospital qualifying criteria and payment adjustment methodology will revert to that which was in effect prior to the amendments made by the Affordable Care Act and subsequent legislation (that is, the low-volume hospital payment adjustment policy in effect for FYs 2005 through 2010). The regulations implementing the hospital payment adjustment policy are at § 412.101.

In addition, CMS is implementing an adjustment parallel to the low-volume hospital payment
adjustment so that, for discharges occurring in FY 2018 and subsequent years, only the
distance between Indian Health Service (IHS) or Tribal hospitals will be considered when
assessing whether an IHS or Tribal hospital meets the mileage criterion under § 412.101(b)(2).
Similarly, only the distance between non-IHS hospitals would be considered when assessing
whether a non-IHS hospital meets the mileage criterion under § 412.101(b)(2). This parallel
adjustment is implemented in 42 CFR 412.101(e).

For FY 2018, a hospital must make a written request for low-volume hospital status that is
received by its MAC no later than September 1, 2017, in order for the 25-percent, low-volume,
add-on payment adjustment to be applied to payments for its discharges beginning on or after
October 1, 2017 (through September 30, 2018). Under this procedure, a hospital that qualified
for the low-volume hospital payment adjustment for FY 2017 may continue to receive a low-
volume hospital payment adjustment for FY 2018 without reapplying if it meets both the
discharge criterion and the mileage criterion applicable for FY 2018. As in previous years, such
a hospital must send written verification that is received by its MAC no later than September 1,
2017, stating that it meets the mileage criterion applicable for FY 2018. For FY 2018, this written
verification must also state, based upon the most recently submitted cost report, that the
hospital meets the discharge criterion applicable for FY 2018 (that is, less than 200 discharges
total, including both Medicare and non-Medicare discharges). If a hospital’s request for low-
volume hospital status for FY 2018 is received after September 1, 2017, and if the MAC
determines the hospital meets the criteria to qualify as a low-volume hospital, the MAC will
apply the 25-percent, low-volume hospital payment adjustment to determine the payment for the
hospital’s FY 2018 discharges, effective prospectively within 30 days of the date of the MAC’s
low-volume hospital status determination. CMS notes that this process mirrors its established
application process but is updated to ensure that providers currently receiving the low-volume
hospital payment adjustment verify that they meet both the mileage criterion and the discharge
criterion applicable for FY 2018 to continue receiving the adjustment for FY 2018.

The low-volume hospital payment is based on and in addition to all other IPPS per discharge
payments, including capital, DSH (including the uncompensated care payment), Indirect Medical
Education (IME) and outliers. For SCHs (and MDHs, when applicable), the low-volume hospital
payment is based on and in addition to either payment based on the Federal rate or the
hospital-specific rate, whichever results in a greater operating IPPS payment.

M. Hospital Quality Initiative

The hospitals that will receive the quality initiative bonus are listed at www.qualitynet.org.
Should a provider later be determined to have met the criteria after publication of this list, they
will be added to the list.

N. Hospital Acquired Condition Reduction Program (HAC)

Under the HAC Reduction Program, a 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 2018 was not publicly available in the final rule because the review and correction process was not yet completed. MACs will receive a preliminary list of hospitals subject to the HAC Reduction Program. Updated hospital level data for the HAC Reduction Program will be made publicly available following the review and corrections process.

**O. Hospital Value Based Purchasing (VBP)**

For FY 2018, 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 2018. CMS expects to post the value-based incentive payment adjustment factors for FY 2018 in the near future in Table 16B of the FY 2018 IPPS/LTCH PPS final rule (which will be available through the Internet on the FY 2018 IPPS Final Rule Tables webpage).

**P. Hospital Readmissions Reduction Program**

The readmissions payment adjustment factors for FY 2018 are in Table 15 of the FY 2018 IPPS/LTCH PPS final rule (which are available through the Internet on the FY 2018 IPPS Final Rule Tables webpage). Hospitals that are not subject to a reduction under the Hospital Readmissions Reduction Program in FY 2018 (such as Maryland hospitals), have a readmission adjustment factor of 1.0000. For FY 2018, hospitals should only have a readmission adjustment factor between 1.0000 and 0.9700.

**NOTE:** Hospitals located in Maryland (for FY 2018) and in Puerto Rico are not subject to the Hospital Readmissions Reduction Program, and therefore, are not listed in Table 15. Therefore, MACs shall follow the instructions in the second bullet above for the PSF for these hospitals.

**Q. Medicare Disproportionate Share Hospitals (DSH) Program**

Section 3133 of the Affordable Care Act modified the Medicare DSH program beginning in FY 2014. Under current law, 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 the aggregate amount available for uncompensated care payments based on its share of total uncompensated care reported by Medicare DSH hospitals. A Medicare DSH hospital’s share of uncompensated care for FY 2018 is based on the average of three individual Factor 3s calculated using three sets of data. The first two sets of data consist of Medicaid days and Medicare SSI days, while the third consists of hospital uncompensated care costs from Worksheet S-10.

The Medicare DSH payment is 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 is applied in PRICER.

The total uncompensated care payment amount to be paid to Medicare DSH hospitals was finalized in the FY 2018 IPPS Final Rule, and the uncompensated care payment will continue to be paid on the claim as an estimated per discharge amount to the hospitals that have been projected to receive Medicare DSH for FY 2018. 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 SCHs to determine if a claim is paid under the hospital-specific rate or Federal rate (and for MDHs 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, when applicable). 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.

For FY 2018, new hospitals with a CCN established after October 1, 2014 that are eligible for Medicare DSH will have their Factor 3 calculated at cost report settlement using uncompensated care costs reported on Line 30 of Worksheet S-10 as the numerator and a denominator of $25,199,302,174. Factor 3 is then applied to the total uncompensated care payment amount finalized in the FY 2018 IPPS Final Rule to determine the total amount to be paid to the hospital. MACs can refer to the Medicare DSH Supplemental Data File on the CMS website to confirm whether a hospital should be treated as new.

R. 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 2018 subject to the policy for replaced devices offered without cost or with a credit.

CMS is revising the titles to MS-DRGs 023 (Craniotomy with Major Device Implant or Acute Complex Central Nervous System (CNS) Principal Diagnosis (PDX) with MCC or Chemotherapy Implant or Epilepsy with Neurostimulator), 469 (Major Hip and Knee Joint Replacement or Reattachment of Lower Extremity with MCC or Total Ankle Replacement), and 470 (Major Hip and Knee Joint Replacement or Reattachment of Lower Extremity without MCC). These MS-DRGs continue to be subject to the replaced devices offered without cost or with a credit policy, effective October 1, 2017.
LTCH PPS FY 2018 Update

2018 LTCH PPS Rates and Factors

The FY 2018 LTCH PPS Standard Federal Rates are located in Table 1E available on the FY 2018 Final Rule Tables webpage. Other FY 2018 LTCH PPS Factors are in MAC Implementation File 2 available on the FY 2018 MAC Implementation File webpage.

The LTCH PPS Pricer has been updated with the Version 35.0 MS-LTC-DRG table, weights and factors, effective for discharges occurring on or after October 1, 2017, and on or before September 30, 2018.

A. Application of the Site Neutral Payment Rate

Section 1206(a) of Public Law 113–67 amended section 1886(m) of the 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 (80 FR 49601-49623). Section 15009 of the 21st Century Cures Act establishes a temporary exception to the application of the site neutral payment rate for certain spinal cord specialty hospitals, effective for discharges occurring during such LTCHs' cost reporting periods beginning during FY 2018 and FY 2019. Section 15010 of the 21st Century Cures Act establishes a temporary exception to the site neutral payment rate for certain severe wound discharges from certain LTCHs for cost reporting periods beginning during FY 2018. Information on the requirements implementing these temporary exceptions is available in CRs 10182 at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1883OTN.pdf and 10185 at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1895OTN.pdf, respectively.

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.

Effective with discharges occurring in LTCHs' cost reporting periods beginning on or after October 1, 2017 (FY 2018), the transitional blended payment rate for site neutral payment rate cases is no longer applicable, and such cases will be paid based on 100 percent of the site neutral payment rate for the discharge.
B. Changes to the Short-Stay Outlier (SSO) Payment Adjustment

CMS is revising the payment formula used to determine payments for SSO cases beginning in FY 2018. This change is reflected in the LTCH PPS Pricer logic.

Effective for LTCH PPS discharges occurring on or after October 1, 2017, the adjusted payment for a SSO case is equal to the “blended payment amount option” under the previous SSO policy. That is, the adjusted payment for a SSO case is equal a blend of an amount comparable to what would otherwise be paid under the IPPS, computed as a per diem, and capped at the full IPPS DRG comparable amount, and the 120 percent LTC-DRG per diem amount. Note there has been no change in the definition of a SSO case (and it continues to be for discharges where the covered length of stay that is less than or equal to five sixths of the geometric average length of stay for each MS-LTC–DRG).

C. Changes to High-Cost Outlier (HCO) Payments for LTCH PPS Standard Federal Payment Rate Cases

When CMS implemented the LTCH PPS, it established a policy allowing for HCO payments to cases where the estimated cost of the case exceeds the outlier threshold. In general, the outlier threshold is the LTCH PPS payment plus a fixed-loss amount that is determined annually. Historically, CMS set this threshold so that aggregate estimated HCO payments accounted for 8 percent of the estimated total aggregate payments to LTCH PPS Standard Federal payment rate cases. In addition, to ensure these estimated HCO payments did not increase or decrease its estimated payments to LTCH PPS Standard Federal Payment Rates, CMS reduced the LTCH PPS Standard Federal payment rate by 8 percent.

Section 15004(b) of the 21st Century Cures Act (Pub. L. 114-255) requires that beginning in FY 2018, CMS continue to reduce the LTCH PPS standard Federal payment rate by 8 percent, but establish the HCO fixed-loss amount so that aggregate HCO payments are estimated to be 7.975 percent of estimated aggregate payments for standard Federal payment rate cases. Accordingly, the FY 2018 fixed-loss amount of $27,381 for LTCH PPS Standard Federal Payment Rate cases reflects this statutory requirement.

D. LTCH Quality Reporting (LTCHQR) Program

Section 3004(a) of the Affordable Care Act requires the establishment of the Long-Term Care Hospital Quality Reporting (LTCHQR) Program. For FY 2018, 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.

E. Provider Specific File (PSF)

The PSF required fields for all provider types which require a PSF is available in the Medicare Claims Processing Manual, Chapter 3, §20.2.3.1 at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf.
As noted above in section A.1., effective with discharges occurring in LTCHs’ cost reporting periods beginning on or after October 1, 2017 (FY 2018), the transitional blended payment rate for site neutral payment rate cases is no longer applicable, and such cases will be paid based 100 percent of the site neutral payment rate for the discharge. **MACs shall ensure that the Fiscal Year Beginning Date field in the PSF (Data Element 4, Position 25) is updated as applicable with the correct date.**

Table 8C contains the FY 2018 Statewide average LTCH total cost-to-charge ratios (CCRs) for urban and rural LTCHs. Table 8C is available on the FY 2018 Final Rule Tables webpage. Per the regulations in 42 CFR sections 412.525(a)(4)(iv)(C) and 412.529(l)(4)(iii), for FY 2018, Statewide average CCRs are used in the following instances:

1. New hospitals that have not yet submitted their first Medicare cost report. (For this purpose, a new hospital is defined as an entity that has not accepted assignment of an existing hospital’s provider agreement in accordance with 42 CFR 489.18).

2. LTCHs with a total CCR is in excess of 1.280 (referred to as the total CCR ceiling).

3. Any hospital for which data to calculate a CCR is not available.

**NOTE:** Hospitals and/or MACs can request an alternative CCR to the statewide average CCR per the instructions in section 150.24 of chapter 3 of the Medicare Claims Processing Manual.

**F. Cost of Living Adjustment (COLA) under the LTCHPPS**

The LTCH PPS incorporates a COLA for hospitals located in Alaska and Hawaii. The COLAs, which have been updated for FY 2018, and effective for discharges occurring on or after October 1, 2017, can be found in the FY 2018 IPPS/LTCH PPS final rule and are also located in MAC Implementation File 2 available on the FY 2018 MAC Implementation Files webpage. (Note that the same COLA factors are used under the IPPS and the LTCH PPS for FY 2018.)

**G. 25-percent Threshold Policy**

Section 15006 of the 21st Century Cures Act established a moratorium on the implementation of the 25-percent threshold policy until October 1, 2017. CMS also established an additional regulatory moratorium on the implementation of the 25-percent threshold policy effective until October 1, 2018. CMS codified changes to the regulations at § 412.538 in the FY 2018 final rule.

**H. Average Length of Stay Calculation**

Section 15007 of the 21st Century Cures Act excluded Medicare Advantage and site neutral discharges from the calculation of the average length of stay for all LTCHs. CMS codified changes to the regulations at § 412.23(e)(3) in the FY 2018 final rule.
I. 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 of its DPP upon final settlement of the cost report.

J. Extended Neoplastic Disease Care Hospitals

Section 15008 of the 21st Century Cures Act removed certain hospitals, previously referred to as “subclause (II) LTCHs,” from the IPPS-exclude hospital designation of an LTCH and created a new category of IPPS-excluded hospital for these entities, now referred to as “extended neoplastic disease care hospitals.” As such, these hospitals are no longer subject to the LTCH PPS effective with for cost reporting periods beginning on or after January 1, 2015.

Section 15008 of the 21st Century Cures Act further specifies that, for cost reporting periods beginning on or after January 1, 2015, payment for inpatient operating costs for such hospitals is to be made as described in 42 CFR 412.526(c)(3), and payment for capital costs is to be made as described in 42 CFR 412.526(c)(4). (Note that any prior instructions issued by CMS for the payment of such hospitals redesignated by Section 15008 of the 21st Century Cures Act for cost reporting periods beginning on or after January 1, 2015 (for example, CR 9912), any references to “subclause (II) LTCHs” shall be read as “extended neoplastic disease care hospitals”.)

Hospitals Excluded from the IPPS

The update to extended neoplastic disease care hospital’s target amount is the applicable annual rate-of-increase percentage specified in § 413.40(c)(3), which is equal to the percentage increase projected by the hospital market basket index. In the FY 2018 final rule, CMS established an update to an extended neoplastic disease care hospital’s target amount for FY 2018 of 2.7 percent.

ADDITIONAL INFORMATION


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

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
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<tbody>
<tr>
<td>October 18, 2017</td>
<td>This article was revised to reflect a revised CR10273 issued on October 17. The CR was revised to update the factor 3 denominator for hospitals treated as new, the fixed-loss amount for LTCH standard Federal payment rate cases, reference to the Grouper software version, applicable tables and files available on the CMS website, and to clarify the list of ICD-10 codes eligible for the GORE IBE device system new technology add-on payment. In addition, updating the assignment of the wage index for Indian Health Service or Tribal Hospitals of the Pricer in the attachment to the CR. The article was updated accordingly. All other information remains the same.</td>
</tr>
<tr>
<td>September 11, 2017</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>

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Home Health Prospective Payment System (HH PPS) Rate Update for Calendar Year (CY) 2018

MLN Matters Number: MM10310  Related Change Request (CR) Number: 10310
Related CR Release Date: October 20, 2017  Effective Date: January 1, 2018
Related CR Transmittal Number: R3888CP  Implementation Date: January 2, 2018

PROVIDER TYPE AFFECTED

This MLN Matters Article is intended for Home Health Agencies (HHAs) billing Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

WHAT YOU NEED TO KNOW

Change Request (CR) 10310 updates the 60-day national episode rates, the national per-visit amounts, Low Utilization Payment Adjustment (LUPA) add-on amounts, the non-routine medical supply payment amounts, and the cost-per-unit payment amounts used for calculating outlier payments under the HH PPS for Calendar Year (CY) 2018. Be sure your billing staffs are aware of these changes.

BACKGROUND

The CY 2018 HH PPS rate update includes the third year of a 3-year phase-in of a reduction to the national, standardized 60-day episode payment amount to account for estimated case-mix growth unrelated to increases in patient acuity (that is, nominal case-mix growth) between CY 2012 and CY 2014. The nominal case-mix growth reduction is 0.97 percent. The changes described in MM10310 are implemented through the Home Health Pricer software used by Medicare contractor standard systems.

Market Basket Update

Section 411(d) of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) amended Section 1895(b)(3)(B) of the Social Security Act (the Act) such that, for home health payments for CY 2018, the market basket percentage increase shall be 1 percent. Section 1895(b)(3)(B) of the Act requires that the home health payment update be decreased by 2 percentage points for those HHAs that do not submit quality data as required by the Secretary of the Department of Health & Human Services (HHS). For HHAs that do not submit the
required quality data for CY 2018, the home health payment update would be -1 percent (1 percent minus 2 percentage points).

**National, Standardized 60-Day Episode Payment**

As described in the CY 2018 HH PPS final rule, in order to calculate the CY 2018 national, standardized 60-day episode payment rate, the Centers for Medicare & Medicaid Services (CMS) applies a wage index budget neutrality factor of 1.0004 and a case-mix budget neutrality factor of 1.0160 to the previous calendar year’s national, standardized 60-day episode rate. To account for nominal case-mix growth from CY 2012 to CY 2014, CMS applies a payment reduction of 0.97 percent to the national, standardized 60-day episode payment rate. Lastly, the national, standardized 60-day episode payment rate is updated by the CY 2018 HH payment update percentage of 1 percent for HHAs that submit the required quality data and by 1 percent minus 2 percentage points, or -1 percent, for HHAs that do not submit quality data. These two-episode payment rates are shown in Tables 1 and 2. These payments are further adjusted by the individual episode’s case-mix weight and by the wage index.

**Table 1: For HHAs that DO Submit Quality Data – National, Standardized 60-Day Episode Amount for CY 2018**

<table>
<thead>
<tr>
<th>CY 2017 National, Standardized 60 Day Episode Payment</th>
<th>Wage Index Budget Neutrality Factor</th>
<th>Case Mix Weights Budget Neutrality Factor</th>
<th>Nominal Case-Mix Growth Adjustment</th>
<th>CY 2018 HH Payment Update</th>
<th>CY 2018 National, Standardized 60 Day Episode Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>$2,989.97</td>
<td>X 1.0004</td>
<td>X 1.0160</td>
<td>X 0.9903</td>
<td>X 1.01</td>
<td>$3,039.64</td>
</tr>
</tbody>
</table>

**Table 2: For HHAs that DO NOT Submit Quality Data – National, Standardized 60-Day Episode Amount for CY 2018**

<table>
<thead>
<tr>
<th>CY 2017 National, Standardized 60 Day Episode Payment</th>
<th>Wage Index Budget Neutrality Factor</th>
<th>Case Mix Weights Budget Neutrality Factor</th>
<th>Nominal Case-Mix Growth Adjustment</th>
<th>CY 2018 HH Payment Update Minus 2 Percentage Points</th>
<th>CY 2018 National, Standardized 60 Day Episode Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>$2,989.97</td>
<td>X 1.0004</td>
<td>X 1.0160</td>
<td>X 0.9903</td>
<td>X 0.99</td>
<td>$2,979.45</td>
</tr>
</tbody>
</table>
National Per-Visit Rates

To calculate the CY 2018 national per-visit payment rates, CMS starts with the CY 2017 national per-visit rates. CMS applies a wage index budget neutrality factor of 1.0010 to ensure budget neutrality for LUPA per-visit payments after applying the CY 2018 wage index. The per-visit rates are then updated by the CY 2018 HH payment update of 1 percent for HHAs that submit the required quality data and by -1 percent for HHAs that do not submit quality data. The per-visit rates are shown in Tables 3 and 4.

Table 3: For HHAs that DO Submit Quality Data – CY 2018 National Per-Visit Amounts for LUPAs and Outlier Calculations

<table>
<thead>
<tr>
<th>HH Discipline Type</th>
<th>CY 2017 Per Visit Payment</th>
<th>Wage Index Budget Neutrality Factor</th>
<th>CY 2018 HH Payment Update</th>
<th>CY 2018 Per Visit Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Aide</td>
<td>$64.23</td>
<td>X 1.0010</td>
<td>X 1.01</td>
<td>$64.94</td>
</tr>
<tr>
<td>Medical Social Services</td>
<td>$227.36</td>
<td>X 1.0010</td>
<td>X 1.01</td>
<td>$229.86</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>$156.11</td>
<td>X 1.0010</td>
<td>X 1.01</td>
<td>$157.83</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>$155.05</td>
<td>X 1.0010</td>
<td>X 1.01</td>
<td>$156.76</td>
</tr>
<tr>
<td>Skilled Nursing</td>
<td>$141.84</td>
<td>X 1.0010</td>
<td>X 1.01</td>
<td>$143.40</td>
</tr>
<tr>
<td>Speech-Language Pathology</td>
<td>$168.52</td>
<td>X 1.0010</td>
<td>X 1.01</td>
<td>$170.38</td>
</tr>
</tbody>
</table>

Table 4: For HHAs that DO NOT Submit Quality Data – CY 2018 National Per-Visit Amounts for LUPAs and Outlier Calculations

<table>
<thead>
<tr>
<th>HH Discipline Type</th>
<th>CY 2017 Per Visit Payment</th>
<th>Wage Index Budget Neutrality Factor</th>
<th>CY 2018 HH Payment Update</th>
<th>CY 2018 Per Visit Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Aide</td>
<td>$64.23</td>
<td>X 1.0010</td>
<td>X 0.99</td>
<td>$63.65</td>
</tr>
<tr>
<td>Medical Social Services</td>
<td>$227.36</td>
<td>X 1.0010</td>
<td>X 0.99</td>
<td>$225.31</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>$156.11</td>
<td>X 1.0010</td>
<td>X 0.99</td>
<td>$154.70</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>$155.05</td>
<td>X 1.0010</td>
<td>X 0.99</td>
<td>$153.65</td>
</tr>
<tr>
<td>Skilled Nursing</td>
<td>$141.84</td>
<td>X 1.0010</td>
<td>X 0.99</td>
<td>$140.56</td>
</tr>
<tr>
<td>Speech-Language Pathology</td>
<td>$168.52</td>
<td>X 1.0010</td>
<td>X 0.99</td>
<td>$167.00</td>
</tr>
</tbody>
</table>
Non-Routine Supply Payments

Payments for Non-Routine Supplies (NRS) are computed by multiplying the relative weight for a particular NRS severity level by an NRS conversion factor. To determine the CY 2018 NRS conversion factors, CMS updates the CY 2017 NRS conversion factor by the CY 2018 HH payment update of 1 percent for HHAs that submit the required quality data and by -1 percent for HHAs that do not submit quality data. CMS does not apply any standardization factors as the NRS payment amount calculated from the conversion factor is neither wage nor case-mix adjusted when the final payment amount is computed. The NRS conversion factor for CY 2018 payments for HHAs that do submit the required quality data is shown in Table 5a and the payment amounts for the various NRS severity levels are shown in Table 5b. The NRS conversion factor for CY 2018 payments for HHAs that do not submit quality data is shown in Table 6a and the payment amounts for the various NRS severity levels are shown in Table 6b.

Table 5a: CY 2018 NRS Conversion Factor for HHAs that DO Submit the Required Quality Data

<table>
<thead>
<tr>
<th>CY 2017 NRS Conversion Factor</th>
<th>CY 2018 HH Payment Update</th>
<th>CY 2018 NRS Conversion Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>$52.50</td>
<td>X 1.01</td>
<td>$53.03</td>
</tr>
</tbody>
</table>

Table 5b: CY 2018 Relative Weights and Payment Amounts for the 6-Severirt NRS System for HHAs that DO Submit Quality Data

<table>
<thead>
<tr>
<th>Severity Level</th>
<th>Points (Scoring)</th>
<th>Relative Weight</th>
<th>CY 2018 NRS Payment Amounts</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>0.2698</td>
<td>$14.31</td>
</tr>
<tr>
<td>2</td>
<td>1 to 14</td>
<td>0.9742</td>
<td>$51.66</td>
</tr>
<tr>
<td>3</td>
<td>15 to 27</td>
<td>2.6712</td>
<td>$141.65</td>
</tr>
<tr>
<td>4</td>
<td>28 to 48</td>
<td>3.9686</td>
<td>$210.45</td>
</tr>
<tr>
<td>5</td>
<td>49 to 98</td>
<td>6.1198</td>
<td>$324.53</td>
</tr>
<tr>
<td>6</td>
<td>99+</td>
<td>10.5254</td>
<td>$558.16</td>
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</table>

Table 6a: CY 2018 NRS Conversion Factor for HHAs that DO NOT Submit the Required Quality Data

<table>
<thead>
<tr>
<th>CY 2017 NRS Conversion Factor</th>
<th>CY 2018 HH Payment Update Percentage minus 2 Percentage Points</th>
<th>CY 2018 NRS Conversion Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>$52.50</td>
<td>X 0.99</td>
<td>$51.98</td>
</tr>
</tbody>
</table>
Table 6b: CY 2018 Relative Weights and Payment Amounts for the 6-Severiry NRS System for HHAs that DO NOT Submit Quality Data

<table>
<thead>
<tr>
<th>Severity Level</th>
<th>Points (Scoring)</th>
<th>Relative Weight</th>
<th>CY 2018 NRS Payment Amounts</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>0.2698</td>
<td>$14.02</td>
</tr>
<tr>
<td>2</td>
<td>1 to 14</td>
<td>0.9742</td>
<td>$50.64</td>
</tr>
<tr>
<td>3</td>
<td>15 to 27</td>
<td>2.6712</td>
<td>$138.85</td>
</tr>
<tr>
<td>4</td>
<td>28 to 48</td>
<td>3.9686</td>
<td>$206.29</td>
</tr>
<tr>
<td>5</td>
<td>49 to 98</td>
<td>6.1198</td>
<td>$318.11</td>
</tr>
<tr>
<td>6</td>
<td>99+</td>
<td>10.5254</td>
<td>$547.11</td>
</tr>
</tbody>
</table>

Sunset of the Rural Add-On Provision

Section 210 of MACRA extended the rural add-on of a 3-percent increase in the payment amount for HH services provided in a rural area for episodes and visits ending before January 1, 2018. Therefore, for episodes and visits that end on or after January 1, 2018, a rural add-on payment will not apply.

Methodology for Calculating Outlier Payments

In the CY 2017 HH PPS final rule (81 FR 76702), CMS finalized changes to the methodology used to calculate outlier payments, using a cost-per-unit approach rather than a cost-per-visit approach. This change in methodology allows for more accurate payment for outlier episodes, accounting for both the number of visits during an episode of care and also the length of the visits provided. Using this approach, CMS now converts the national per-visit rates into per 15-minute unit rates. These per 15-minute unit rates are used to calculate the estimated cost of an episode to determine whether the claim will receive an outlier payment and the amount of payment for an episode of care. The cost-per-unit payment rates used for the calculation of outlier payments are shown in Tables 7a and 7b. The Fixed Dollar Loss (FDL) ratio remains 0.55 and the loss-sharing ratio remains 0.80.
Table 7a - Cost-Per-Unit Rates for Calculating Outlier Payments for HHAs that DO Submit Required Quality Data

<table>
<thead>
<tr>
<th>HH Discipline</th>
<th>Average Minutes per Visit</th>
<th>CY2018 Per Visit Payment</th>
<th>Cost per Unit (1 unit 15 minutes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Aide</td>
<td>63.0</td>
<td>$64.94</td>
<td>$15.46</td>
</tr>
<tr>
<td>Medical Social Services</td>
<td>56.5</td>
<td>$229.86</td>
<td>$61.02</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>47.1</td>
<td>$157.83</td>
<td>$50.26</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>46.6</td>
<td>$156.76</td>
<td>$50.46</td>
</tr>
<tr>
<td>Skilled Nursing</td>
<td>44.8</td>
<td>$143.40</td>
<td>$48.01</td>
</tr>
<tr>
<td>Speech-Language Pathology</td>
<td>48.1</td>
<td>$170.38</td>
<td>$53.13</td>
</tr>
</tbody>
</table>

Table 7b - Cost-Per-Unit Rates for Calculating Outlier Payments for HHAs that DO NOT Submit Required Quality Data

<table>
<thead>
<tr>
<th>HH Discipline</th>
<th>Average Minutes per Visit</th>
<th>CY2018 Per Visit Payment</th>
<th>Cost per Unit (1 unit 15 minutes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Aide</td>
<td>63.0</td>
<td>$63.65</td>
<td>$15.15</td>
</tr>
<tr>
<td>Medical Social Services</td>
<td>56.5</td>
<td>$225.31</td>
<td>$59.82</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>47.1</td>
<td>$154.70</td>
<td>$49.27</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>46.6</td>
<td>$153.65</td>
<td>$49.46</td>
</tr>
<tr>
<td>Skilled Nursing</td>
<td>44.8</td>
<td>$140.56</td>
<td>$47.06</td>
</tr>
<tr>
<td>Speech-Language Pathology</td>
<td>48.1</td>
<td>$167.00</td>
<td>$52.08</td>
</tr>
</tbody>
</table>
ADDITIONAL INFORMATION


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

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<td>November 9, 2017</td>
<td>Initial article released.</td>
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Implementation of Changes in the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) and Payment for Dialysis Furnished for Acute Kidney Injury (AKI) in ESRD Facilities for Calendar Year (CY) 2018

MLN Matters Number: MM10312 Related Change Request (CR) Number: 10312
Related CR Release Date: November 3, 2017 Effective Date: January 1, 2018
Related CR Transmittal Number: R237BP Implementation Date: January 2, 2018

PROVIDER TYPES AFFECTED

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

WHAT YOU NEED TO KNOW

Change Request (CR) 10312 implements the Calendar Year (CY) 2018 rate updates for the ESRD Prospective Payment System (PPS) and updates the payment for renal dialysis services furnished to beneficiaries with Acute Kidney Injury (AKI) in ESRD facilities. This MLN Matters® (MM) Article summarizes these changes. Make sure that your billing staffs are aware of these changes.

BACKGROUND

Effective January 1, 2011, the Centers for Medicare & Medicaid Services (CMS) implemented the ESRD PPS based on the requirements of Section1881(b)(14) of the Social Security Act (the Act) as added by Section 153(b) of the Medicare Improvements for Patients and Providers Act (MIPPA). Section 1881(b)(14)(F) of the Act, as added by Section 153(b) of MIPPA and amended by Section 3401(h) of the Affordable Care Act. As a result, beginning with CY 2012, and each subsequent year, the Secretary shall annually increase payment amounts by an ESRD market basket increase factor, reduced by the productivity adjustment described in Section 1886(b)(3)(B)(xi)(II) of the Act. The ESRD bundled market basket increase factor minus the productivity adjustment will
update the ESRD PPS base rate. Section 217(b)(2) of the Protecting Access to Medicare Act of 2014 (PAMA) included a provision that dictated how the market basket should be reduced for CY 2018.

In accordance with Section 808(b) of the Trade Preferences Extension Act of 2015 (TPEA), CMS pays ESRD facilities for furnishing renal dialysis services to Medicare beneficiaries with AKI. CR 9598 implemented the payment for renal dialysis services and provides detailed information regarding payment policies. You can view the corresponding MLN Matters Article at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9598.pdf.

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.

CY 2018 ESRD PPS updates are as follows:

**ESRD PPS base rate:**

1. A 0.3 percent update to the CY 2017 payment rate. ($231.55 x 1.003 = $232.24).
2. A wage index budget-neutrality adjustment factor of 1.000531. ($232.24 x 1.000531 = $232.37)

**Wage index:**

1. The wage index adjustment will be updated to reflect the latest available wage data.
2. The wage index floor will remain at 0.4000.

**Labor-related share:**

The labor-related share will remain at 50.673.

**Outlier Policy:**

CMS made the following updates to the adjusted average outlier service Medicare Allowable Payment (MAP) amount per treatment:

1. For adult patients, the adjusted average outlier service MAP amount per treatment is $42.41.
2. For pediatric patients, the adjusted average outlier service MAP amount per treatment is $37.31.

CMS made the following updates to the fixed dollar loss amount that is added to the predicted MAP to determine the outlier threshold:
1. The fixed dollar loss amount is $77.54 for adult patients.
2. The fixed dollar loss amount is $47.79 for pediatric patients.

CMS made the following changes to the list of outlier services:

1. Renal dialysis drugs that are oral equivalents to injectable drugs are based on the most recent prices retrieved from the Medicare Prescription Drug Plan Finder, are updated to reflect the most recent mean unit cost. In addition, CMS will add or remove any renal dialysis items and services that are eligible for outlier payment. See Attachment A of CR10312 for a list of CY2018 outlier services.
2. The mean dispensing fee of the National Drug Codes (NDCs) qualifying for outlier consideration is revised to $0.76 per NDC per month for claims with dates of service on or after January 1, 2018. See Attachment A of CR10312.

Consolidated Billing Requirements:

The CB requirements for drugs and biologicals included in the ESRD PPS is updated by:

1. Adding the following Healthcare Common Procedure Coding System (HCPCS) codes to the bone and mineral metabolism category:
   (a) J0604 - Cinacalcet, oral, 1 mg, (for ESRD on dialysis)
   (b) J0606 - Injection, etelcalcetide, 0.1 mg
2. These drugs are payable under the Transitional Drug Add-on Payment Amount (TDAPA) policy for ESRD beneficiaries and are not separately payable for AKI beneficiaries. The TDAPA was implemented with CR 10065. (See the related MLN Matters article at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm10065.pdf. New drugs and biologicals that are eligible for TDAPA do not qualify as an outlier service.
3. Adding the following HCPCS to the composite rate drugs and biologicals category since these drugs meet the definition of a composite rate drug in the Medicare Benefit Policy Manual, Pub. 100-02, chapter 11, section 20.3.F and are renal dialysis services:
   - J7030 Infusion, normal saline solution, 1000 cc
   - J7050 Infusion, normal saline solution, 250 cc
   - J7040 Infusion, normal saline solution, sterile
   - J7060 5% dextrose/water (500 ml = 1 unit)
   - J7042 5% dextrose/normal saline (500 ml = 1 unit)
   - J7070 Infusion, d5w, 1000 cc
• J7120 Ringers lactate infusion, up to 1000 cc
• J2360 Injection, orphenadrine citrate, up to 60 mg

4. HCPCS J7030, J7050, J7040, J7060, J7042, J7070, J7120, and J2360 do not meet the definition of an outlier service and therefore do not qualify for an outlier payment. In accordance with CR 8978, ESRD facilities should report J7030, J7050, J7040, J7060, J7042, J7070, J7120, and J2360 along with any other composite rate drugs listed in Attachment B of CR10312.

**CY 2018 AKI Dialysis Payment Rate for Renal Dialysis Services:**

2. The labor-related share is 50.673.
3. The AKI dialysis payment rate will be adjusted for wages using the same wage index that is used under the ESRD PPS.
4. The AKI dialysis payment rate is not reduced for the ESRD Quality Incentive Program (QIP).
5. The TDAPA does not apply to AKI claims.

MACs will not allow a separate payment when the AY modifier is present on Type of Bill 72x (ESRD) with the HCPCS codes J0604 and J0606.

**ADDITIONAL INFORMATION**


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Influenza Vaccine Payment Allowances - Annual Update for 2017-2018 Season

MLN Matters Number: MM10224 Related Change Request (CR) Number: CR 10224

Related CR Release Date: November 3, 2017 Effective Date: August 1, 2017

Related CR Transmittal Number: R3908CP Implementation Date: No later than October 2, 2017

Note: This article was revised on November 16, 2017, to add a link to related article SE17026 which updates the Medicare Healthcare Common Procedure Coding System (HCPCS) and Current Procedure Terminology (CPT) codes and payment rates for personal flu and pneumococcal vaccines for 2017-2018. All other information is unchanged.

PROVIDER TYPE AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR 10224 informs MACs about the payment allowances for seasonal influenza virus vaccines, which are updated on August 1 of each year. The Centers for Medicare & Medicaid Services (CMS) will post the payment allowances for influenza vaccines that are approved after the release of CR10224 at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html. Make sure your billing staffs are aware that the payment allowances are being updated.

BACKGROUND

The Medicare Part B payment allowance limits for influenza and pneumococcal vaccines are 95 percent of the Average Wholesale Price (AWP) as reflected in the published compendia except where the vaccine is furnished in a hospital outpatient department, Rural Health Clinic (RHC), or Federally Qualified Health Center (FQHC). Where the vaccine is furnished in the hospital outpatient department, RHC, or FQHC, payment for the vaccine is based on reasonable cost.

The Medicare Part B payment allowances for the following Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes below apply for the
effective dates of August 1, 2017-July 31, 2018:

- CPT 90653 Payment allowance is $50.217.
- CPT 90655 Payment allowance is pending.
- CPT 90656 Payment allowance is $19.247.
- CPT 90657 Payment allowance is pending.
- CPT 90661 Payment allowance is pending.
- CPT 90685 Payment allowance is $21.198.
- CPT 90686 Payment allowance is $19.032.
- CPT 90687 Payment allowance is $9.403.
- CPT 90688 Payment allowance is $17.835.
- HCPCS Q2035 Payment allowance is $17.685.
- HCPCS Q2036 Payment allowance is pending.
- HCPCS Q2037 Payment allowance is $17.685.
- HCPCS Q2038 Payment allowance is pending.

Payment for the following CPT or HCPCS codes may be made if your MAC determines its use is reasonable and necessary for the beneficiary, for the effective dates of August 1, 2017 - July 31, 2018:

- CPT 90630 Payment allowance is $20.343.
- CPT 90654 Payment allowance is pending.
- CPT 90662 Payment allowance is $49.025.
- CPT 90672 Payment allowance is pending.
- CPT 90673 Payment allowance is $40.613.
- CPT 90674 Payment allowance is $24.047.
- CPT 90682 Payment allowance is $46.313. (New code)
- CPT 90756 Payment allowance is $22.793. Effective dates: 1/1/2018-7/31/2018 (Note: Providers and Medicare Administrative Contractors shall use HCPCS Q2039 for dates of service from 8/1/2017 – 12/31/2017. See special note under HCPCS Q2039 for payment amounts for this product prior to 1/1/2018.)
- HCPCS Q2039 Flu Vaccine Adult - Not Otherwise Classified. Payment allowance is to be determined by your MAC with effective dates of 8/1/2017 - 7/31/2018.

Special note: Until CPT code 90756 is implemented on 1/1/2018, Q2039 shall be used for products described by the following language: influenza virus vaccine, quadrivalent (ccILV4), derived from cell cultures, subunit, antibiotic free, 0.5mL dosage, for intramuscular use. The payment allowance for these products, effective for dates of service 8/1/2017 - 12/31/2017 is $22.793.

CMS will post payment limits for influenza vaccines that are approved after the release date of CR10224 on the CMS Seasonal Influenza Vaccines Pricing webpage at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html as information becomes available. Effective dates for these vaccines shall be the date of Food and Drug Administration (FDA) approval.
The payment allowances for pneumococcal vaccines are based on 95 percent of the AWP and are updated on a quarterly basis via the Quarterly Average Sales Price (ASP) Drug Pricing Files.

Providers should note that:

- All physicians, non-physician practitioners, and suppliers who administer the influenza virus vaccination and the pneumococcal vaccination must take assignment on the claim for the vaccine.
- The annual Part B deductible and coinsurance amounts do not apply.

**Note:** MACs will reprocess any previously processed and paid claims for the current flu season, that were paid using influenza vaccine payment allowances other than the allowances published in the influenza vaccine pricing website for the 2017/2018 season that began on August 1, 2017. MACs will initiate the mass adjustment process to reprocess claims by November 1, 2017. A MAC that requires more time to meet this deadline may contact their Contracting Officer’s Representative (COR) for additional direction.

**ADDITIONAL INFORMATION**


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<td>This article was revised to add a link to related article SE17026 which updates the Medicare HCPCS and CPT codes and payment rates for personal flu and pneumococcal vaccines for 2017-2018.</td>
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<td>November 3, 2017</td>
<td>The article was revised to reflect an updated Change Request (CR). That CR changed the instruction to the MACs for searching files- see note on page 3 above. The CR release date, transmittal number and link to the transmittal also changed.</td>
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<td>November 2, 2017</td>
<td>This article was revised to add a reference to MLN Matters Article SE17026 which reminds health care professionals that Medicare Part B reimburses health care providers for flu vaccines and their administration. <em>(Medicare provides coverage of the flu vaccine without any out-of-pocket costs to the Medicare patient. No deductible or copayment/coinsurance applies.)</em></td>
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Inpatient Rehabilitation Facility (IRF) Annual Update: Prospective Payment System (PPS) PRICER Changes for FY 2018

MLN Matters Number: MM10125  Related Change Request (CR) Number: CR 10125
Related CR Release Date: August 25, 2017  Effective Date: October 1, 2017
Related CR Transmittal Number: R3849CP  Implementation Date: October 2, 2017

PROVIDER TYPE AFFECTED

This MLN Matters Article is intended for Inpatient Rehabilitation Facilities (IRFs) submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

WHAT YOU NEED TO KNOW

This article is based on CR 10125, which notifies you that a new IRF PRICER software package will be released prior to October 1, 2017, that will contain the updated rates that are effective for claims with discharges that fall within October 1, 2017, through September 30, 2018. MACs will install and pay IRF claims with the FY 2018 IRF Prospective Payment System (PPS) PRICER for discharges on or after October 1, 2017.

BACKGROUND

On August 7, 2001, the Centers for Medicare & Medicaid Services (CMS) published in the Federal Register a final rule that established the PPS for IRFs, as authorized under Section1886 (j) of the Social Security Act (the Act). In that final rule, CMS set forth per discharge Federal rates for Federal fiscal year (FY) 2002. These IRF PPS payment rates became effective for cost reporting periods beginning on or after January 1, 2002. Annual updates to the IRF PPS rates are required by Section 1886 (j)(3)(C) of the Act.

KEY POINTS FOR FY 2018 IRF PPS

The FY 2018 IRF PPS Final Rule, issued on July 31, 2017, sets forth the prospective payment rates applicable for IRFs for FY 2018. A new IRF PRICER software package will be released prior to October 1, 2017, that will contain the updated rates that are effective for claims with
discharges that fall within October 1, 2017 through September 30, 2018.

1. Phase Out of Rural Adjustment

CMS has implemented a 3-year budget neutral phase out of the rural adjustment for those IRFs that meet the definition in Section 412.602 as rural in FY 2015 and became urban under the FY 2016 CBSA-based designations. CMS will afford existing IRFs designated in FY 2015 as rural IRFs (pursuant to Section 412.602) and re-designated as an urban facility in FY 2016 (pursuant to Section 412.602), a 3-year phase out in order to mitigate the payment effect upon a rural facility that is re-designated as an urban facility (effective FY 2016) and thereby loses the rural adjustment of 1.149. This is the third year of the phase out of rural adjustment.

2. Removal of 25 Percent Payment Penalty

3. PRICER Updates for IRF PPS FY 2018 (October 1, 2017 – September 30, 2018)

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<td>Adjusted standard Federal rate</td>
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<td>Fixed loss amount</td>
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<td>Non-labor related share</td>
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<td>Rural national average CCR</td>
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<td>Low Income Patient (LIP) Adjustment</td>
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<td>Teaching Adjustment</td>
<td>1.0163</td>
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<tr>
<td>Rural Adjustment</td>
<td>1.149</td>
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Section 1886(j)(7)(A)(i) of the Act requires application of a 2 percentage point reduction of the applicable market basket increase factor for IRFs that fail to comply with the quality data submission requirements. The mandated reduction will be applied in FY 2018 for IRFs that failed to comply with the data submission requirements during the data collection period January 1, 2016 through December 31, 2016. Thus, in compliance with 1886(j)(7)(A)(i) of the Act, we will apply a 2 percentage point reduction to the applicable FY 2018 market basket.
increase factor (1.0 percent) in calculating an adjusted FY 2018 standard payment conversion factor to apply to payments for only those IRFs that failed to comply with the data submission requirements.

Application of the 2 percentage point 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. Also, reporting-based reductions to the market basket increase factor will not be cumulative; they will only apply for the FY involved.

The adjusted FY 2018 standard payment conversion factor that will be used to compute IRF PPS payment rates for any IRF that failed to meet the quality reporting requirements for the period from January 1, 2016 through December 31, 2016 will be $15,524.

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

MLN Matters Number: MM10320 Related Change Request (CR) Number: 10320
Related CR Release Date: October 6, 2017 Effective Date: January 1, 2018
Related CR Transmittal Number: R3878CP Implementation Date: January 2, 2018

PROVIDER TYPE AFFECTED

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

WHAT YOU NEED TO KNOW

Change Request (CR) 10320 instructs MACs to download and implement the January 2018 and, if released, the revised October 2017, July 2017, April 2017, and January 2017, ASP drug pricing files for Medicare Part B drugs via the Centers for Medicare & Medicaid Services (CMS) Data Center (CDC). Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after January 2, 2018, with dates of service January 1, 2018, through March 31, 2018. Make sure your billing staffs are aware of these changes.

BACKGROUND

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

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

File: July 2017 ASP and ASP NOC -- Effective for Dates of Service: July 1, 2017, through September 30, 2017

File: April 2017 ASP and ASP NOC -- Effective for Dates of Service: April 1, 2017, through June 30, 2017

File: January 2017 ASP and ASP NOC -- Effective for Dates of Service: January 1, 2017, through March 31, 2017

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, MACs will determine the payment allowance limits in accordance with instructions for pricing and payment changes for infusion drugs furnished through an item of Durable Medical Equipment (DME) on or after January 1, 2017, associated with the passage of the 21st Century Cures Act.

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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)

This article was rescinded.
October Quarterly Update for 2017 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule

MLN Matters Number: MM10248
Related Change Request (CR) Number: CR 10248

Related CR Release Date: September 8, 2017
Effective Date: October 1, 2017
Implementation Date: October 2, 2017

Related CR Transmittal Number: R3859CP

PROVIDER TYPE AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 10248 provides instructions regarding the October quarterly update for the 2017 DMEPOS and parenteral and enteral nutrition (PEN) fee schedules and the October 2017 DMEPOS Rural ZIP code file containing the Quarter 4, 2017 Rural ZIP code changes. 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 schedule is updated on a quarterly basis, when necessary, to implement fee schedule amounts for new codes and correct any fee schedule amounts for existing codes, and the quarterly update process for the DMEPOS fee schedule is covered in the Medicare Claims Processing Manual, Chapter 23, Section 60 at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf

Payment on a fee schedule basis is required for DMEPOS and surgical dressings by the Social Security Act, Section 1834(a), (h), and (i) at https://www.ssa.gov/OP_Home/ssact/title18/1834.htm. Also, payment on a fee schedule basis is a regulatory requirement at 42 CFR §414.102 for PEN, splints and casts, and intraocular lenses (IOLs) inserted in a physician's office.
Additionally, the Social Security Act (Section 1834(a)(1)(F)(iii)) mandates adjustments to the fee schedule amounts for certain items furnished on or after January 1, 2016, in areas that are not competitive bid areas, based on information from competitive bidding programs (CBPs) for DME. The Social Security Act (Section 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 at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9642.pdf, 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.

Effective with the October update, code K0861 RR KF is removed from the fee schedule file.

The October 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.

**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>September 12, 2017</td>
<td>Initial article released</td>
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Qualified Medicare Beneficiary Indicator in the Medicare Fee-For-Service Claims Processing System

Provider Types Affected

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

Provider Action Needed

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

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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**


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>November 16, 2017</td>
<td>The article was revised to reflect a revised CR9911 issued on November 15, 2017. In the article, the CR release date, transmittal number, and the Web address of CR9911 are revised. All other information remains the same.</td>
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<tr>
<td>July 24, 2017</td>
<td>The article was revised to add links to related MLN Matters Articles. <strong>SE1128</strong> reminds all Medicare providers that they may not bill beneficiaries enrolled in the QMB program for Medicare cost-sharing. <strong>MM9817</strong> 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.</td>
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<tr>
<td>June 29, 2017</td>
<td>The article was revised to reflect a revised CR9911 issued on June 28, 2017. In the article, the CR release date, transmittal number, and the Web address of CR9911 are revised. Clarifications were also made to the second paragraph of the Background section.</td>
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<tr>
<td>May 1, 2017</td>
<td>The article was revised to reflect a revised CR9911 issued on April 28, 2017. In the article, the CR release date, transmittal number, and the Web address of CR9911 are revised.</td>
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<td>February 3, 2017</td>
<td>Initial article released</td>
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Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) – October 2017 Update

MLN Matters Number: MM10222
Related Change Request (CR) Number: 10222
Related CR Release Date: August 25, 2017
Effective Date: January 1, 2017
Related CR Transmittal Number: R3838CP
Implementation Date: October 2, 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) 10222 amends payment files that were issued to the MACs based upon the Calendar Year (CY) 2017 Medicare Physician Fee Schedule (MPFS) Final Rule. Please make sure your billing staffs are aware of these changes.

BACKGROUND

Payment files are 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 of the Department of Health & Human Services (HHS) to establish ancillary policies necessary to implement relative values for physicians’ services.

This article presents a summary of the changes for the October update to the 2017 MPFSDB. Unless otherwise stated, these changes are effective for dates of service on and after January 1, 2017.

<table>
<thead>
<tr>
<th>CPT/HCPCS &amp; Mod</th>
<th>Action</th>
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</thead>
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<tr>
<td>20245</td>
<td>Pre Op = 0, Intra Op = 0, Post Op = 0</td>
</tr>
<tr>
<td>36473</td>
<td>Bilateral Surg = 1</td>
</tr>
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</table>
The following new codes have been added to the HCPCS file, effective August 1, 2017. The HCPCS file coverage code is C (carrier judgment) for these new codes. Coverage and payment will be determined by your MAC (they are not part of the MPFS).

<table>
<thead>
<tr>
<th>CPT/HCPCS &amp; Mod</th>
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<tbody>
<tr>
<td>64897</td>
<td>Post Op = 0.13</td>
</tr>
<tr>
<td>93668</td>
<td>Status Indicator = C for dates of service 1/1/17 or after</td>
</tr>
<tr>
<td>A4575</td>
<td>Status Indicator = X for dates of service 4/3/17 or after</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
</tr>
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<tbody>
<tr>
<td>0006U</td>
<td>RX MNTR 120+ DRUGS &amp; SBSTS</td>
<td>Prescription drug monitoring, 120 or more drugs and substances, definitive tandem mass spectrometry with chromatography, urine, qualitative report of presence (including quantitative levels, when detected) or absence of each drug or substance with description and severity of potential interactions, with identified substances, per date of service</td>
</tr>
<tr>
<td>0007U</td>
<td>RX TEST PRSMV UR W/DEF CONF</td>
<td>Drug test(s), presumptive, with definitive confirmation of positive results, any number of drug classes, urine, includes specimen verification including DNA authentication in comparison to buccal DNA, per date of service</td>
</tr>
<tr>
<td>0008U</td>
<td>HPYLORI DETCJ ABX RSTNC DNA</td>
<td>Helicobacter pylori detection and antibiotic resistance, DNA, 16S and 23S rRNA, gyrA, pwp1, rdxA and rpoB, next generation sequencing, formalin-fixed paraffin embedded or fresh tissue, predictive, reported as positive or negative for resistance to clarithromycin, fluoroquinolones, metronidazole, amoxicillin, tetracycline and rifabutin</td>
</tr>
<tr>
<td>0009U</td>
<td>ONC BRST CA ERBB2 AMP/NONAMP</td>
<td>Oncology (breast cancer), ERBB2 (HER2) copy number by FISH, tumor cells from formalin fixed paraffin embedded tissue isolated using image-based dielectrophoresis (DEP) sorting, reported as ERBB2 gene amplified or non-amplified</td>
</tr>
<tr>
<td>0010U</td>
<td>NFCT DS STRN TYP WHL GEN SEQ</td>
<td>Infectious disease (bacterial), strain typing by whole genome sequencing, phylogenetic-based report of strain relatedness, per submitted isolate</td>
</tr>
<tr>
<td>CPT Code</td>
<td>Short Descriptor</td>
<td>Long Descriptor</td>
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<tr>
<td>0011U</td>
<td>RX MNTR LC-MS/MS ORAL FLUID</td>
<td>Prescription drug monitoring, evaluation of drugs present by LC-MS/MS, using oral fluid, reported as a comparison to an estimated steady-state range, per date of service including all drug compounds and metabolites</td>
</tr>
<tr>
<td>0012U</td>
<td>GERMLN DO GENE REARGMT DETCJ</td>
<td>Germline disorders, gene rearrangement detection by whole genome next-generation sequencing, DNA, whole blood, report of specific gene rearrangement(s)</td>
</tr>
<tr>
<td>0013U</td>
<td>ONC SLD ORG NEO GENE REARGMT</td>
<td>Oncology (solid organ neoplasia), gene rearrangement detection by whole genome next-generation sequencing, DNA, fresh or frozen tissue or cells, report of specific gene rearrangement(s)</td>
</tr>
<tr>
<td>0014U</td>
<td>HEM HMTLMF NEO GENE REARGMT</td>
<td>Hematology (hematolymphoid neoplasia), gene rearrangement detection by whole genome next-generation sequencing, DNA, whole blood or bone marrow, report of specific gene rearrangement(s)</td>
</tr>
<tr>
<td>0015U</td>
<td>RX METAB ADVRS RX RXN DNA</td>
<td>Drug metabolism (adverse drug reactions), DNA, 22 drug metabolism and transporter genes, real-time PCR, blood or buccal swab, genotype and metabolizer status for therapeutic decision support</td>
</tr>
<tr>
<td>0016U</td>
<td>ONC HMTLMF NEO RNA BCR/ABL1</td>
<td>Oncology (hematolymphoid neoplasia), RNA, BCR/ABL1 major and minor breakpoint fusion transcripts, quantitative PCR amplification, blood or bone marrow, report of fusion not detected or detected with quantitation</td>
</tr>
<tr>
<td>0017U</td>
<td>ONC HMTLMF NEO JAK2 MUT DNA</td>
<td>Oncology (hematolymphoid neoplasia), JAK2 mutation, DNA, PCR amplification of exons 12-14 and sequence analysis, blood or bone marrow, report of JAK2 mutation not detected or detected</td>
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</table>

The short descriptors for the technical and professional components of the following codes were not displaying properly on the MPFS and did not match the HCPCS file. The global procedure accurately reflects the short descriptor from the HCPCS file. This display issue has been corrected and the short descriptors for the technical and professional components now read as follows on the MPFS:

- 92978 – TC  Endoluminal ivus oct c 1st
- 92978 – 26  Endoluminal ivus oct c 1st
- 92979 – TC  Endoluminal ivus oct c ea
- 92979 – 26  Endoluminal ivus oct c ea
- G0202 – TC  Scr mammo bi incl cad
- G0202 – 26  Scr mammo bi incl cad
- G0204 – TC  Dx mammo incl cad bi
Providers should be aware that MACs do not need to search their files to either retract payment for claims already paid or to retroactively pay claims. However, MACs will adjust claims that you bring to their attention.

**ADDITIONAL INFORMATION**


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

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Revision to Publication 100.06, Chapter 3, Medicare Overpayment Manual, Section 200, Limitation on Recoupment

Revised: This article was revised on September 15, 2017, to reflect an updated Change Request that corrected format errors in the manual instructions. In the article, the CR release date, transmittal number, and 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 provided to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 9815 updates the Centers for Medicare & Medicaid Services (CMS) “Medicare Financial Management Manual,” Chapter 3, Sections 200-200.2.1, Limitation on Recoupment Overpayments. CR9815 is the first of four CRs that are forthcoming and incorporated into this manual. Make sure your billing staffs are aware of these updates that relate to the limitation on recovery of certain overpayments.

Background

Section 1893(f)(2)(a) of the Social Security Act and the provision in the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) prohibits recouping Medicare overpayments from a provider or supplier that seeks a reconsideration from a Qualified Independent Contractor (QIC). This provision changed how interest is to be paid to a provider or supplier whose overpayment is reversed at subsequent...
administrative or judicial levels of appeal. The final rule defines the overpayments to which the limitation applies, how the limitation works in concert with the appeals process, and the change in our obligation to pay interest to a provider or supplier whose appeal is successful at levels above the QIC. This section also limits recoupment of Medicare overpayments when a provider or supplier seeks a redetermination until a redetermination decision is rendered.

The MAC will cease recoupment or not begin recoupment when the MAC receives a valid redetermination or reconsideration request timely on an overpayment subject to these limitations. The provider has until the appeal deadline to file an appeal (refer to the “Medicare Claims Processing Manual,” Chapter 29 at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c29.pdf). If a provider wants to delay recoupment, it must submit the redetermination appeal request within 30 days of the demand letter date. To continue the delayed recoupment, the provider will have 60 days from the redetermination decision to submit a reconsideration request. If the request is received before the appeal deadline but after recoupment has started, the MAC will stop the recoupment. The MAC shall not refund any monies collected back to the provider, unless otherwise directed by the Centers for Medicare & Medicaid Services (CMS). The MAC will be accountable to ensure the debts continue to age and accrue interest until the debt is paid in full.

After the first two levels of appeal are completed, the MAC shall resume recoupment and normal debt collection processes. Whether or not the provider subsequently appeals the overpayment to the Administrative Law Judge (ALJ), or subsequent levels (Department Appeals Board (DAB), or Federal court), the MAC shall initiate recoupment at 100% until the debt is satisfied in full, unless an Extended Repayment Schedule (ERS) is established. If the debt was referred to Treasury and the provider files for an appeal, the MAC shall recall the debt from Treasury while in an appeal status. If the appeal decision is unfavorable to the provider, any outstanding debt will be referred back to Treasury, unless an approved Extended Repayment Schedule (ERS) is established or the provider pays the debt in full.

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 to Rural Health Clinic (RHC) All Inclusive Rate (AIR) Payment Limit for Calendar Year (CY) 2018

MLN Matters Number: MM10333       Related Change Request (CR) Number: 10333
Related CR Release Date: November 9, 2017       Effective Date: January 1, 2018
Related CR Transmittal Number: R3919CP       Implementation Date: January 2, 2018

PROVIDER TYPE AFFECTED

This MLN Matters Article is intended for Rural Health Clinics (RHCs) billing Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

WHAT YOU NEED TO KNOW

The RHC payment limit per visit for Calendar Year (CY) 2018 is $83.45 effective January 1, 2018, through December 31, 2018. The CY 2018 RHC payment limit reflects a 1.4 percent increase above the CY 2017 payment limit of $82.30.

BACKGROUND

Medicare Part B payment to RHCs is 80 percent of the All-Inclusive Rate (AIR), subject to a payment limit for medically necessary medical, and qualified preventive face-to-face visits with a practitioner and a Medicare beneficiary for RHC services. As authorized by Section 1833(f) of the Social Security Act (the Act), the payment limits for a subsequent year shall be increased in accordance with the rate of increase in the Medicare Economic Index (MEI). Based on historical data through second quarter 2017, the CY 2018 MEI is 1.4 percent. The RHC payment limit per visit for CY 2018 is $83.45 effective January 1, 2018, through December 31, 2018. The CY 2018 RHC payment limit reflects a 1.4 percent increase above the CY 2017 payment limit of $82.30.

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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