### COMMUNIQUE

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Update to Chapter 15, Pub. 100-08, Certification Statement Policies

MLN Matters Number: MM10845 Revised
Related Change Request (CR) Number: 10845
Related CR Release Date: September 5, 2018
Effective Date: October 1, 2018
Related CR Transmittal Number: R824PI
Implementation Date: October 1, 2018

Note: This article was revised on September 5, 2018, to reflect a revised CR10845 issued the same day. The revised CR did not change any substantive information in the article. Within the article, there is a revised transmittal number, CR release date, and Web address for accessing the CR. All other information remains the same.

PROVIDER TYPE AFFECTED

This MLN Matters® Article is intended for physicians and providers, including Home Health Agencies (HHAs), submitting certain Internet-based applications to Medicare Administrative Contractors (MACs) via the Provider Enrollment Chain and Ownership System (PECOS).

PROVIDER ACTION NEEDED

Change Request (CR) 10845 makes modifications to certain provider enrollment certification statement policies. Specifically, you may upload provider enrollment certification statements using PECOS functionality.

CR10845 makes these modifications via changes to the Medicare Program Integrity Manual, Chapter 15, Section 15.5.14.4. The revised manual section is attached to CR10845. Make sure your billing staff are aware of these changes.

BACKGROUND

PECOS functionality provides an option to upload paper certification statements. CR10845 aligns the provider enrollment certification statement policy with this PECOS functionality.

CR10845 and the accompanying revised portion of the manual requires your MACs to:
- Accept all handwritten signatures for paper forms CMS-855, CMS-20134, CMS-460 and CMS-588 application submissions
- Accept e-signed or uploaded signatures for web-based application submissions. MACs will no longer accept paper certification statements for web-based application submissions (CMS-855 and CMS-20134 only) via mail. If the provider chooses to
submit its certification statement via paper rather than through e-signature, it shall do so via PECOS upload functionality
- Not accept stamped signatures
- Accept uploaded, faxed and emailed paper certification statements in response to a development request.
- Begin processing ALL applications upon receipt and shall develop for missing certification statements and all other missing information, including application fee, upon review
- Consider the web-based application date of receipt as the date of the web-based application submission

Note: There is no legislative or regulatory impact associated with CR10845.

ADDITIONAL INFORMATION


If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

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Update to Medicare Deductible, Coinsurance and Premium Rates for 2019

MLN Matters Number: MM11025
Related Change Request (CR) Number: CR 11025
Related CR Release Date: November 2, 2018
Effective Date: January 1, 2019
Related CR Transmittal Number: R119GI
Implementation Date: January 7, 2019

PROVIDER TYPE AFFECTED

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

PROVIDER ACTION NEEDED

CR 11025 provides instruction for MACs to update the claims processing system with the new Calendar Year (CY) 2019 Medicare deductible, coinsurance, and premium rates. Make sure your billing staffs are aware of these changes.

BACKGROUND

Beneficiaries who use covered Part A services may be subject to deductible and coinsurance requirements. A beneficiary is responsible for an inpatient hospital deductible amount, which is deducted from the amount payable by the Medicare program to the hospital, for inpatient hospital services furnished in a spell of illness. When a beneficiary receives such services for more than 60 days during a spell of illness, he or she is responsible for a coinsurance amount equal to one-fourth of the inpatient hospital deductible per-day for the 61st - 90th day spent in the hospital.

An individual has 60 lifetime reserve days of coverage, which they may elect to use after the 90th day in a spell of illness. The coinsurance amount for these days is equal to one-half of the inpatient hospital deductible. A beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible per day for the 21st through the 100th day of Skilled Nursing Facility (SNF) services furnished during a spell of illness.

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

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

2019 PART A - HOSPITAL INSURANCE (HI)

- **Part A Deductible**: $1,364.00
- **Part A Coinsurance**
  - $341.00 a day for 61st-90th day
  - $682.00 a day for 91st-150th day (lifetime reserve days)
  - $170.50 a day for 21st-100th day (SNF) coinsurance
- **Base Premium (BP)**: $437.00 a month
- **BP with 10% surcharge**: $480.70 a month
- **BP with 45% reduction**: $240.00 a month (for those who have 30-39 quarters of coverage)
- **BP with 45% reduction and 10% surcharge**: $264.00 a month

2019 PART B - SUPPLEMENTARY MEDICAL INSURANCE (SMI)

- **Standard Premium**: $135.50 a month
- **Deductible**: $185.00 a year
- **Pro Rata Data Amount**:
  - $133.57 1st month
  - $51.43 2nd month
- **Coinsurance**: 20 percent

Note that the Part B premium may vary based on beneficiary income above certain levels. CR11025 has additional information showing Part B premium rates as adjusted for income.

**ADDITIONAL INFORMATION**

and Payment Limitations), Sections 10.3 (Basis for Determining the Part A Coinsurance Amounts), 20.2 (Part B Annual Deductible), and 20.6 (Part B Premium) is attached to that CR.

If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

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MLN Matters Number: MM10981
Related Change Request (CR) Number: 10981
Related CR Release Date: October 5, 2018
Effective Date: January 1, 2019
Related CR Transmittal Number: R4143CP
Implementation Date: January 7, 2019

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

CR 10981 makes changes to HCPCS codes and Medicare Physician Fee Schedule (MPFS) designations that will be used to revise Common Working File (CWF) edits to allow 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 (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c06.pdf). Make sure your billing staff are aware of these changes.

BACKGROUND

The 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 SNF CB to be paid separately. Barring any delay in the MPFS, Medicare will provide the new code files CWF by November 1, 2018.

By the first week in December 2018, Medicare will post the new code files at https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/index.html. The files will be applicable to claims with dates of service on or after January 1, 2019, through December 31, 2019. It is important and necessary for the provider 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


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

MLN Matters Number: MM10857
Related Change Request (CR) Number: 10857
Related CR Release Date: August 24, 2018
Effective Date: January 1, 2019
Related CR Transmittal Number: R4116CP
Implementation Date: No later than January 7, 2019

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 10857 directs MACs to obtain the most recent Healthcare Provider Taxonomy Codes (HPTCs) code set and use it to update their internal HPTC tables and/or reference files. Make sure your billing staffs are aware of these updates.

BACKGROUND

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

The Health Insurance Portability and Accountability Act (HIPAA) requires that covered entities comply with the requirements in the electronic transaction format implementation guides adopted as national standards. 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 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.

Although the NUCC generally posts their updates on the Washington Publishing Company (WPC) website 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, revisions made since the last release are identified.

**Note:** MACs having the capability to do so will update the HPTC table, such that claims received on and after October 1, 2018, will be validated against the October 1, 2018, HPTC set. MACs lacking the capability to implement the updated October 2018 HPTC set, for claims received on or after October 1, 2018, will implement the October 2018 HPTC update as soon as possible after October 1, 2018, but no later than January 7, 2019.

**ADDITIONAL INFORMATION**


If you have questions, your MACs may have more information. Find their website at [http://go.cms.gov/MAC-website-list](http://go.cms.gov/MAC-website-list).

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New Waived Tests

MLN Matters Number: MM10958  Revised Related Change Request (CR) Number: 10958
Related CR Release Date: November 15, 2018  Effective Date: January 1, 2019
Related CR Transmittal Number: R4169CP  Implementation Date: January 7, 2019

Note: This was revised on November 16, 2018, to reflect a revised CR10958 issued on November 15. The CR was revised to correct the description of CPT code 81003QW. Also, the CR release date, transmittal number, and the Web address for accessing the CR were revised. All other information remains the same.

PROVIDER TYPE AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 10958 informs MACs of new Clinical Laboratory Improvement Amendments of 1988 (CLIA) waived tests approved by the Food and Drug Administration (FDA). Since these tests are marketed immediately after approval, the Centers for Medicare & Medicaid Services (CMS) must notify its MACs of the new tests so they can accurately process claims. Make sure your billing staffs are aware of these CLIA-related changes.

BACKGROUND

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

Listed below are the latest tests approved by the FDA as waived tests under CLIA. The Current Procedural Terminology (CPT) codes for the following new tests must have the modifier QW to be recognized as a waived test. However, the tests mentioned on the first page of the list attached to CR10958 (namely, CPT codes 81002, 81025, 82270, 82272, 82962, 83026, 84830, 85013, and 85651) do not require a QW modifier to be recognized as a waived test.

The CPT code, effective date and description for the latest tests approved by the FDA as waived tests under CLIA are as follows:
• 80305QW, March 8, 2018, Express Diagnostics International DrugCheck Multi Panel Drug Test Cups
• 80305QW, March 8, 2018, Express Diagnostics International DrugCheck Multi Panel Drug Test DipCards
• 87651QW, May 2, 2018, Alere i Instrument (Alere i Strep A 2)
• 82274QW, G0328QW, May 4, 2018, McKesson Consult Immunochemical Fecal Occult Blood Test
• 80305QW, May 15, 2018, MyDrugTestCups.com, MyDrugTest Multi-Drug Urine Test Cup
• 80305QW, May 15, 2018, MyDrugTestCups.com, MyDrugTest Multi-Drug Urine Test Dip Card
• 80305QW, May 16, 2018, Confirm BioSciences, Smart Choice Multi Panel DOA Test Cup
• 80305QW, May 16, 2018, Confirm BioSciences, Smart Choice Multi Panel DOA Test Dip Card;
• 82044QW, 82570QW, June 14, 2018, BTNX, Inc., Rapid Response U120S Urine Analyzer Test System (BTNX, Inc. Rapid Response Urinalysis Reagent Strips (Microablumin/Creatinine))
• 80305QW, July 16, 2018, Express Diagnostics International DrugCheck Multi Panel Drug Test Cups
• 80305QW, July 16, 2018, Express Diagnostics International DrugCheck Multi Panel Drug Test Dip Card
• 81003QW, July 27, 2018, BTNX, Inc., Rapid Response U120S Urine Analyzer Test System
• 80305QW, July 30, 2018, Hangzhou Clongene Biotech Co., ltd. Clungene Multi-Drug Test Easy Cup
• 80305QW, July 30, 2018, Hangzhou Clongene Biotech Co., ltd. Clungene Multi-Drug Test Dip Card
• 87502QW, August 10, 2018, Mesa Biotech Accula (Accula Flu A/Flu B test)
• 87502QW, August 10, 2018, Sekisui Inc., Silaris Dock (Silaris Influenza A&B Test)

Note: MACs will not search their files to either retract payment or retroactively pay claims. However, they should adjust claims that you bring to their attention.

ADDITIONAL INFORMATION


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Next Generation Accountable Care Organization (NGACO) Model Post Discharge Home Visit HCPCS

MLN Matters Number: MM10907
Related Change Request (CR) Number: 10907
Related CR Release Date: October 26, 2018
Effective Date: January 1, 2019
Related CR Transmittal Number: R213DEMO
Implementation Date: April 1, 2019

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

CR10907 makes modifications to the operations of a current benefit enhancement offered by the NGACO Model. Claims for Post Discharge Home Visit Waiver shall be processed for reimbursement and paid when they meet the appropriate payment requirements as outlined in CR1907. Make sure your billing staffs are aware of these changes.

BACKGROUND

The Social Security Act (the Act) (Section 1115A; https://www.ssa.gov/OP_Home/ssact/title11/1115A.htm) added by the Affordable Care Act (Section 3021; 42 U.S.C. 1315a; https://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf) authorizes the Centers for Medicare & Medicaid Services (CMS) to test innovative health care payment and service delivery models that have the potential to lower Medicare, Medicaid, and the Child Health Insurance Program (CHIP) spending while maintaining or improving the quality of beneficiaries’ care.

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

In order to emphasize high-value services and support the ability of ACOs to manage the care of beneficiaries, CMS is issuing the authority under Section 1115A of the Act (added by Section 3021 of the Affordable Care Act) to conditionally waive certain Medicare payment requirements as part of the NGACO Model. An ACO may choose not to implement all or any of these benefit...
enhancements. Applicants will be asked questions specific to their proposed implementation of these benefit enhancements, but acceptance into the NGACO Model is not contingent upon an ACO implementing any particular benefit enhancement.

Participants in the NGACO Model are required to provide implementation information to CMS, which, upon approval, will enable the ACO’s use of the optional benefit enhancements. Each optional benefit enhancement will have such an “implementation plan” requiring, for example:

1. Descriptions of the ACO’s planned strategic use of the benefit enhancement
2. Self-monitoring plans to demonstrate meaningful efforts to prevent unintended consequences
3. Documented authorization by the governing body to participate in the benefit enhancement

Note: RTI International is the specialty contractor creating the Next Generation ACO provider alignment files.

For dates of service of April 1, 2019, and later, MACs will allow NGACO, including the Vermont (VT) ACO, post discharge home visit claims for licensed clinicians under the general supervision of an NGACO or VT ACO provider when this benefit enhancement is elected by the provider for the Date of Service (DOS) on the claims and only when the claim contains the following HCPCS codes: G0064; G0065; G0066; G0067; G0068; G0069; G0070; G0071; G0072; G0073; G0074; and G0075. This applies to Type of Bill (TOB) 85X, Rev Codes 96X; 97X; and 98X.

The payment rate for these HCPCS codes will be in the annual Medicare Physician Fee Schedule (MPFS). Medicare will reimburse Critical Access Hospital Method II providers billing on TOB 85X with Revenue codes 96X, 97X, and 98X based on the lesser of the billed charge or the MPFS rate.

Note that MACs will reject or return as unprocessable if a claim or if separate claims with the same DOS contains a Post Discharge Home Visit HCPCS code and a Care Management Home Visit HCPCS code.

**ADDITIONAL INFORMATION**


If you have questions, your MACs may have more information. Find their website at [http://go.cms.gov/MAC-website-list](http://go.cms.gov/MAC-website-list).
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Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes – October 2018 Update

MLN Matters Number: MM10834 Revised  Related Change Request (CR) Number: 10834

Related CR Release Date: September 13, 2018  Effective Date: July 12, 2018, for Q5108; October 1, 2018, for Q5110

Related CR Transmittal Number: R4134CP  Implementation Date: October 1, 2018

Note: This article was revised on September 20, 2018, to delete the note that stated MACs should hold claims for Q5108 and Q5110 until CR10834 is implemented, since that is no longer a requirement. All other information remains the same.

PROVIDER TYPES AFFECTED

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

WHAT YOU NEED TO KNOW

The HCPCS code set is updated on a quarterly basis. CR 10834 informs MACs of the October 2018 addition of new HCPCS codes, Q5108 and Q5110. The codes are payable by Medicare effective with dates of service on or after July 12, 2018, for Q5108 and effective with dates of service on or after October 1, 2018, for Q5110.

The short descriptor for Q5108 is Injection, fulphila, and the long descriptor is Injection, pegfilgrastim-jmdb, biosimilar, (fulphila), 0.5 mg. The Type of Service (TOS) Codes for Q5108 are 1, P.

The short descriptor for Q5110 is Nivestym, and the long descriptor is Injection, filgrastim-aafi, biosimilar, (nivestym), 1 microgram. The TOS Codes for Q5110 are 1, P. The Medicare Physician Fee Schedule Database (MPFSDB) Status Indicator for both codes is E.

ADDITIONAL INFORMATION


If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.
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Quarterly Influenza Virus Vaccine Code Update - January 2019

MLN Matters Number: MM10871 Revised
Related Change Request (CR) Number: 10871
Related CR Release Date: September 5, 2018
Effective Date: January 1, 2019
Related CR Transmittal Number: R4127CP
Implementation Date: January 7, 2019

Note: This article was revised on September 6, 2018 to reflect the revised CR10871 issued on September 5. In the article, the CR release date, transmittal number, and the Web address for accessing CR10871 are revised. All other information remains the same.

PROVIDER TYPE AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 10871 provides instructions for payment and edits for Medicare’s Common Working File (CWF) and Fiscal Intermediary Shared System (FISS) to include and update new or existing influenza virus vaccine codes. This update includes one new influenza virus vaccine code: 90689. Please make certain your billing staffs are aware of this update.

BACKGROUND

Effective for claims processed with Dates of Service (DOS) on or after January 1, 2019, influenza virus vaccine code 90689 (Influenza virus vaccine quadrivalent (IIV4), inactivated, adjuvanted, preservative free, 0.25mL dosage, for intramuscular use) will be payable by Medicare. The short descriptor is VACC IIV4 NO PRSRV 0.25ML IM. This new code will be included on the 2019 Medicare Physician Fee Schedule Database file update and the annual Healthcare Common Procedure Coding System (HCPCS) update.

Except as noted below, MACs will use the Centers for Medicare & Medicaid Services (CMS) Seasonal Influenza Vaccines Pricing webpage: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html to obtain the payment rate for 90689. The new influenza virus vaccine code 90689 is not retroactive to August 1, 2018. No claims should be accepted for influenza virus vaccine code 90689 between the DOS August 1, 2018, and December 31, 2018. If claims are received in January 2019 with code 90689 for DOS between August 1, 2018, and December 31, 2018, MACs will follow their normal
course of action for codes billed prior to their effective date.

**Payment Basis for Institutional Claims**

MACs will pay for influenza virus vaccine code 90689 with a Type of Service (TOS) of V based on reasonable cost to:

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

MACs will pay for influenza virus vaccine code 90689 with a TOS of V based on the lower of the actual charge or 95 percent of the Average Wholesale Price (AWP), to:

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

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

**ADDITIONAL INFORMATION**


If you have questions, your MACs may have more information. Find their website at [http://go.cms.gov/MAC-website-list](http://go.cms.gov/MAC-website-list).

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Revision of SNF CB Edits for Ambulance Services Rendered to Beneficiaries in a Part A Skilled Nursing Facility Stay

MLN Matters Number: MM10955  Related Change Request (CR) Number: 10955
Related CR Release Date: November 2, 2018  Effective Date: April 1, 2019
Related CR Transmittal Number: R2176OTN  Implementation Date: April 1, 2019

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 10955 revises the SNF Consolidated Billing (CB) edits to ensure accurate payment of ambulance services rendered to beneficiaries in a covered Part A SNF stay. CR10955 does not contain any new policy and only further revises existing claim system edits to ensure accurate payment of ambulance transports that are included in or excluded from SNF CB. Make sure your billing staffs are aware of these revisions.

BACKGROUND

CR6700 (Transmittal 595, issued Nov. 6, 2009) implemented certain claim system edits intended to deny claims for Part B ambulance services that should be bundled under SNF CB rules. In 2017, the Inspector General conducted a follow-up audit of Medicare payments for Part B ambulance services furnished to beneficiaries in a Part A covered SNF stay. The Inspector General found that the current claim system editing is insufficient to prevent overpayments to ambulance providers and suppliers for transports that should have been bundled under SNF CB.

Generally, ambulance services are bundled when furnished to a beneficiary who has the status of a SNF “resident” for CB purposes. This general principle is one that the SNF PPS basically inherited from the Inpatient Prospective Payment System (IPPS), which has a similar rule for hospital bundling of ambulance transports.

One exception to this general SNF CB rule on ambulance services is when such transports are furnished in connection with the receipt of offsite Part B dialysis services. Even though the receipt of offsite dialysis doesn’t affect the beneficiary’s SNF “resident” status, dialysis-related
ambulance services are nevertheless excluded from CB per Section 103 of the Balanced Budget Refinement Act (BBRA) of 1999, which amended Section 1888(e)(2)(A)(iii)(I) of the Social Security Act (the Act) specifically to carve out dialysis-related ambulance transports from the SNF CB bundle.

Under the general rule set forth above, the initial ambulance trip that first brings a beneficiary to the SNF is not subject to CB because the beneficiary has not yet been admitted to the SNF as a resident at that point. Similarly, an ambulance transport that conveys a beneficiary from the SNF at the end of a stay is not subject to CB when it occurs in connection with one of the following events specified in subclauses (i) through (iv) of 42 CFR 411.15(p)(3) as ending the beneficiary’s SNF “resident” status:

- A trip for an inpatient admission to a Medicare-participating hospital or Critical Access Hospital (CAH)
  - Note: See the discussion below on “Transfers Between Two SNFs,” regarding an ambulance trip that conveys a beneficiary from the discharging SNF for a same-day inpatient admission to another SNF.
- A trip to the beneficiary’s home to receive services from a Medicare participating home health agency under a plan of care
- A trip to a Medicare participating hospital or CAH for the specific purpose of receiving emergency services or certain other exceptionally intensive outpatient services (Magnetic Resonance Imaging (MRI), Computed Tomography (CT) scans, cardiac catheterizations, ambulatory surgery that requires the use of an operating room or comparable facilities, and so forth) that the Centers for Medicare & Medicaid Services (CMS) has designated as being beyond the general scope of SNF comprehensive care plans
- A formal discharge (or other departure) from the SNF, unless the beneficiary returns to that or another SNF before the following midnight.

Transfers Between Two SNFs: When a beneficiary is discharged from a covered stay in SNF 1 and then transfers to SNF 2 before the following midnight, that day is a covered Part A day for the beneficiary, to which CB applies. Accordingly, the ambulance trip that conveys the beneficiary would be bundled back to SNF 1 since, under Section 411.15(p)(3)(i), the beneficiary would continue to be considered a “resident” of SNF 1 (for CB purposes) up until the actual point of admission to SNF 2. By contrast, when an individual leaves an SNF via ambulance and does not return to that or another SNF before the following midnight, the day is not a covered Part A day. Accordingly, CB would not apply to that ambulance trip.

Roundtrip to Physician’s Office: Confusion sometimes arises over the issue of an ambulance roundtrip that transports a SNF resident to a physician’s office, since this is a type of destination that the Part B ambulance benefit doesn’t normally cover. It’s important to note that the regulations at 42 CFR 409.27(c) on coverage of ambulance transports under the SNF benefit provide that such transports must meet the general medical necessity requirement, described in 42 CFR 410.40(d)(1), that applies under the separate Part B ambulance benefit (that is, the beneficiary’s condition must be such that transportation by any means other than ambulance would be medically contraindicated). However, while the Part A SNF regulations incorporate this
general requirement, they don’t incorporate the more detailed coverage restrictions that apply to the Part B ambulance benefit—such as the limitation of coverage under Part B to include only those trips that transport a beneficiary to certain specified destinations (42 CFR 410.40(e)). Thus, if a SNF’s Part A resident requires transportation to a physician’s office and meets the general medical necessity requirement for transport by ambulance (using any other means of transport would be medically contraindicated), then the ambulance roundtrip is subject to CB and included in the SNF bundle.

**Non-ambulance Forms of Transport:** In contrast to the ambulance coverage discussed above, Medicare simply doesn’t provide any coverage at all – under Part A or B – for any non-ambulance forms of transportation, such as ambulette, wheelchair van, or litter van. Thus, in those situations where it’s medically feasible to convey a SNF resident by some means other than an ambulance, the transportation of such a resident (regardless of the type of vehicle used) would neither be included within the SNF bundle nor coverable under the separate Part B ambulance benefit but would simply be altogether noncovered by Medicare. As with any other noncovered service for which a resident may be financially liable, the SNF is required under the regulations at 42 CFR 483.10(g)(18) to, “… inform each resident before, or at the time of admission, and periodically during the resident’s stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare and/or Medicaid, or by the facility’s per diem rate.”

**ADDITIONAL INFORMATION**


If you have questions, your MACs may have more information. Find their website at [http://go.cms.gov/MAC-website-list](http://go.cms.gov/MAC-website-list).

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L34592 VERTEBROPLASTY (PERCUTANEOUS) & VERTEBRAL AUGMENTATION INCLUDING CAVITY CREATION, KYPHOPLASTY MASS ADJUSTMENT

WPS GHA will be implementing a mass adjustment of previously denied claims for kyphoplasty (CPT codes 22510-22515) for Place of Service (POS) 11 (office setting) for dates of service January 1, 2017, to September 13, 2018. We believe that best practice is for the physician providing the service to document the use of x-ray guidance, either fluoroscopy or CT scan in all settings, including an office setting. The edit that had been in place is no longer operational. Affected providers do not need to take any action; the provider’s remittance advice will serve as notification that the mass adjustment has occurred. We anticipate all adjustments will be completed by October 19, 2018.

This pertains to Local Coverage Determination (LCD) Vertebroplasty (Percutaneous) & Vertebral Augmentation including cavity creation, L34592 (https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=34592). The policy will be clarified to reflect these documentation recommendations with the next available update which is planned for November 1, 2018.

It is important to point out that claims can deny for many reasons. All services must be reasonable and necessary, documents must be properly signed, and other documentation requirements must be met. If you need further information regarding this notification or if you find that your claim(s) meeting this criteria haven’t been appropriately adjusted by October 31, 2018, please feel free to contact Customer Service at:

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

MEDICARE BENEFICIARIES AND HOSPICE BENEFITS

Medicare beneficiaries who have a terminal illness with a life expectancy of six months or less and who are entitled to Hospital Insurance (Part A) have the option of electing hospice benefits in lieu of standard Medicare coverage for treatment and management of their terminal condition. The hospice provisions only cover care provided by a Medicare-certified hospice. The coverage is available for two 90-day periods and an unlimited number of 60-day periods during the hospice patient's lifetime. The coverage of the hospice benefit is discussed in the Centers for Medicare & Medicaid Services (CMS) Internet-Only Manual (IOM) Publication 100-04, Chapter 11. You can access this publication on the following CMS website: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c11.pdf

When the patient elects hospice care, the beneficiary waives all rights to Medicare Part B payments for services related to the treatment and management of the terminal illness during any period the beneficiary's hospice benefit is in force, except for the professional services of an "attending physician." Payment for all services related to the patient's terminal illness is made through the hospice under Medicare Part A benefits. Services not related to the patient's terminal illness are made under normal Medicare payment guidelines.
For more information concerning the reimbursement of an attending physician please see our article **Attending Physician for Patients who Elect Hospice Coverage:** [https://www.wpsgha.com/wps/portal/mac/site/fees-and-reimbursements/guides-and-resources/hospice-attending-phys](https://www.wpsgha.com/wps/portal/mac/site/fees-and-reimbursements/guides-and-resources/hospice-attending-phys)

For more information concerning modifiers GV and GW, please go to the following resources:


## MEDICARE BENEFICIARIES IN 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), ([http://www.gpo.gov/fdsys/pkg/CFR-2012-title42-vol2/pdf/CFR-2012-title42-vol2-sec411-4.pdf](http://www.gpo.gov/fdsys/pkg/CFR-2012-title42-vol2/pdf/CFR-2012-title42-vol2-sec411-4.pdf)) respectively.

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](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.

NEW RESOURCE: INTRAARTICULAR KNEE INJECTIONS OF HYALURONAN BILLING GUIDELINES


The article supports purified natural hyaluronates, which have been approved by the FDA for the treatment of symptomatic osteoarthritis of the knee in patients who have failed to respond adequately over a three-month period to a past history of treatment with analgesics and conservative nonpharmacologic therapy and a radiological exam to support the diagnosis of osteoarthritis. The future coverage article will be effective December 1, 2018, on the Medicare Coverage Database. A lapse in coverage will not occur. For more information, see the new resource on our website: https://www.wpsgha.com/wps/portal/mac/site/policies/guides-and-resources/intraarticular-knee-injections-hyaluronan-billing-guidelines
Changes to the Laboratory National Coverage Determination (NCD) Edit Software for January 2019

<table>
<thead>
<tr>
<th>MLN Matters Number: MM10941</th>
<th>Related Change Request (CR) Number: 10941</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related CR Release Date: September 28, 2018</td>
<td>Effective Date: January 1, 2019</td>
</tr>
<tr>
<td>Related CR Transmittal Number: R4139CP</td>
<td>Implementation Date: January 7, 2019</td>
</tr>
</tbody>
</table>

### 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

This MLN Matters® Article is based on Change Request (CR) 10941 which informs MACs about the changes that will be included in the January 2019 quarterly release of the edit module for clinical diagnostic laboratory services. Make sure your billing staffs are aware of these changes.

### BACKGROUND

CR 10941 announces the changes that will be included in the January 2019 quarterly release of the edit module for clinical diagnostic laboratory services. The National Coverage Determinations (NCDs) for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee, and the final rule was published on November 23, 2001. Nationally uniform software was developed and incorporated in the Medicare shared systems so that laboratory claims subject to one of the 23 NCDs (Publication 100-03, Sections 190.12 - 190.34) were processed uniformly throughout the nation, effective April 1, 2003.

In accordance with 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 10941 communicates requirements to MACs notifying them of changes to the laboratory edit module to update it for changes in laboratory NCD code lists for January 2019.
Please access the following link for the NCD spreadsheets included with CR10941

**Note:** 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**

The official instruction, CR10941, issued to your MAC regarding this change is available at

If you have questions, your MACs may have more information. Find their website at

**DOCUMENT HISTORY**

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
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<tbody>
<tr>
<td>September 28, 2018</td>
<td>Initial article released.</td>
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ub04@healthforum.com

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

MLN Matters Number: MM10859 Revised
Related CR Number: 10859
Related CR Release Date: November 8, 2018
Effective Date: January 1, 2019
Related CR Transmittal Number: R2200OTN
Implementation Date: January 7, 2019, shared edits. September 28, 2018, local edits (See following note box for further implementation information.)

Note: This article was revised on November 9, 2018, to reflect a revised CR10859 issued on November 8. The CR was revised to (1) add ICD-10 dx H35.52 and remove H35.53 from NCD80.11, (2) remove ICD-10 dx D61.1 from the NCD110.21 non-covered list, and (3) correct NCD220.6.17 spreadsheet dx tab to align with requirements by removing ICD-10 dx C4A.12 and adding C4A.21. In addition, the correction revises business requirements 10859.1.1.1.1 (NCD80.11) and 10859.2 (NCD110.21) of the CR as well as the implementation date. The edits included in NCD80.11 and NCD110.21 will be implemented 30 days after the issuance of the revised CR. Also, MCS, which processes professional claims, to implement addition of ICD-10 H35.52, removal of ICD-10 H35.53 from NCD80.11 April 1, 2019. FISS & MCS to implement removal of ICD-10 D61.1 from NCD110.21 April 1, 2019. In the article, the CR release date, transmittal number, and the Web address for accessing the CR are revised. All other information remains the same.

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 10859 constitutes a maintenance update of International Classification of Diseases, Tenth Revision (ICD-10) conversions and other coding updates specific to national coverage determinations (NCDs). These NCD coding changes are the result of newly available codes, coding revisions to NCDs released separately, or coding feedback received. Please follow the link below for the NCD spreadsheets included with this CR:
Make sure that your billing staffs are aware of these changes.
BACKGROUND

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

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

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

CR10859 makes coding and clarifying adjustments to the following NCDs:

- NCD80.11 Vitrectomy
- NCD110.21 Erythropoiesis-Stimulating Agents (ESAs) for Cancer
- NCD190.3 Cytogenetics
- NCD190.11 Home Prothrombin Time (PT)/International Normalized Ratio (INR)
- NCD220.6.17 Positron Emission Tomography (PET) for Oncologic Conditions
- NCD270.3 Blood-Derived Products for Chronic, Non-Healing Wounds
- NCD260.1 Adult Liver Transplantation
- NCD110.18 Aprepitant for Chemo-Induced Emesis
- NCD270.1 Electrical Stimulation, Electromagnetic Therapy for Wounds

Note/Clarification: A/B MACs shall use default Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) messages where appropriate: Remittance Advice Remark Codes (RARC) N386 with Claim Adjustment Reason Code (CARC) 50, 96, and/or 119. See latest CAQH CORE update. When denying claims associated with the NCDs referenced in CR10859, except where otherwise indicated, A/B MACs shall use:
• Group Code PR (Patient Responsibility) assigning financial responsibility to the beneficiary (if a claim is received with occurrence code 32, or with occurrence code 32 and a GA modifier, indicating a signed Advance Beneficiary Notice (ABN) is on file).

• Group Code CO (Contractual Obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file). For modifier GZ, use CARC 50 and Medicare Summary Notice (MSN) 8.81 per instructions in CR 7228/TR 2148.

**ADDITIONAL INFORMATION**


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</tr>
<tr>
<td>September 11, 2018</td>
<td>The article was revised to reflect a revised CR10859 issued on September 11. The CR was revised to remove ICD-10 diagnosis code H25.13 from NCD80.11 spreadsheet that was retained in error. In the article, the CR release date, transmittal number, and the Web address for accessing the CR are revised. All other information remains the same.</td>
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<tr>
<td>Date of Change</td>
<td>Description</td>
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<tr>
<td>August 14, 2018</td>
<td>Initial article released.</td>
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Local Coverage Determinations (LCDs)

MLN Matters Number: MM10901 Related Change Request (CR) Number: 10901
Related CR Release Date: October 3, 2018 Effective Date: October 3, 2018
Related CR Transmittal Number: R829PI Implementation Date: January 8, 2019

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 10901 notifies MACs that, in accordance with Section 4009 of H.R. 34-21st Century Cures Act (Public Law No: 114-255), the Centers for Medicare & Medicaid Services (CMS) is updating the Medicare Program Integrity Manual with detailed changes to the Local Coverage Determination (LCD) process. You should ensure that your staffs are aware of these changes.

BACKGROUND

Through feedback received in the proposed Calendar Year (CY) 2018 Physician Fee Schedule (PFS) Rule (82 FR 33950), and through meetings and correspondence; stakeholders, including providers and healthcare associations, have provided CMS with valuable insight regarding modernization of the LCD process.

Most stakeholders acknowledged that the local coverage process is an important means to provide decisions related to the items and services that benefit Medicare’s beneficiaries and to ensure beneficiary access to life saving and medically necessary products and procedures. However, there is concern about the lack of local coverage process transparency, including notifying stakeholders of proposed revisions to, and drafting of, new LCDs.

Additional stakeholder concerns include: ineffective MAC processes for soliciting from, and providing to, stakeholders feedback on information provided during open public meetings, a lack of non-physician representation on Contractor Advisory Committees (CACs), and concerns that CAC meetings are not open to the public.

In CR10901, the revisions to the Medicare Program Integrity Manual, Chapter 13, CMS is revising instructions to MACs, reflecting policy process changes in response to the new statutory (21st century Cures Act) requirements and to the stakeholder comments. These
changes will help to increase transparency, clarity, consistency, reduce provider burden and enhance public relations while retaining the ability to be responsive to local clinical and coverage policy concerns.

The 2016 21st Century Cures Act included changes to the LCD process, adding language to 1862(l)(5)(D) of the Social Security Act (the Act) to describe the LCD process. Section 1862(l)(5)(D), of the Act requires each MAC that develops an LCD to make available on their Internet website on the Medicare website, at least 45 days before the effective date of such determination, the following information:

- Such determination in its entirety
- Where and when the proposed determination was first made public
- Hyperlinks to the proposed determination and a response to comments submitted to the MAC with respect to such proposed determination
- A summary of evidence that was considered by the contractor during the development of such determination and a list of the sources of such evidence
- An explanation of the rationale that supports such determination

CMS revamped the format of the manual so that it could be used as a roadmap to understand the steps of the local coverage process, which enable stakeholders to effectively engage in the process. This transparency also carries through to the reconsideration process, which is a process by which stakeholders can request a MAC take a second look at an existing decision using evidence that has developed since its first review.

The manual also sets forth consistent requirements for communication to providers and other stakeholders to occur at predictable milestones so anyone with an interest in the local policy can stay informed as the policy moves through the process.

**NEW LCD PROCESS**

The key parts of the New LCD Process are summarized as follows:

1. **The New LCD Process may begin with informal meetings in which interested parties within the MAC’s jurisdiction can discuss potential LCD requests. These educational meetings, which are not required, can be held either in person, using web-based technologies, or via teleconference, which allow discussions before requestors submit a formal request.**

2. **New LCD Requests**

   The New LCD Request Process is a mechanism through which interested parties within a MAC’s jurisdiction can request a new LCD. In this process, MACs will consider all new LCD requests from:

   - Beneficiaries residing or receiving care in the MAC’s jurisdiction
   - Health care professionals doing business in the MAC’s jurisdiction
Any interested party doing business in the MAC's jurisdiction

MACs will consider a New LCD Request to be a complete, formal request if the following requirements are met. The request:

- Is in writing and is sent to the MAC via e-mail, facsimile or written letter
- Clearly identifies the statutorily-defined Medicare benefit category to which the requestor believes the item or service applies
- Identifies the language that the requestor wants in an LCD
- Includes a justification supported by peer-reviewed evidence (full copies of published evidence must be included or the request is not valid)
- Addresses relevance, usefulness, clinical health outcomes, or the medical benefits of the item or service
- Fully explains the design, purpose, and/or method, as appropriate, of using the item or service for which the request is made.

Within 60 calendar days of the day they receive the request; MACs will review the materials and determine whether the request is complete or incomplete. If the request is complete, the MAC will follow the New LCD Process, as described in the revised manual. If, however, the process is incomplete, they will respond, in writing, to the requestor explaining why the request was incomplete.

3. Clinical Guidelines, Consensus Documents and Consultation

During an LCD’s development, MACs should (when applicable and available) supplement their research with clinical guidelines, consensus documents, or consultation by experts (recognized authorities in the field), medical associations or other health care professionals for an advisory opinion. They will summarize the opinions they receive as a result of this consultation with healthcare professional expert(s), professional societies, and others prior to the drafting of a proposed or final LCD, and include this information in the proposed or final LCD. Note that acceptance by individual health care providers, or even a limited group of health care providers, does not indicate general acceptance of the item or service by the medical community.

4. Publication of the Proposed LCD

The public announcement of a MAC’s proposed determination begins with the date the proposed LCD is published on the Medicare Coverage Database (MCD) at https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. Once the proposed LCD is published, MACs will provide a minimum of 45 calendar days for public comment, and will contact the CMS if they determine an extension to the comment period is needed.

These processes shall be used for all LCDs except in the following situations:

- Revised LCD Being Issued for Compelling Reasons.
• Revised LCD that Makes a Non-Substantive Correction - For example, typographical or grammatical errors that do not substantially change the LCD.
• Revised LCD that Makes a Non-discretionary Coverage Update - Contractors shall update LCDs to reflect changes in NCDs or when a conflict with national policy occurs, coverage provisions in interpretive manuals, and payment systems.
• Revise LCD to effectuate an Administrative Law Judge’s decision to nullify an existing LCD due to an LCD Challenge.

5. Contractor Advisory Committee (CAC)

The CAC is to be composed of healthcare professionals, beneficiary representatives, and representatives of medical organizations; and is used to supplement the MAC’s internal expertise, and to ensure an unbiased and contemporary consideration of “state of the art” technology and science. Additionally, all CAC meetings will be open to the public to attend and observe.

MACs will establish one CAC per state or one per jurisdiction with representation from each state, ensuring that each state has a full committee and the opportunity to discuss the quality of evidence used to make a determination.

The CAC’s purpose is to provide a formal mechanism for healthcare professionals to be informed of the evidence used in developing the LCD and promote communications between the MACs and the healthcare community. The CAC is advisory in nature, with the final decision on all issues resting with MACs.

6. Open Meeting

After the proposed LCD is made public, MACs will hold open meetings to discuss the review of the evidence and the rationale for the proposed LCD(s) with stakeholders in their jurisdiction. Interested parties (generally those that would be affected by the LCD, including providers, physicians, vendors, manufacturers, beneficiaries, caregivers, etc.) can make presentations of information related to the proposed LCDs. Members of the CAC may also attend these open meetings. MACs must notify the public about the dates and location for the open meeting. MACs have the option of setting up email listservs to announce this information or may use other education methods to adequately inform the public. The listserv or other method should clearly identify the location, dates and telephone/video/online conference information for the open meeting to ensure that this information is clearly distinguished from the information for the CAC meetings.

7. Publication of the Final Determination

After the close of the comment period and the required meetings and consultation, the final LCD and the Response to Comment (RTC) Article will be published on the MCD.

8. Response to Public Comments

MACs will respond to all comments received during the comment period of the proposed LCD by using the RTC article associated with the LCD. The RTC Article is published on the
start date of the notice period. The RTC Article will remain publicly available indefinitely on
the MCD or the MCD Archive.

9. Notice Period

The date the final LCD is published on the MCD, marks the beginning of the required notice
period of at least 45 calendar days before the LCD can take effect. If the notice period is not
extended by the MAC, the effective date of the LCD is the 46th calendar day after the notice
period began.

Full details of this new process are contained in the updated manual which is an attachment to
CR10901.

LCD RECONSIDERATION PROCESS

The LCD reconsideration process is a mechanism by which a beneficiary or stakeholder
(including a medical professional society or physician) in the MAC’s jurisdiction can request a
revision to an LCD. The LCD reconsideration process differs from an initial request for an LCD
in that it is available only for final effective LCDs. The whole LCD or any provision of the LCD
may be reconsidered. In addition, MACs have the discretion to revise or retire their LCDs at any
time on their own initiative. This process is summarized as follows:

1. MACs shall consider all LCD reconsideration requests from:
   - Beneficiaries residing or receiving care in a contractor’s jurisdiction
   - Providers doing business in a contractor’s jurisdiction
   - Any interested party doing business in a contractor’s jurisdiction

2. MACs should only accept reconsideration requests for LCDs published as an effective final.
   Requests shall not be accepted for other documents including:
   - National Coverage Determinations (NCDs);
   - Coverage provisions in interpretive manuals;
   - Proposed LCDs;
   - Template LCDs, unless or until they are adopted and in effect by the contractor;
   - Retired LCDs;
   - Individual claim determinations
   - Bulletins, articles, training materials; and
   - Any instance in which no LCD exists, i.e., requests for development of an LCD.

3. Process Requirements - The requestor shall submit a valid LCD reconsideration request to
   the appropriate MAC, following instructions on the MAC’s Web site. Within 60 calendar
days of the day the request is received, the MAC shall determine whether the request is
valid or invalid. If the request is invalid, the MAC will respond, in writing, to the requestor
explaining why the request was invalid. If the request is valid, the MAC will open the LCD
and follow the LCD process as outlined in the above for new LCDs or include the LCD on
the MAC’s waiting list. The MAC shall respond, in writing, to the requestor notifying the requestor of the acceptance, and if applicable, wait-listing, of the reconsideration request.

OTHER IMPORTANT CHANGES

Other key changes to the manual include the following:

- MACs shall finalize or retire all proposed LCDs within one calendar year of publication date on the MCD.
- Upon further notice from CMS, it will no longer be appropriate to routinely include Current Procedure Terminology (CPT) codes or International Classification of Diseases-Tenth Revision-Clinical Modification (ICD-10-CM) codes in the LCDs. All codes will be removed from LCDs and placed in billing & coding articles that are linked to the LCD.

ADDITIONAL INFORMATION


If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

As part of the CMS commitment to continuous improvement, CMS invites interested stakeholders to submit feedback on their experience with the revised LCD process. CMS will collect feedback via submissions to LCDmanual@cms.hhs.gov and consider additional revisions based on stakeholder feedback.

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Magnetic Resonance Imaging (MRI)

MLN Matters Number: MM10877  Related Change Request (CR) Number: 10877
Related CR Release Date: October 19, 2018  Effective Date: April 10, 2018
Related CR Transmittal Number: R4147CP and R208NCD  Implementation Date: December 10, 2018

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

CR10877 informs MACs and providers that effective for claims with dates of service on and after April 10, 2018, Medicare will allow for MRI coverage for beneficiaries with an Implanted Pacemaker (PM), Implantable Cardioverter Defibrillator (ICD), Cardiac Resynchronization Therapy Pacemaker (CRT-P), or Cardiac Resynchronization Therapy Defibrillator (CRT-D). Please make sure your billing staffs are aware of these changes.

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) opened a National Coverage Analysis (NCA) to reconsider coverage indications for MRI, specifically, in the Medicare National Coverage Determinations (NCD) Manual, Section 220.2(C)(1) Contraindications. This NCA focused on the contraindications for a PM, ICD, CRT-P, or CRT-D in patients undergoing MRIs both on and off Food and Drug Administration (FDA) label.

CMS determined the evidence is sufficient to conclude that MRI for Medicare beneficiaries with an Implanted Pacemaker (PM), Implantable Cardioverter Defibrillator (ICD), Cardiac Resynchronization Therapy Pacemaker (CRT-P), or Cardiac Resynchronization Therapy Defibrillator (CRT-D) is reasonable and necessary under Section 1862(a)(1)(A) of the Social Security Act (the Act) under certain circumstances. CMS is modifying the NCD to eliminate the collection of additional information under the Coverage with Evidence Development (CED) paradigm under Section 1862(a) (1)(E) of the Act.
CMS is revising the language in the NCD Manual to:

1. Remove the contraindication for Medicare coverage of MRI in a beneficiary who has an implanted PM or ICD (Section 220(C)(1))
2. Expand coverage to include CRT-P, or CRT-D devices (Section 220.2(B)(3))
3. Expand coverage for beneficiaries who have an implanted Food & Drug Administration (FDA)-approved, ICD, CRT-P, or CRT-D correspondingly under 220.2(B)(3) of the NCD Manual as a nationally covered MRI indication
4. Expand coverage for beneficiaries with an implanted PM, ICD, CRT-P, or CRT-D device that does not have FDA labeling specific for an MRI under certain conditions under Section 220.2(B)(3)
5. Remove the CED requirement

Effective for claims with dates of service on or after April 10, 2018, MACs will allow MRI line items for beneficiaries with implanted PMs, implanted ICDs, CRT-Ps, and CRT-Ds that include an appropriate MRI code, AND, ICD-10 diagnosis (dx) code Z95.0 - presence of cardiac pacemaker, (Z95.0 also includes presence of CRT-P), OR, ICD-10 dx Z95.810 presence of automatic ICD (Z95.810 also includes presence of automatic ICD with CRT-P, and, presence of CRT-D). MRI line items for beneficiaries with implanted PMs, implanted ICDs, CRT-Ps, and CRT-Ds that do not meet these requirements will be denied with the following messages:

1. Claim Adjustment Reason Code (CARC) 146 – Diagnosis was invalid for the date(s) of service reported
2. Group Code - CO

Your MAC will pay claims as follows for these Types of Bills (TOB) (deductible and coinsurance apply):

1. Professional claims (practitioners and suppliers) - based on the Medicare Physician Fee Schedule (MPFS)
2. TOB 11X - Prospective payment system (PPS), based on the diagnosis-related group
3. TOB 13X – Outpatient Prospective Payment System (OPPS), based on the ambulatory payment classification
4. Rural Health Clinics/Federally Qualified Health Centers (71x/77x). The professional component bills for the MRI with a qualified visit only, there is no payment for this service on an RHC/FQHC claim. The technical component is outside the scope of the RHC/FQHC benefit. Therefore, the provider of the technical service bills their MAC on the ANSI X12N 837P or hardcopy Form CMS-1500 and payment is made under the MPFS
5. TOB 85X (Critical Access Hospitals (CAHs) - For CAHs that elected the optional method of payment for outpatient services, the payment for technical services would be the same as the CAHs that did not elect the optional method - Reasonable cost. The professional component will be paid at 115 percent of the MPFS.
Effective April 10, 2018, the -Q0 and -KX modifiers on claims for MRIs for beneficiaries with an implanted pacemaker are no longer required and can be end-dated.

Any MRI for patients with an implanted pacemaker, ICD, CRT-P, or CRT-D that does not have FDA labeling specific to use in an MRI environment is only covered under the following conditions:

- MRI field strength is 1.5 Tesla using Normal Operating Mode;
- The PM, ICD, CRT-P, or CRT-D system has no fractured, epicardial, or abandoned leads;
- The facility has implemented a checklist which includes the following:
  - Patient assessment is performed to identify the presence of a PM, ICD, CRT-P, or CRT-D;
  - Before the scan, the facility communicates the benefits and harms of the MRI scan to the patient or the patient’s delegated decision-maker;
  - Prior to the MRI scan, the PM, ICD, CRT-P, or CRT-D is interrogated and programmed into the appropriate MRI scanning mode;
  - A qualified physician, nurse practitioner, or physician assistant with expertise with PMs, ICDs, CRT-Ps, or CRT-Ds must directly supervise the MRI scan as defined in 42 CFR § 410.28 and 410.32;
  - Patients are observed throughout the MRI scan via visual and voice contact and monitored with equipment to assess vital signs and cardiac rhythm;
  - An advanced cardiac life support provider must be present for the duration of the MRI scan;
  - A discharge plan that includes before being discharged from the hospital/facility, the patient is evaluated, and the PM, ICD, CRT-P, or CRT-D is re-interrogated immediately after the MRI scan to detect and correct any abnormalities that might have developed.

Be Aware: For claims with dates of service on or after April 10, 2018, but processed prior to implementation of CR10877, MACs will not search their files. However, your MAC will adjust claims brought to their attention.

**ADDITIONAL INFORMATION**


If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.
DOCUMENT HISTORY

<table>
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<tr>
<th>Date of Change</th>
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<tbody>
<tr>
<td>October 22, 2018</td>
<td>Initial article released.</td>
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Next Generation Accountable Care Organization (ACO) Model
2019 Benefit Enhancement

MLN Matters Number: MM10824 Revised Related Change Request (CR) Number: 10824
Related CR Release Date: August 28, 2018 Effective Date: January 1, 2019
Related CR Transmittal Number: R205DEMO Implementation Date: January 7, 2019

Note: This article was revised on August 29, 2018, to reflect a revised CR10824 issued on August 28. The CR was revised to show this is year four of the NGACO model. The article was revised accordingly. In the article, the CR release date, transmittal number, and the Web address of the CR are also revised. All other information remains the same.

PROVIDER TYPE AFFECTED

This MLN Matters® Article is intended for providers who are participating in Next Generation Accountable Care Organizations (NGACOs) and submitting claims to Medicare Administrative Contractors (MACs) for certain care management home visit services to Medicare beneficiaries that would not otherwise be covered by Original Fee-For-Service (FFS) Medicare.

PROVIDER ACTION NEEDED

Change Request (CR) 10824 provides instruction on implementing one new Benefit Enhancement for program year four of the NGACO Model.

BACKGROUND

The goal of the NGACO Model is to improve the quality of care, population health outcomes, and patient experience for the beneficiaries who choose traditional FFS Medicare. The Model provides greater alignment of financial incentives and greater access to tools that may aid beneficiaries and providers in achieving better health at lower costs. Some of the tools that are available to beneficiaries and providers are conditional waivers of certain Medicare payment requirements, called Benefit Enhancements. These Benefit Enhancements currently include the Three-Day Skilled Nursing Facility Rule Waiver, the Post-Discharge Home Visits Waiver, and the Telehealth Expansion Waiver. There are Medicare Learning Network articles available describing each of these and the links for them are available in the Additional Information section.
New Benefit Enhancement for 2019

Care Management Home Visits

Building upon the NGACOs’ experience in offering the Post-Discharge Home Visits Benefit Enhancement, the Model will offer a new Care Management Home Visits Benefit Enhancement to equip the NGACOs with a new tool to provide home visits proactively and in advance of a potential hospitalization. Next Generation Participants and Preferred Providers who have initiated a care treatment plan for aligned beneficiaries will be eligible to receive up to two Care Management Home Visits within 90 days of seeing that Next Generation Participant or Preferred Provider.

CMS will extend the conditional Medicare payment rule waiver issued under the Post-Discharge Home Visits Benefit Enhancement to establish the Care Management Home Visits Benefit Enhancement. Specifically, the scope of covered items and services under this Benefit Enhancement include those services and supplies that would be covered under Medicare Part B and are furnished “incident to” the professional services of a physician or other practitioner.

With the exception that CMS will waive the direct supervision requirement such that the services and supplies may be furnished by auxiliary personnel under the billing physician’s or other billing practitioner’s general supervision, this new Care Management Home Visits Benefit Enhancement will provide NGACO Participants and Preferred Providers greater flexibility to furnish these services within a beneficiary’s home or place of residence.

The items and services provided as part of these care management home visits are intended to supplement, rather than substitute for, visits to a primary care provider or specialist in a traditional health care setting. As such, these home visits are not intended to be performed on an ongoing basis, nor to serve as a substitute for the Medicare home health benefit, nor as the primary mechanism to meet beneficiaries’ care needs. Also, note that this is not a home health benefit, and beneficiaries eligible to receive home health services will not be eligible for this Benefit Enhancement.

The Healthcare Common Procedure Coding System (HCPCS) codes for the Care Management Home Visit services are:

- G0076: Brief (20 minutes) care management home visit for a new patient. For use only in a Medicare-approved Center for Medicare & Medicaid Innovation (CMMI) model. (Services must be furnished within a beneficiary’s home, domiciliary, rest home, assisted living and/or nursing facility.)

- G0077: Limited (30 minutes) care management home visit for a new patient. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary’s home, domiciliary, rest home, assisted living and/or nursing facility.)

- G0078: Moderate (45 minutes) care management home visit for a new patient. For use only in a Medicare-approved CMMI model. (Services must be furnished within a
beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility.)

- G0079: Comprehensive (60 minutes) care management home visit for a new patient. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility.)

- G0080: Extensive (75 minutes) care management home visit for a new patient. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility.)

- G0081: Brief (20 minutes) care management home visit for an existing patient. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility.)

- G0082: Limited (30 minutes) care management home visit for an existing patient. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility.)

- G0083: Moderate (45 minutes) care management home visit for an existing patient. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility.)

- G0084: Comprehensive (60 minutes) care management home visit for an existing patient. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility.)

- G0085: Extensive (75 minutes) care management home visit for an existing patient. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility.)

- G0086: Limited (30 minutes) care management home care plan oversight. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary’s home, domiciliary, rest home, assisted living and/or nursing facility.)

- G0087: Comprehensive (60 minutes) care management home care plan oversight. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary’s home, domiciliary, rest home, assisted living and/or nursing facility.)

These codes should be submitted on Type of Bill: 85X, with Revenue Codes 96X, 97X, or 98X. The payment rates will be in the Medicare Physician Fee Schedule (MPFS). However, Medicare will reimburse the lesser of the billed charge or MPFS rate for Critical Access Hospital Method II providers billing on Type of Bill 85X, with Revenue Codes 96X, 97X, or 98X.
ADDITIONAL INFORMATION


Information on the CRs previously implemented for the Next Generation ACO Model are available at:


More information about the Next Generation ACO Model is available at: https://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/.

If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

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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 2018 – There are no new policies for December 2018

November 2018

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<tr>
<th>Contract</th>
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<th>CMS MCD Policy #</th>
<th>WPS Policy #</th>
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<tr>
<td>J5/J8</td>
<td>Intraarticular Knee Injections of Hyaluronan Billing Guidelines</td>
<td>A56157</td>
<td>NA</td>
<td>12/01/2018</td>
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<td>J5/J8</td>
<td>MolDX: CORUS® CAD ASSAY</td>
<td>L37770</td>
<td>MolDX-046</td>
<td>12/17/2018</td>
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October 2018 – There are no new policies/articles for October 2018

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

Visit our website at the link below for more information:

December 2018 – There are no retired policies for December 2018

November 2018

<table>
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<tr>
<th>Contract</th>
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<th>CMS MCD Policy #</th>
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<tr>
<td>J5/J8</td>
<td>Intra-articular Injections of Hyaluronan</td>
<td>L34525</td>
<td>INJ-033</td>
<td>12/01/2018</td>
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<td></td>
<td>This LCD with Billing and Coding Guidelines are being retired December 1, 2018, and replaced with A56157 Article Intra-articular Knee Injections of Hyaluronan Billing Guidelines.</td>
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<td>J5/J8</td>
<td>MolDX: clonoSEQ® Assay for Assessment of Minimal Residual Disease (MRD) in Patients with Specific Lymphoid Malignancies</td>
<td>DL37917</td>
<td>MolDX-050</td>
<td>11/01/2018</td>
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<tr>
<td>J5/J8</td>
<td>MolDX: Comprehensive Genomic Profiling to Guide Treatment in Patients with Advanced Primary Perioteal, Fallopian Tube and Ovarian Cancer</td>
<td>DL37203</td>
<td>MolDX-028</td>
<td>11/01/2018</td>
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<tr>
<td>J5/J8</td>
<td>MolDX: Comprehensive Genomic Profiling to Guide Treatment in Patients with Metastatic Melanoma</td>
<td>DL37220</td>
<td>MolDX-032</td>
<td>11/01/2018</td>
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<td>J5/J8</td>
<td>MolDX: NSCLC, Comprehensive Genomic Profile Testing</td>
<td>L36803</td>
<td>MolDX-017</td>
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<td>J5/J8</td>
<td>MolDX: Vita Risk™ Pharmacogenetic Test for Dry Age-related Macular Degeneration (AMD)</td>
<td>DL37218</td>
<td>MolDX-031</td>
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<td>J5/J8</td>
<td>MolDX: Approved Gene Testing</td>
<td>A55248</td>
<td>NA</td>
<td>10/01/2018</td>
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<td>J5/J8</td>
<td>MolDX: VectraDA, a Multibiomarker Disease Activity Test for Rheumatoid Arthritis (RA)</td>
<td>DL37201</td>
<td>MolDX-027</td>
<td>10/01/2018</td>
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REVISED POLICIES

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

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<tr>
<td>J5/J8</td>
<td>Cosmetic and Reconstructive Surgery</td>
<td>L34698</td>
<td>GSURG-032</td>
<td>12/01/2018</td>
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- CMS National Coverage Policy:
  Updated IOM references/titles/chapters and sections,

- Added CMS PUB. 100-03 Medicare National Coverage Determinations Manual, Chapter 1, Part 4, §250.4 – Treatment of Actinic Keratosis,

- Added CMS PUB. 100-02 Medicare Benefit Policy Manual, Chapter 16-General Exclusions from Coverage, §120 Cosmetic Surgery,

- Added National Coverage Determination 250.5 Dermal Injections for the Treatment of Facial Lipodystrophy Syndrome and to Coverage Indications, Limitations, and/or Medical Necessity to B. 10 Dermal Injections.

- CMS National Coverage Policy added additional verbiage to Title XVIII of the Social Security Act (SSA): 1862 (a)(1)(A) Medically Reasonable & Necessary tests used in the diagnosis and management of illness or injury or to improve the function of a malformed body part.

- Added: Title XVIII of the Social Security Act (SSA): 1862 (a)(1)(D) Investigational or Experimental;

- Added: Title XVIII of the Social Security Act, Section 1862 (a)(10). This section excludes Cosmetic Surgery.


- Coverage Indications, Limitations, and/or Medical Necessity added Per the Medicare Benefit Policy Manual cosmetic surgery or expenses incurred in connection with such surgery, for the sole purpose of improving one’s appearance, is not covered.

  No change in coverage.

- Updated Billing and Coding Guidelines:
  Removed verbiage performed for a cosmetic reason will be denied as non-covered from #1.- #7. and #9.

  Removed #10. Billing for dermal injections for the treatment of Facial Lipodystrophy Syndrome (LDS) that meet the criteria in the NCD and associated information. Dermal injection guidance provided in policy.


  No change in coverage.

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<tr>
<td>J5/J8</td>
<td>Drug Administration Coding</td>
<td>A54176</td>
<td>NA</td>
<td>12/01/2018</td>
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</table>

- Added J3490 Onpattro™ (patissiran).
- Added the following verbiage for NOC Drug Billing:
Office/Clinic:

Providers submit NOC codes in the 2400/SV101-2 data element in the 5010 professional claim transaction (837P). When billing an NOC code, providers are required to provide a description in the 2400/SV101-7 data element. The 5010 TR3 Implementation Guide instructs: "Use SV101-7 to describe non-specific procedure codes." (Do not use the 2400 NTE segment to describe non-specific procedure codes with 5010.) The SV101-7 data element allows for 80 bytes (i.e., characters, including spaces) of information.

In order for WPS GHA to correctly reimburse NOC drugs and biologicals, providers must indicate the following in the 2400/SV101-7 data element, or Item 19 of the CMS 1500 form:

- The name of the drug,
- The total dosage (plus strength of dosage, if appropriate), and
- The method of administration.

Important: List one unit of service in the 2400/SV1-04 data element or in item 24G of the CMS 1500 form. Do not quantity-bill NOC drugs and biologicals even if multiple units are provided. Medicare determines the proper payment of NOC drugs and biologicals by the narrative information, not the number of units billed. Medicare will reject as unprocessable claims for NOC drugs and biologicals if any of the information above is missing, or if the NOC code is billed with more than one unit of service. (Note: The remittance notice will include remark code M123, "Missing/incomplete/invalid name, strength, or dosage of the drug furnished," even if the rejection is due to the number of units billed.)

See NOC Billing/NOC Drug and Biological Codes on our website for further information: https://www.wpsgha.com/wps/portal/mac/site/claims/guides-and-resources/not-otherwise-classified-billing

ASC and Hospital Outpatient Departments:

HCPCS code C9399, Unclassified drug or biological, should be used for new drugs and biologicals that are approved by FDA on or after January 1, 2004, for which a specific HCPCS code has not been assigned.


- Claims for discarded drugs or biologicals amount not administered to any patient shall be submitted using the JW modifier. Unused drugs or biologicals from single use vials or single use packages that are opened and the entire dose/quantity is not administered and the remainder is discarded. (except those provided under the Competitive Acquisition Program (CAP) for Part B drugs and biologicals).
- Providers must document the discarded drugs or biologicals in the patient's medical record.
- This modifier, billed on a separate line, will provide payment for the amount of discarded drugs or biologicals.

See CR 9603

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<td>J5/J8</td>
<td>Electrocardiographic (EKG or ECG) Monitoring (Holter or Real-Time Monitoring)</td>
<td>L34636</td>
<td>CV-016</td>
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Added the following codes to Group 1 (memory loop recordings), Group 2 (other up
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Reformatted article guidance without change in coverage.

Added the following information under Article Guidance: All procedures are furnished by and administered by a physician and/or appropriately trained providers in the appropriate setting.

Removed the following items: the definition of Osteoarthritis, the reference to clinical studies of sodium hyaluronate, and removed duplicative information regarding coverage of incident to and FDA safety and effectiveness.

Billing of Viscosupplements: added the following sentence: Dosing frequency of injections per series and/or dosing frequency per series as listed/supported with the FDA approved dosing/package insert must be documented in the medical record. Providers are responsible for determining the code that most accurately describes the intraarticular agent furnished.

Added the following Sources of Information: FDA package inserts including Safety and Effectiveness Data;

The Medical Letter (August 27, 2018). Two New Intra-articular Injections for Knee Osteoarthritis. Vol. 60 (1554);


Other MACs LCD/Articles.

| J5/J8 | MolDX: ConfirmMDx Epigenetic Molecular Assay | L37005 | MolDX-020 | 12/01/2018 |

The Analysis of Evidence was updated: Quality: Limited to Moderate changed to Moderate and Strength and Weight were limited and changed to Low. It now reads:

**Analysis of Evidence**
(Rationale for Determination)

**Level of Evidence**
Quality of Evidence – Moderate
Strength – Low
Weight – Low

| J5/J8 | Nerve Conduction Studies and Electromyography and Billing and Coding Guidelines | L34594 | NEURO-005 | 12/01/2018 |

Coverage Guidance: removed sentence: “It would be highly unlikely that this training and/or credentialing is possessed by providers other than Neurologists, or Physical Medicine & Rehabilitation physicians.”
<table>
<thead>
<tr>
<th>Contract</th>
<th>Policy Title</th>
<th>CMS MCD Policy #</th>
<th>WPS Policy #</th>
<th>Effective Date</th>
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<tr>
<td>J5/J8</td>
<td>Somatosensory Testing</td>
<td>L32902</td>
<td>NEURO-013</td>
<td>12/01/2018</td>
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</table>

Added TC indicator “66” for CPT 95872 for clarification.

Billing and Coding Guidelines
Changed “physician” to providers in the following sections:

1. The table below provides a reasonable maximum number of studies per diagnostic category necessary for a provider to arrive at a diagnosis in 90% of patients with that final diagnosis.
2. The appropriate number of studies to be performed is left to the judgment of the provider performing the evaluation; however, in the small number of cases, which require testing in excess of the numbers listed in the table, the provider should be able to provide supplementary documentation to justify the additional testing.

CPT Code 95937 - Neuromuscular Junction Studies
When this study is performed, the provider’s report should note characteristics of the test, including the rate of repetition of stimulations, and any significant incremental or decremental response.

The following section has been updated with the TC indicator of 66 for CPT code 95872 and the definition of the Physician Supervision indicator 09 has been added for clarification:

Needle electromyographic (EMG) code 95872 has the designation 66 for the technical portion of the test.

CMS long-standing policy that the concept of physician supervision does not apply (PSI of “09”) to these PT-designated diagnostic services, which allows payment to be made for the PC or global code to the ABPTS-PT, excepted by regulation, as long as it is legal for the ABPTS-PT to provide the service in that state, and the TC has been either personally performed by the ABPTS-PT or the PT without the ABPTS certification has met the supervision requirements for the technical component portion of the service consistent with the applicable supervision indicator.

Coverage Guidance: Changed “physician” to “providers” in the following sentences:
A provider trained in interpreting clinical evoked potential studies analyzes the waveforms

Documentation Requirements:
Medical record documentation maintained by the performing provider must clearly indicate the medical necessity of the service being billed.
This documentation should include a hard copy computer generated recording of the test results along with the provider’s interpretation.
The provider’s SEP report should note which nerves were tested, latencies at various testing points, and an evaluation of whether the resulting values are normal or abnormal.

Coverage Guidance for clarification added paragraph:
CMS long-standing policy that the concept of physician supervision does not apply
(PSI of “09”) to these PT-designated diagnostic services, which allows payment to be made for the PC or global code to the ABPTS-PT, excepted by regulation, as long as it is legal for the ABPTS-PT to provide the service in that state, and the TC has been either personally performed by the ABPTS-PT or the PT without the ABPTS certification has met the supervision requirements for the technical component portion of the service consistent with the applicable supervision indicator.

In training and expertise sentence added the following verbiage to “certification by a nationally recognized organization, or by an accredited post-graduate training course covering anatomy, neurophysiology and forms of electrodiagnostics (including both NCS and EMG).”

In Coverage Guidance removed the sentence: “It is anticipated only allopathic or osteopathic physicians will have the necessary training to meet these requirements.”

### November 2018

<table>
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<tr>
<th>Contract</th>
<th>Policy Title</th>
<th>CMS MCD Policy #</th>
<th>WPS Policy #</th>
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<tbody>
<tr>
<td>J5/J8</td>
<td>MolDX: Afirma™ Assay by Veracyte Update</td>
<td>A55139</td>
<td>NA</td>
<td>11/01/2018</td>
</tr>
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</table>

Policy Clarification:
Added numbering and “patient must have 1 and 2” to the coverage below.

The MolDX Team has completed the Afirma assessment and determined that the test meets criteria for analytical and clinical validity, and clinical utility as a reasonable and necessary Medicare benefit. Effective 01/01/12, MolDX will reimburse Afirma services for patients with the following conditions (patient must have 1 and 2):

1. Patients with one or more thyroid nodules with a history or characteristics suggesting malignancy such as:
   - Nodule growth over time
   - Family history of thyroid cancer
   - Hoarseness, difficulty swallowing or breathing
   - History of exposure to ionizing radiation
   - Hard nodule compared with rest of gland consistency
   - Presence of cervical adenopathy

2. Have an indeterminate follicular pathology on fine needle aspiration

Changed coverage date from 01/01/2012 to 10/01/2015.

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<th>WPS Policy #</th>
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<tr>
<td>J5/J8</td>
<td>MolDX: Decipher® Prostate Cancer Classifier Assay</td>
<td>L36791</td>
<td>MolDX-010</td>
<td>11/01/2018</td>
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</table>

The quality, strength, and weight of evidence have been updated.

Analysis of Evidence
(Rationale for Determination)

Level of Evidence
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<tbody>
<tr>
<td>J5/J8</td>
<td>Quality of Evidence – Moderate Strength – Low Weight – Low</td>
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<tr>
<td></td>
<td>J5/J8 MolIDX: Molecular Diagnostic Tests (MDT)</td>
<td>L36807</td>
<td>MolDX-004</td>
<td>10/01/2018</td>
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<td>Due to the 04Q18 Code Update &amp; AMA CPT Proprietary Laboratory Analyses (PLA)</td>
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<tr>
<td></td>
<td>Codes Long Descriptors document, the following deleted codes have been removed</td>
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<tr>
<td></td>
<td>0020U Rx test prsmv ur w/def conf</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>0028U Cyp2d6 gene cpy nmr cmn vrnt</td>
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</tr>
<tr>
<td>J5/J8</td>
<td>J5/J8 Vertebroplasty (Percutaneous) and Vertebral Augmentation including cavity creation</td>
<td>L34592</td>
<td>RAD-032</td>
<td>11/01/2018</td>
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<tr>
<td></td>
<td>Added the following statement under Documentation Requirements: We believe that</td>
<td></td>
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<tr>
<td></td>
<td>best practice is for the physician providing the service to document the use of x-ray guidance, either fluoroscopy or CT scan in all settings, including an office setting</td>
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</table>

**October 2018**

<table>
<thead>
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<tr>
<td>J5/J8</td>
<td>2019 ICD-10 Code Update</td>
<td>NA</td>
<td>NA</td>
<td>10/01/2018</td>
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<tr>
<td>J5/J8</td>
<td>Chemotherapy Agents for Non-Oncologic Conditions</td>
<td>A55639</td>
<td>NA</td>
<td>10/01/2018</td>
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<tr>
<td></td>
<td>ICD-10 CM Code updates: Group 6: O00.212 description change.</td>
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<tr>
<td></td>
<td>The article addresses chemotherapy administration codes which apply to parenteral administration of anti-neoplastic agents provided for treatment of noncancer diagnoses or to substances such as monoclonal antibody agents, and other biologic response modifiers.</td>
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<tr>
<td></td>
<td>The article has been updated and reformatted to support Article Guidance on Non-Oncological Conditions.</td>
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<td></td>
<td>Removed from Group 1 Code Table: A9606 Radium ra-223 dichloride therapeutic, per microcurie</td>
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<tr>
<td></td>
<td>J9151 Injection, Daunorubicin citrate, liposomal formulation 10 mg</td>
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<tr>
<td></td>
<td>J9165 Injection, Diethylstilbestrol diphosphate 250 mg</td>
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</tr>
<tr>
<td></td>
<td>J9270 Injection, Plicamycin 2.5mg and</td>
<td></td>
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<tr>
<td></td>
<td>Q2017 Injection, Teniposide 50 mg.</td>
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<tr>
<td></td>
<td>These medications were removed as they are applicable to oncologic conditions and do not support the article guidance for non-oncological conditions. This article is related to LCD L37205 Chemotherapy Drugs and their Adjuncts. Please refer to the</td>
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<tr>
<td>Contract</td>
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<td>CMS MCD Policy #</td>
<td>WPS Policy #</td>
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<tr>
<td>L5/J8</td>
<td><strong>Erythropoiesis Stimulating Agents (ESAs) and Billing and Coding Guidelines</strong></td>
<td>L34633</td>
<td>INJ-023</td>
<td>10/01/2018</td>
</tr>
</tbody>
</table>

Added CR 10859 ICD-10 and Other Coding Revisions to National Coverage Determinations (NCDs), effective 01/01/2019 to CMS National Coverage Policy Section.

Changes/reformatting to

Group 4 Paragraph:

C. Indications other than Renal Disease
   1. Anemias related to therapy with Zidovudine (AZT)

Requires one of the following:

- Group 4

LCD for coverage for chemotherapy agents.

Removed Group 1 Paragraph and associated information.

A9606 Radium ra-223 dichloride, (Xofigo) therapeutic, per microcurie

For the treatment of patients with castration-resistant prostate cancer, symptomatic bone metastases and no known visceral metastatic disease. It is administered at 4-week intervals for a total of 6 doses. Off label use is not covered. Do not use both diagnosis codes if the indications have not been met.

C61 and C79.51 or C79.52.

Group 1 Codes:

- C61: Malignant neoplasm of prostate
- C79.51: Secondary malignant neoplasm of bone
- C79.52: Secondary malignant neoplasm of bone marrow.

Please refer to NCCN Radiation Therapy Compendium™ for guidance.

Removed Group 3 Paragraph and associated information:

J9151 Daunorubicin citrate, liposomal formulation (DaunoXome) 10 mg,

J9165 Diethylstilbestrol diphosphate 250 mg,

J9270 Plicamycin (Mithracin) 2.5 mg, and

Q2017 Teniposide (Vumon) 50 mg.

Removed Group 3 Codes:

- [C00.0 - C96.0] Malignant neoplasms of lip, oral cavity and pharynx- Multifocal and multisystemic (disseminated) Langerhans-cell histiocytosis
- [C96.21 - D46.9] Aggressive systemic mastocytosis - myelodysplastic syndrome, unspecified
- [D47.09 - D49.9] Other mast cell neoplasms of uncertain behavior – Neoplasm of unspecified behavior of unspecified site
- [E34.0 - E34.9] Carcinoid syndrome-Endocrine disorder, unspecified.

Group Paragraphs and Group Codes corrected for numerical order.
<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>removed D64.9 Anemia, unspecified and replaced with D64.89 Other specified anemias or D75.9 Disease of blood and blood-forming organs, unspecified.</td>
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<tr>
<td></td>
<td>Group 6 Paragraph: THREE DIAGNOSES ARE NECESSARY FOR J0881 or J0885</td>
<td></td>
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<tr>
<td></td>
<td>Requires: *D64.81, *Z79.899, AND an additional diagnosis code INDICATING THE CONDITION BEING TREATED</td>
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</tr>
<tr>
<td></td>
<td>Group 6 Codes</td>
<td>removed D64.9 Anemia, unspecified and replaced with D64.81* Anemia due to antineoplastic therapy.</td>
<td></td>
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</tr>
<tr>
<td>J5/J8</td>
<td>Human Granulocyte/Macrophage Colony Stimulating Factor</td>
<td>L34699</td>
<td>INJ-019</td>
<td>10/01/2018</td>
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<tr>
<td></td>
<td>Please see combined article for ICD-10 CM Code Updates.</td>
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<tr>
<td></td>
<td>Coverage Indications updated verbiage to match FDA indications to F. Indications for tbo-filgrastim (GRANIX) (J1447)</td>
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</tr>
<tr>
<td></td>
<td>1. To decrease the duration of severe neutropenia in adult and pediatric patients 1 month and older with non-myeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a clinically significant incidence of febrile neutropenia.</td>
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<tr>
<td></td>
<td>Added to Group 5 Codes</td>
<td>T45.1X5D Adverse effect of antineoplastic and immunosuppressive drugs, subsequent encounter</td>
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<tr>
<td></td>
<td>Change Request 10923, October 2018 Update of the Hospital Outpatient Prospective Payment System (OPPS) - Effective October 1, 2018</td>
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<tr>
<td></td>
<td>Coverage Indications, Limitations, and/or Medical Necessity added:</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>1. To decrease the incidence of infection, as manifested by febrile neutropenia, for patients with non-myeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a significant incidence of febrile neutropenia.</td>
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</tr>
</tbody>
</table>
1. Decrease the incidence of infection, as manifested by febrile neutropenia, in patients with nonmyeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a significant incidence of severe neutropenia with fever.
2. Reduce the time to neutrophil recovery and the duration of fever, following induction or consolidation chemotherapy treatment of patients with acute myeloid leukemia (AML).
3. Reduce the duration of neutropenia and neutropenia-related clinical sequelae, e.g., febrile neutropenia, in patients with nonmyeloid malignancies undergoing myeloablative chemotherapy followed by bone marrow transplantation (BMT).
4. Mobilize autologous hematopoietic progenitor cells into the peripheral blood for collection by leukapheresis.
5. Reduce the incidence and duration of sequelae of severe neutropenia (e.g., fever, infections, oropharyngeal ulcers) in symptomatic patients with congenital neutropenia, cyclic neutropenia, or idiopathic neutropenia.

Group 1 Paragraph: added
Q5108 Injection, Pegfilgrastim-jmdb, biosimilar, (fulphila), 0.5 mg
Q5110 Injection, filgrastim-aafi, biosimilar, (nivestym), 1 microgram

Group 8 Paragraph
Q5108

Group 8 Codes
D61.810 Antineoplastic chemotherapy induced pancytopenia
D70.1 Agranulocytosis secondary to cancer chemotherapy
T45.1X5A Adverse effect of antineoplastic and immunosuppressive drugs, initial encounter
T45.1X5D Adverse effect of antineoplastic and immunosuppressive drugs, subsequent encounter
T45.1X5S Adverse effect of antineoplastic and immunosuppressive drugs, sequela
Z51.11 Encounter for antineoplastic chemotherapy
Z92.21 Personal history of antineoplastic chemotherapy

Group 9 Paragraph
Q5110

Group 9 Codes
C92.00 Acute myeloblastic leukemia, not having achieved remission
C92.02 Acute myeloblastic leukemia, in relapse
C92.40 Acute promyelocytic leukemia, not having achieved remission
C92.42 Acute promyelocytic leukemia, in relapse
C92.50 Acute myelomonocytic leukemia, not having achieved remission
C92.52 Acute myelomonocytic leukemia, in relapse
C92.60 Acute myeloid leukemia with 11q23-abnormality not having achieved remission
C92.62 Acute myeloid leukemia with 11q23-abnormality in relapse
C92.A0 Acute myeloid leukemia with multilineage dysplasia, not having achieved remission
<table>
<thead>
<tr>
<th>Contract</th>
<th>Policy Title</th>
<th>CMS MCD Policy #</th>
<th>WPS Policy #</th>
<th>Effective Date</th>
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<tbody>
<tr>
<td></td>
<td>remission</td>
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<td>C92.A2</td>
<td>Acute myeloid leukemia with multilineage dysplasia, in relapse</td>
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<td>D61.810</td>
<td>Antineoplastic chemotherapy induced pancytopenia</td>
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<td>D70.0</td>
<td>Congenital agranulocytosis</td>
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<td>D70.1</td>
<td>Agranulocytosis secondary to cancer chemotherapy</td>
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<td>D70.4</td>
<td>Cyclic neutropenia</td>
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<td>D70.8</td>
<td>Other neutropenia</td>
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<td>D70.9</td>
<td>Neutropenia, unspecified</td>
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<tr>
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<td>T45.1X5A</td>
<td>Adverse effect of antineoplastic and immunosuppressive drugs, initial encounter</td>
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<td>T45.1X5D</td>
<td>Adverse effect of antineoplastic and immunosuppressive drugs, subsequent encounter</td>
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<td></td>
<td>Z48.290</td>
<td>Encounter for aftercare following bone marrow transplant</td>
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<td>Z51.11</td>
<td>Encounter for antineoplastic chemotherapy</td>
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<td>Z52.011</td>
<td>Autologous donor, stem cells</td>
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<td></td>
<td>Z52.091</td>
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<td>Z92.21</td>
<td>Personal history of antineoplastic chemotherapy</td>
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<td>Z94.81</td>
<td>Bone marrow transplant status</td>
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<td></td>
<td>Z94.84</td>
<td>Stem cells transplant status</td>
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**J5/J8 MolDX: Avise PG Assay Billing/Coding Update**

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<tr>
<td>M05.09</td>
<td>Felty's syndrome, multiple sites</td>
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<tr>
<td>M05.19</td>
<td>Rheumatoid lung disease with rheumatoid arthritis of multiple sites</td>
</tr>
<tr>
<td>M05.29</td>
<td>Rheumatoid vasculitis with rheumatoid arthritis of multiple sites</td>
</tr>
<tr>
<td>M05.39</td>
<td>Rheumatoid heart disease with rheumatoid arthritis of multiple sites</td>
</tr>
<tr>
<td>M05.49</td>
<td>Rheumatoid myopathy with rheumatoid arthritis of multiple sites</td>
</tr>
<tr>
<td>M05.69</td>
<td>Rheumatoid arthritis of multiple sites with involvement of other organs and systems</td>
</tr>
<tr>
<td>M05.79</td>
<td>Rheumatoid arthritis with rheumatoid factor of multiple sites without organ or systems involvement</td>
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<tr>
<td>M05.89</td>
<td>Other rheumatoid arthritis with rheumatoid factor of multiple sites</td>
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<tr>
<td>M06.09</td>
<td>Rheumatoid arthritis without rheumatoid factor, multiple sites</td>
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<tr>
<td>M06.29</td>
<td>Rheumatoid bursitis, multiple sites</td>
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<td>M06.39</td>
<td>Rheumatoid nodule, multiple sites</td>
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<tr>
<td>M06.89</td>
<td>Other specified rheumatoid arthritis, multiple sites</td>
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**J5/J8 MolDX: Biomarkers in Cardiovascular Risk Assessment**

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<th>Code</th>
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<tr>
<td>I63.00</td>
<td>Cerebral infarction due to thrombosis of unspecified precerebral artery</td>
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<tr>
<td>I63.36</td>
<td>Cerebral infarction due to thrombosis of right vertebral artery</td>
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<td>-------------------------------------------</td>
</tr>
<tr>
<td>I63.019</td>
<td>artery</td>
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<tr>
<td>I63.02</td>
<td>Cerebral infarction due to thrombosis of unspecified vertebral artery</td>
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<tr>
<td>I63.031-163.033</td>
<td>Cerebral infarction due to thrombosis of right carotid artery</td>
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<tr>
<td>I63.039</td>
<td>Cerebral infarction due to thrombosis of unspecified carotid artery</td>
</tr>
<tr>
<td>I63.09</td>
<td>Cerebral infarction due to thrombosis of other precerebral artery</td>
</tr>
<tr>
<td>I63.10</td>
<td>Cerebral infarction due to embolism of unspecified precerebral artery</td>
</tr>
<tr>
<td>I63.111-I63.113</td>
<td>Cerebral infarction due to embolism of right vertebral artery</td>
</tr>
<tr>
<td>I63.119</td>
<td>Cerebral infarction due to embolism of unspecified vertebral artery</td>
</tr>
<tr>
<td>I63.12</td>
<td>Cerebral infarction due to embolism of basilar artery</td>
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<td>I63.131-I63.133</td>
<td>Cerebral infarction due to embolism of right carotid artery</td>
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<td>I63.139</td>
<td>Cerebral infarction due to embolism of unspecified carotid artery</td>
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<td>I63.19</td>
<td>Cerebral infarction due to embolism of other precerebral artery</td>
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<td>Cerebral infarction due to unspecified occlusion or stenosis of unspecified precerebral arteries</td>
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<td>Cerebral infarction due to unspecified occlusion or stenosis of right vertebral artery</td>
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<td>Cerebral infarction due to unspecified occlusion or stenosis of unspecified vertebral arteries</td>
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<td>Cerebral infarction due to thrombosis of unspecified cerebral artery</td>
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<tr>
<td>Cerebral infarction due to thrombosis of right middle cerebral artery</td>
<td>I63.311-I63.313</td>
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<tr>
<td>Cerebral infarction due to thrombosis of left middle cerebral artery</td>
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<td>Cerebral infarction due to thrombosis of bilateral middle cerebral arteries</td>
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<td>Cerebral infarction due to thrombosis of unspecified middle cerebral artery</td>
<td>I63.319</td>
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<tr>
<td>Cerebral infarction due to thrombosis of right anterior</td>
<td>I63.321-I63.323</td>
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|          | cerebral artery  
Cerebral infarction due to thrombosis of left anterior cerebral artery  
Cerebral infarction due to thrombosis of bilateral anterior cerebral arteries | I63.329 | Cerebral infarction due to thrombosis of unspecified anterior cerebral artery |          |
|          | Cerebral infarction due to thrombosis of right posterior cerebral artery  
Cerebral infarction due to thrombosis of left posterior cerebral artery  
Cerebral infarction to thrombosis of bilateral posterior cerebral arteries | I63.331-I63.333 | Cerebral infarction due to thrombosis of unspecified posterior cerebral artery |          |
|          | Cerebral infarction due to thrombosis of right cerebellar artery  
Cerebral infarction due to thrombosis of left cerebellar artery  
Cerebral infarction to thrombosis of bilateral cerebellar arteries | I63.341- I63.343 | Cerebral infarction due to thrombosis of unspecified cerebellar artery |          |
|          | Cerebral infarction due to thrombosis of other cerebral artery | I63.349 | Cerebral infarction due to thrombosis of unspecified cerebellar artery |          |
|          | Cerebral infarction due to embolism of unspecified cerebral artery | I63.39 | Cerebral infarction due to thrombosis of other cerebral artery |          |
|          | Cerebral infarction due to embolism of unspecified middle cerebral artery | I63.40 | Cerebral infarction due to embolism of unspecified cerebral artery |          |
|          | Cerebral infarction due to embolism of right middle cerebral artery  
Cerebral infarction due to embolism of left middle cerebral artery  
Cerebral infarction due to embolism of bilateral middle cerebral arteries | I63.411- I63.413 | Cerebral infarction due to embolism of unspecified middle cerebral artery |          |
<p>|          | Cerebral infarction due to embolism of right anterior cerebral artery | I63.419 | Cerebral infarction due to embolism of unspecified middle cerebral artery |          |
|          | Cerebral infarction due to embolism of right anterior cerebral artery | I63.421-I63.423 | Cerebral infarction due to embolism of right anterior cerebral artery |          |</p>
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<td>I63.439</td>
<td>Cerebral infarction due to embolism of unspecified posterior cerebral artery</td>
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<td>I63.511-I63.513</td>
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<td></td>
<td>Cerebral infarction due to unspecified occlusion or stenosis of bilateral middle cerebral arteries</td>
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<tr>
<td>I63.519</td>
<td>Cerebral infarction due to unspecified occlusion or stenosis of unspecified middle cerebral artery</td>
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<td>I63.521-I63.523</td>
<td>Cerebral infarction due to unspecified occlusion</td>
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Criteria for Testing

- Individual with breast, ovarian, pancreatic, or prostate cancer from a family with a known deleterious BRCA1 or BRCA2 gene mutation.
- Individual with a personal history of ovarian cancer
- Individual with a breast cancer diagnosis meeting any of the following

<table>
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<tr>
<th>Contract</th>
<th>Policy Title</th>
<th>CMS MCD Policy #</th>
<th>WPS Policy #</th>
<th>Effective Date</th>
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<tbody>
<tr>
<td>J5/J8</td>
<td>MolDX: BRCA1 and BRCA2 Genetic Testing</td>
<td>L36813</td>
<td>MolDX-007</td>
<td>10/01/2018</td>
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<tr>
<th>I63.529</th>
<th>Cerebral infarction due to unspecified occlusion or stenosis of unspecified anterior cerebral artery</th>
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<tbody>
<tr>
<td>I63.531-I63.533</td>
<td>Cerebral infarction due to unspecified occlusion or stenosis of unspecified anterior cerebral artery</td>
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<td>I63.539</td>
<td>Cerebral infarction due to unspecified occlusion or stenosis of unspecified posterior cerebral artery</td>
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<td>I63.541-I63.543</td>
<td>Cerebral infarction due to unspecified occlusion or stenosis of unspecified posterior cerebral artery</td>
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<tr>
<td>I63.549</td>
<td>Cerebral infarction due to unspecified occlusion or stenosis of unspecified cerebellar artery</td>
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<tr>
<td>I63.59</td>
<td>Cerebral infarction due to unspecified occlusion or stenosis of other cerebral artery</td>
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<tr>
<td>I63.9</td>
<td>Cerebral infarction, unspecified</td>
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Also see the 2019 ICD-10 code update article.
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<tr>
<th>Contract</th>
<th>Policy Title</th>
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<th>WPS Policy #</th>
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</tbody>
</table>

Criteria:
- Diagnosed ≤45 y
- Diagnosed 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
- Diagnosed at 46-50 with:
  - An additional breast cancer primary
  - ≥1 first, second, or third degree relative with breast cancer at any age, or
  - ≥1 first, second, or third degree relative with prostate cancer (Gleason score ≥ 7) or
  - An unknown or limited family history
- Breast cancer diagnosed 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 ovarian cancer at any age, or
  - ≥1 first, second, or third degree relative with metastatic prostate cancer or pancreatic cancer at any age, or
  - ≥2 additional diagnoses of breast cancer at any age in patient and/or in close blood relatives, or
  - A first, second, or third degree male relative with breast cancer
  - For an individual of ethnicity associated with higher mutation frequency (e.g. Ashkenazi Jewish) no additional family history may be required
- Male breast cancer
  - Personal history of prostate cancer (Gleason score ≥ 7) at any age with:
    - ≥1 first, second, or third degree relative with ovarian cancer at any age, or
    - ≥1 first, second, or third degree relative with breast cancer ≤50 y, or
    - ≥1 first, second, or third degree relative with pancreatic cancer at any age, or
    - ≥1 first, second, or third degree relative with metastatic prostate cancer pancreatic cancer at any age, or
    - Ashkenazi Jewish ancestry
  - Personal history of pancreatic cancer at any age
  - Personal history of metastatic prostate cancer (radiographic evidence of or biopsy-proven disease)
  - BRCA1/2 pathogenic mutation detected by tumor profiling on any tumor type in the absence of germline mutation analysis

*1Includes fallopian tube and primary peritoneal cancers. BRCA-related ovarian cancers are associated with epithelial, non-mucinous histology.
2Two breast cancer primaries includes bilateral (contralateral) disease or two or more clearly separate ipsilateral primary tumors either synchronously or asynchronously.
Medicare will cover BRCA-testing for an adopted individual with breast cancer diagnosed ≤ 50 y that is suspicious of being a BRCA-related cancer. Individuals with limited family history/structure, defined as fewer than 2 female first- or second-degree relatives having lived beyond age 45 in either lineage may also be eligible for BRCA gene testing. Similar to all testing, these situations require explanation of medical necessity for BRCA testing in the patient's medical record, and documentation of genetic counseling prior to BRCA testing.

Testing for Ashkenazi Jewish founder-specific mutations should be performed first. Comprehensive BRCA1/2 testing may be considered if ancestry also includes non-Ashkenazi Jewish relatives or if any of the other BRCA-related criteria are met. 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.

<table>
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<tr>
<th>J5/J8</th>
<th>MolDX: Genetic Testing for BCR-ABL Negative Myeloproliferative Disease</th>
<th>L36815</th>
<th>MolDX-016</th>
<th>10/01/2018</th>
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<td><strong>Effective 07/01/2017: The following diagnosis codes have been added to the list of ICD-10 Codes that Support Medical Necessity:</strong></td>
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<td>C91.00  Acute lymphoblastic leukemia not having achieved remission</td>
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<td>C91.01  Acute lymphoblastic leukemia, in remission</td>
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<td></td>
<td>C91.02  Acute lymphoblastic leukemia, in relapse</td>
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<tr>
<th>J5/J8</th>
<th>MolDX: Genomic Health™ Oncotype DX® Prostate Cancer Assay</th>
<th>L36789</th>
<th>MolDX-009</th>
<th>07/01/2018</th>
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<td>CPT 81479 Unlisted molecular pathology code has been replaced with the new code 0047U Oncology (prostate), mRNA, gene expression profiling by real-time RT-PCR of 17 genes (12 content and 5 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a risk score.</td>
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<th>J5/J8</th>
<th>MolDX: Molecular Diagnostic Tests (MDT)</th>
<th>L36807</th>
<th>MolDX-004</th>
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<td>The following new codes are effective 07/01/2018 and have been added to this policy:</td>
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<td>0045U ONC BRST DUX CARC IS 12 GENE;</td>
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<td>0046U FLT3 GENE ITD VARIANTS QUAN;</td>
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<td>0047U ONC PRST8 MRNA 17 GENE ALG;</td>
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<td>0048U ONC SLD ORG NEO DNA 468 GENE;</td>
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<td>0049U NPM1 GENE ANALYSIS QUAN;</td>
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<td>0050U TRGT GEN SEQ DNA 194 GENES;</td>
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<td>0052U LPOPRTN BLD W/5 MAJ CLASSES;</td>
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<td>0053U ONC PRST8 CA FISH ALYS 4 GEN;</td>
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<td>0054U RX MNTR 14+ DRUGS &amp; SBSTS;</td>
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<td>0055U CARD HRT TRNSPL 96 DNA SEQ;</td>
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<td>0056U HEM AML DNA GENE REARGMT;</td>
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<td>0057U ONC SLD ORG NEO MRNA 51 GENE;</td>
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<td>0058U ONC MERKEL CLL CARC SRM QUAN;</td>
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<td>0059U ONC MERKEL CLL CARC SRM +/-;</td>
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<td>0060U TWIN ZYG GEN SEQ ALYS CHRM52;</td>
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<td>0061U TC MEAS 5 BMRK SFDI M-S ALYS;</td>
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<td>J5/J8</td>
<td>MolDX: Myriad’s BRACAnalysis CDx® Coding and Billing Guidelines</td>
<td>A55224</td>
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<td>11/15/2018</td>
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The following unspecified diagnosis codes have been removed from this article. The article has more specific codes in it.

- C50.019 Malignant neoplasm of nipple and areola, unspecified female breast
- C50.029 Malignant neoplasm of nipple and areola, unspecified male breast
- C50.119 Malignant neoplasm of central portion of unspecified female breast
- C50.129 Malignant neoplasm of central portion of unspecified male breast
- C50.219 Malignant neoplasm of upper-inner quadrant of unspecified female breast
- C50.229 Malignant neoplasm of upper-inner quadrant of unspecified male breast
- C50.319 Malignant neoplasm of lower-inner quadrant of unspecified female breast
- C50.329 Malignant neoplasm of lower-inner quadrant of unspecified male breast
- C50.419 Malignant neoplasm of upper-outer quadrant of unspecified female breast
- C50.429 Malignant neoplasm of upper-outer quadrant of unspecified male breast
- C50.519 Malignant neoplasm of lower-outer quadrant of unspecified female breast
- C50.529 Malignant neoplasm of lower-outer quadrant of unspecified male breast
- C50.619 Malignant neoplasm of axillary tail of unspecified female breast
- C50.629 Malignant neoplasm of axillary tail of unspecified male breast
- C50.819 Malignant neoplasm of overlapping sites of unspecified female breast
- C50.829 Malignant neoplasm of overlapping sites of unspecified male breast
- C50.919 Malignant neoplasm of unspecified site of unspecified female breast
- C50.929 Malignant neoplasm of unspecified site of unspecified male breast
- C56.9 Malignant neoplasm of unspecified ovary
- C57.00 Malignant neoplasm of unspecified fallopian tube

| J5/J8    | MolDX: Oncotype DX® Breast Cancer for DCIS (Genomic Health™) | L37199 | MolDX-026 | 07/01/2018 |

CPT 81479 Unlisted molecular pathology code has been replaced with the new code 0045U Oncology (breast ductal carcinoma in situ), mRNA, gene expression profiling by realtime RT-PCR of 12 genes (7 content and 5 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as recurrence score.

| J5/J8    | Wound Care Coding Companion for Wound Care L37228 | A55909 | NA | 10/01/2018 |

Added L98.495 to Group One ICD-10 Codes. Also see combined article for ICD-10 CM Code Updates.
MLN Matters Article: Claim Status Category and Claim Status Codes Update

**PROVIDER TYPE AFFECTED**

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

**PROVIDER ACTION NEEDED**

Change Request (CR) 10925 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 (January/February, June, and September/October) and makes decisions about additions, modifications, and retirement of existing codes. The Committee allows the industry 6 months for implementation of newly added or changed codes.

All code changes approved during the September/October 2018 committee meeting shall be posted on these sites on or about November 1, 2018.

The Centers for Medicare & Medicaid Services (CMS) will issue future updates to these codes, as needed. MACs 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 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 CR 10925.

The CMS’ Medicare contractors must comply with the requirements contained in the current standards adopted under HIPAA for electronically submitting certain health care transactions, among them the ASC X12 276/277 Health Care Claim Status Request and Response. These contractors must use valid Claim Status Category Codes and Claim Status Codes when sending ASC X12 277 Health Care Claim Status Responses. They must also use valid Claim Status Category Codes and Claim Status Codes when sending ASC X12 277 Healthcare Claim Acknowledgments. References in CR 10925 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 questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

DOCUMENT HISTORY

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<tr>
<th>Date of Change</th>
<th>Description</th>
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<tbody>
<tr>
<td>August 24, 2018</td>
<td>Initial article released.</td>
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Implement Operating Rules - Phase III Electronic Remittance Advice (ERA) Electronic Funds Transfer (EFT): Committee on Operating Rules for Information Exchange (CORE) 360 Uniform Use of Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC) and Claim Adjustment Group Code (CAGC) Rule - Update from Council for Affordable Quality Healthcare (CAQH) CORE

MLN Matters Number: MM10904  Related Change Request (CR) Number: 10904
Related CR Release Date: August 24, 2018  Effective Date: January 1, 2019
Related CR Transmittal Number: R4117CP  Implementation Date: January 7, 2019

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 MACs and Home Health & Hospice MACs, for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

CR 10904 instructs the MACs and Medicare’s Shared System Maintainers to update their systems based on the CORE 360 Uniform Use of CARC, RARC, and CAGC Rule publication. These system updates are based on the CORE Code Combination List to be published on or about October 1, 2018. Make sure that your billing staff is aware of these changes.

BACKGROUND

The Department of Health and Human Services (HHS) 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 amended the Social Security Act by adding Part C—Administrative Simplification—to Title XI, requiring the Secretary of HHS 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.
CR10904 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 October 1, 2018. This update is based on the CARC and RARC updates as posted at the Washington Publishing Company (WPC) website on or about July 1, 2018. This will also include updates based on market-based review that CAQH CORE conducts once a year to accommodate code combinations that are currently being used by Health Plans including Medicare as the industry needs them. See: http://www.wpc-edi.com/, for reference for CARC and RARC updates and http://www.caqh.org/sites/default/files/core/phase-iii/code-combinations/CORE-required_CodeCombos.xlsx?token=_29xvBua for CAQH CORE defined code combination updates.

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 questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

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Internet Only Manual Updates to Pub. 100-01, 100-02 and 100-04 to Correct Errors and Omissions (SNF) (2018 Q4)

MLN Matters Number: MM11004  Related Change Request (CR) Number: 11004
Related CR Release Date: November 2, 2018  Effective Date: December 4, 2018
Related CR Transmittal Number: R120GI, R249BP, and R4163CP  Implementation Date: December 4, 2018

PROVIDER TYPE AFFECTED

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

WHAT YOU NEED TO KNOW

CR 11004 updates the Medicare manuals to clarify existing content about SNF policy. These changes correct various omissions and minor technical errors. No policy, processing, or system changes are anticipated.

BACKGROUND

The Medicare General Information, Eligibility, and Entitlement Manual (Pub. 100-01) is revised as follows:

Chapter 4, Section 40.1: This section is revised by adding appropriate cross-references.

Chapter 5, Section 10.2: This section is revised by adding an appropriate cross-reference.

The Medicare Benefit Policy Manual (Pub. 100-02) is revised as follows:

Chapter 8, Section 10.1: This section is revised to correct a cross-reference.

Chapter 8, Section 20.1: This section is revised to clarify that “general inpatient care” under the hospice benefit can count toward meeting the SNF benefit’s qualifying hospital stay requirement only when actually furnished in the hospital setting.

Chapter 8, Section 30.6: This section is revised to correct a typographical error.

Chapter 8, Section 70.4: This section is revised to clarify that HHS’s Office of the Inspector
General (OIG) is the component that addresses questions on interpreting and enforcing the statutory anti-kickback provisions, and by adding an appropriate cross-reference.

**The Medicare Claims Processing Manual (Pub. 100-04) is revised as follows:**

Chapter 1, Section 30.1.3: This section is revised by adding appropriate cross-references.

Chapter 6, Section 10: This section is revised to clarify that the exclusion of certain customized devices from consolidated billing applies solely to designated prosthetic devices and not to orthotics (which, as a class, remain subject to consolidated billing), and by adding appropriate cross-references.

Chapter 6, Section 10.1: This section is revised in order to abbreviate the term “consolidated billing” (CB) consistently throughout the section, and by adding an appropriate cross-reference.

Chapter 6, Section 10.4.1: This section is revised to clarify the language on sample agreements between SNFs and their suppliers, and by adding an appropriate cross-reference.

Chapter 6, Section 20.2.2: This section is revised to clarify the explanation of why hospice services are not subject to consolidated billing.

Chapter 6, Section 20.4: This section is revised to clarify the explanation of why certain Part-D-only preventive vaccines are not subject to consolidated billing.

**ADDITIONAL INFORMATION**


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MLN Matters MM11004 Related CR 11004

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Provider Education

EDUCATION SCHEDULE

WPS GHA Learning Center

WPS GHA Provider Outreach & Education (POE) has numerous educational opportunities in our Learning Center http://wpsghalearningcenter.com/store-catalog. We offer on-demand learning, allowing you to access the education at your convenience. We also offer live events via seminar, teleconference, and webinar on many subjects. You may browse through and register for these events in the Learning Center. Our education offers Certificates of Achievement identifying the length of time of education events. You may use these certificates (without an index number) to receive Continuing Education Units (CEUs) from most accrediting organizations.

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

Here are some of the events currently available in the Learning Center, for registration and those coming in the near future:

**Teleconferences:**

**New to Medicare Series**
This is a series of teleconferences specifically created for provider staff who have no experience billing Medicare claims. This series is designed to give the billing novice a basic understanding of the Medicare program.

All calls — 9:00 AM - 10:00 AM CT (10:00 AM - 11:00 AM ET)
01/08/2019 — New to Medicare – LCDs and NCDs
02/05/2019 — New to Medicare – Finding What You Need
03/05/2019 — New to Medicare – Getting Started with Provider Enrollment
04/02/2019 — New to Medicare – Determining Patient Eligibility

**Provider Enrollment Series**
Beginning with an Ask-the-Contractor teleconference, this series of teleconferences explains the various processes involved with enrolling as a Medicare provider. Throughout the year, each month will address provider enrollment for specific provider types.

10:00 AM - 11:30 AM CT (11:00 AM - 12:30 PM ET)
01/16/2019 — Provider Enrollment Ask-the-Contractor Teleconference (ACT)
This ACT is an opportunity for our Part A and Part B provider communities to address provider enrollment questions.

All other calls: 10:00 AM CT - 11:00 AM CT (11:00 AM ET - 12:00 PM ET)
02/20/2019 — Provider Enrollment – Revalidation
03/20/2019 — Provider Enrollment – Physicians
04/17/2019 — Provider Enrollment – Hospitals
2019 Updates to Medicare

WPS GHA Provider Outreach and Education will present a teleconference covering updates to Medicare regulation for 2019. Important updates from final rules and transmittals will be highlighted.

9:00 AM - 11:30 AM CT (8:00 AM - 10:30 AM ET)
01/09/2019 — What’s New for 2019

Webinars

9:00 AM – 10:00 AM CT (10:00 AM – 11:00 AM ET)
02/12/2019 — New to Medicare – Exploring Resources

J5B In Person Events

Clinic or Group Practice Provider Enrollment
02/06/2019 — Bellevue, NE — 1:00 PM – 4:00 PM CT

Facilities Completing Provider Enrollment
02/05/2019 — Bellevue, NE — 8:30 AM – 11:30 AM CT

Outpatient Therapy Billing and Payment
02/05/2019 — Bellevue, NE — 1:00 PM – 4:00 PM CT

Outpatient Therapy (PT and OT) – Effective Documentation
02/05/2019 — Bellevue, NE — 8:30 AM – 11:30 AM CT

Professionals Completing Provider Enrollment
02/06/2019 — Bellevue, NE — 8:30 AM – 11:30 AM CT

Redeterminations, Reconsideration or Reopening?
02/06/2019 — Bellevue, NE — 1:00 PM – 4:00 PM CT

Suppliers Completing Provider Enrollment
02/05/2019 — Bellevue, NE — 1:00 PM – 4:00 PM CT

Targeted Probe and Educate: Findings and Future Reviews
02/06/2019 — Bellevue, NE — 8:30 AM – 11:30 AM CT

J8B In Person Events

Coming soon!

MEDICARE LEARNING NETWORK (MLN)

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

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

QUARTERLY PROVIDER UPDATE

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

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

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


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

2019 Annual Update for the Health Professional Shortage Area (HPSA) Bonus Payments

MLN Matters Number: MM10968  Related Change Request (CR) Number: 10968
Related CR Release Date: September 28, 2018  Effective Date: January 1, 2019
Related CR Transmittal Number: R4142CP  Implementation Date: January 7, 2019

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 10968 provides files for the automated payments of Health Professional Shortage Area (HPSA) bonuses for dates of service January 1, 2019, through December 31, 2019. Make sure 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 Centers for Medicare & Medicaid Services (CMS) automated HPSA ZIP code file are populated using the latest designations as close as possible to November 1st of each year. The HPSA ZIP code file shall be made available to the MACs in early December of each year. MACs shall implement the HPSA ZIP code file and for claims with dates of service January 1st to December 31st of the following year and make automatic HPSA bonus payments to physicians providing eligible services in a ZIP code contained on the file.

You should review the Physician Bonuses webpage at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HPSAPSAPhysicianBonuses/index.html 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.
ADDITIONAL INFORMATION


If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

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Annual Clotting Factor Furnishing Fee Update 2019

MLN Matters Number: MM10918
Related Change Request (CR) Number: 10918
Related CR Release Date: September 7, 2018
Effective Date: January 1, 2019
Related CR Transmittal Number: R4128CP
Implementation Date: January 7, 2019

PROVIDER TYPE 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

CR 10918 announces the clotting factor furnishing fee for 2019 is $0.220 per unit. Make sure that your billing staffs are aware of the update to the annual clotting factor furnishing fee for 2019.

BACKGROUND

The Medicare Modernization Act Section 303(e)(1) added Section 1842(o)(5)(C) of the Social Security Act which requires that a furnishing fee will be paid for items and services associated with clotting factor.

The Centers for Medicare & Medicaid Services 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 make payment for the furnishing fee. For dates of service from January 1, 2019, through December 31, 2019, the clotting factor furnishing fee of $0.220 per unit is added to the payment limit for the clotting factor.

ADDITIONAL INFORMATION

If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

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Influenza Vaccine Payment Allowances - Annual Update for 2018-2019 Season

MLN Matters Number: MM10914
Related Change Request (CR) Number: 10914
Related CR Release Date: August 31, 2018
Effective Date: August 1, 2018
Related CR Transmittal Number: R4124CP
Implementation Date: No later than October 1, 2018

PROVIDER TYPES 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) 10914 informs MACs about payment allowances for 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 CR 10914 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.

Annual Part B deductible and coinsurance amounts do not apply. 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 Medicare Part B payment allowances for dates of service of August 1, 2018, through July 31, 2019, are still pending as of the date of CR10914 for CPT codes 90630, 90653, 90654, 90655, 90656, 90657, 90661, 90662, 90672, 90673, 90674, 90682, 90685, 90686, 90687,
90688, 90756, and HCPCS codes Q2035, Q2036, Q2037, and Q2038. Once payment allowances are available, they will be posted at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html.

Payment allowances for codes for which products have not yet been approved will be provided when the products have been approved and pricing information becomes available to CMS.

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.

**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 2018/2019 season, that began on August 1, 2018. This reprocessing should occur by November 1, 2018.

**ADDITIONAL INFORMATION**


If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

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January 2019 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

MLN Matters Number: MM11016  Related Change Request (CR) Number: 11016
Related CR Release Date: October 26, 2018  Effective Date: January 1, 2019
Related CR Transmittal Number: R4154CP  Implementation Date: January 7, 2019

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 11016 provides the quarterly update for Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to the prior quarterly pricing files. CR11016 instructs MACs to download and implement the January 2019 and, if released, the revised October 2018, July 2018, April 2018, and January 2018 files. Medicare shall use the January 2019 ASP and Not Otherwise Classified (NOC) drug pricing files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after January 1, 2019 with dates of service January 1, 2019, through March 31, 2019. Make sure your billing staffs are aware of these updates.

BACKGROUND

The ASP methodology is based on quarterly data submitted to the Centers for Medicare & Medicaid Services (CMS) by manufacturers. CMS will supply 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 OPPS are incorporated into the Outpatient Code Editor (OCE) through separate instructions that can be located in Chapter 4, Section 50 of the Medicare Claims Processing Manual at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf.
• File: January 2019 ASP and ASP NOC -- Effective Dates of Service: January 1, 2019, through March 31, 2019
• File: October 2018 ASP and ASP NOC -- Effective Dates of Service: October 1, 2018, through December 31, 2018
• File: July 2018 ASP and ASP NOC -- Effective Dates of Service: July 1, 2018, through September 30, 2018
• File: April 2018 ASP and ASP NOC -- Effective Dates of Service: April 1, 2018, through June 30, 2018
• File: January 2018 ASP and ASP NOC -- Effective Dates of Service: January 1, 2018, through March 31, 2018

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

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 which is available at https://www.gpo.gov/fdsys/pkg/PLAW-114publ255/pdf/PLAW-114publ255.pdf.

**Note:** MACs will not search and adjust claims that have already been processed unless you bring such claims to their attention.

**ADDITIONAL INFORMATION**


If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

**DOCUMENT HISTORY**

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<tr>
<td>October 26, 2018</td>
<td>Initial article released.</td>
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specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2017 American Medical Association. All rights reserved.

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Medicare Cost Report E-Filing (MCReF)

MLN Matters Number: MM10611 Revised
Related Change Request (CR) Number: 10611

Related CR Release Date: November 2, 2018
Effective Date: June 12, 2018

Related CR Transmittal Number: R2194OTN
Implementation Date: June 12, 2018

Note: This article was revised on November 6, 2018, to reflect revisions to CR10611, issued on October 24 and November 2. The article was revised to extend the MAC portals to be open until January 2, 2019, instead of July 2, 2018. As a result of the revision to the article, providers that wish to electronically submit their MCR must do so using MCReF on or after January 2, 2019, instead of the original date of July 2, 2018. As a result of the November 2 CR revision, an incorrect Web address for new user registration is corrected. In addition, the CR release date, transmittal number, and the Web address for CR10611 are also revised. All other information remains the same.

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

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

BACKGROUND

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

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

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

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

**Streamlined the MCR Filing Process:**

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

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

**Medicare Cost Report e-Filing (MCReF) System Access:**

MCReF will be hosted at the following URL: https://mcref.cms.gov. System access to MCReF will be controlled by the EIDM system, as previously noted. Part A Provider Security Officials (SOs) and their backups (BSOs), already registered in EIDM for access to CMS PS&R, will inherit access to MCReF by default through their existing account.
Providers that are not registered in EIDM, but wish to gain access to MCreF, must register in EIDM and assign an SO for their organization. New user registration is available at https://portal.cms.gov/wps/portal/unauthportal/selfservice/newuserregistration.

**Note:** It is important for providers to keep their EIDM credentials in good standing to avoid problems using MCreF to e-file cost reports and obtaining PS&R. This includes password updates per CMS policy and the timely replacement of SOs due to staffing changes. Issues with maintaining EIDM credentials will not constitute a valid reason for filing a cost report past its due date.

Starting January 2, 2019, providers that wish to e-file their MCR must use MCreF. MAC portals will no longer be an acceptable means of submission. Providers that wish to mail or hand deliver MCRs to MACs, may continue to do so.

**Benefits of Streamlined MCR Processes:**

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

**ADDITIONAL INFORMATION**

The official instruction, CR10611, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R2194OTN.pdf. A detailed MCreF System Overview is attached to the CR. CMS encourages cost report staff to review this overview.

Chapter 1 of the Provider Reimbursement Manual is available at
If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

**DOCUMENT HISTORY**

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<td>November 6, 2018</td>
<td>The article was revised to extend the MAC portals to be open until January 2, 2019, instead of July 2, 2018. As a result of this revision to the article, providers that wish to electronically submit their MCR must do so using MCreF on or after January 2, 2019, instead of the original date of July 2, 2018. Also, an incorrect Web address for new user registration is corrected. In addition, the CR release date, transmittal number, and the Web address for CR10611 are also revised. All other information remains the same.</td>
</tr>
<tr>
<td>May 2, 2018</td>
<td>Initial article released.</td>
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October 2018 Update of the Ambulatory Surgical Center (ASC) Payment System

MLN Matters Number: MM10932  Related Change Request (CR) Number: 10932
Related CR Release Date: August 31, 2018  Effective Date: October 1, 2018
Related CR Transmittal Number: R4125CP  Implementation Date: October 1, 2018

PROVIDER TYPE AFFECTED

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

PROVIDER ACTION NEEDED

This Change Request (CR) 10932 informs MACs about changes to the ASC payment center and billing instructions for various payment policies implemented in the October 2018 ASC payment system update. The CR also includes Healthcare Common Procedure Coding System (HCPCS) updates. Make sure your billing staffs are aware of these changes.

BACKGROUND

CR10932 describes changes to and billing instructions for various payment policies implemented in the October 2018 ASC payment system update. As appropriate, this notification also includes HCPCS updates. Included in the CR are Calendar Year (CY) 2018 payment rates for separately payable drugs and biologicals, including descriptors for newly created Level II HCPCS codes for drugs and biologicals (ASC DRUG) files. CR10932 also includes an update file for the ASC Fee Schedule (ASCFS). No ASC Code Pair file is issued with this CR10932.

The key changes are as follows:

1. **New Separately Payable Procedure Code Effective October 1, 2018**

Effective October 1, 2018, HCPCS code C9750 has been created as described in Table 1. This procedure was previously described by Category III CPT code 0302T which was deleted December 31, 2017.
Table 1 — New Separately Payable Procedure Code Effective October 1, 2018

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>ASC PI</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9750</td>
<td>Ins/rem-replace compl iims</td>
<td>Insertion or removal and replacement of intracardiac ischemia monitoring system including imaging supervision and interpretation and peri-operative interrogation and programming; complete system (includes device and electrode)</td>
<td>G2</td>
</tr>
</tbody>
</table>

2. Drugs and Biologicals

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

For CY 2018, payment for non-pass-through drugs and biologicals continues to be made at a single rate of ASP + 6 percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug or biological. In addition, in CY 2018, a single payment of ASP + 6 percent continues to be made for OPPS pass-through drugs, and biologicals to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items. Payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. Updated payment rates effective October 1, 2018, are in the October 2018 update of ASC Addendum BB on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html.

b. HCPCS Codes and Dosage Descriptors for Certain Drugs and Biologicals Effective October 1, 2018

Two (2) new HCPCS codes have been created for reporting drugs and biologicals in the ASC payment system effective October 1, 2018, where there have not previously been specific codes available. These new codes are listed in Table 2.

Table 2 — HCPCS Codes and Dosage Descriptors for Certain Drugs and Biologicals Effective October

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>ASC PI</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9033</td>
<td>Inj, akynzeo</td>
<td>Injection, fosnetupitant 235 mg and palonosetron 0.25 mg</td>
<td>K2</td>
</tr>
<tr>
<td>C9034</td>
<td>Injection, dexamethasone 9%</td>
<td>Injection, dexamethasone 9%, intraocular, 1 mcg</td>
<td>K2</td>
</tr>
</tbody>
</table>
c. HCPCS Code Payment Indicator Changes to Separately Payable Status Effective October 1, 2018

Four (4) HCPCS codes will have their ASC PI change from ASC PI=N1 (Packaged service/item; no separate payment made.) to ASC PI= K2 (Drugs and biologicals paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate.) effective October 1, 2018. The HCPCS codes, their July 2018 ASC PI, and their new ASC PI effective October 1, 2018 are listed in Table 3.

Table 3 — HCPCS Code Payment Indicator Changes to Separately Payable Status Effective October 1, 2018

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>ASC PI Effective July 1, 2018</th>
<th>ASC PI Effective October 1, 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>A9586</td>
<td>Florbetapir f18</td>
<td>N1</td>
<td>K2</td>
</tr>
<tr>
<td>C9447</td>
<td>Inj, phenylephrine ketorolac</td>
<td>N1</td>
<td>K2</td>
</tr>
<tr>
<td>Q4172</td>
<td>Puraply or puraply am</td>
<td>N1</td>
<td>K2</td>
</tr>
<tr>
<td>Q9950</td>
<td>Inj sulf hexa lipid microph</td>
<td>N1</td>
<td>K2</td>
</tr>
</tbody>
</table>

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

Some drugs and biologicals based on ASP methodology may have payment rates that are corrected retroactively. These retroactive corrections typically occur on a quarterly basis. The list of drugs and biologicals with corrected payment rates will be accessible on the CMS Web site on the first date of the quarter at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/ASC-Restated-Payment-Rates.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/ASC-Restated-Payment-Rates.html).

Suppliers who think they may have received an incorrect payment for drugs and biologicals impacted by these corrections may request MAC adjustment of the previously processed claims.

e. New Biosimilar HCPCS Code Effective July 12, 2018

HCPCS code Q5108, listed in Table 4, is a biosimilar with the trade name Fulphila that will be paid separately in the ASC payment system. The code will be included in the ASC payment system with an effective date retroactive to July 12, 2018, per CR10834 which states that HCPCS code is payable for Medicare for claims with a date of service on or after July 12, 2018.

Table 4 — New Biosimilar HCPCS Code Effective July 12, 2018

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>ASC PI</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5108</td>
<td>Injection, fulphila</td>
<td>Injection, pegfilgrastim-jmdb, biosimilar, (fulphila), 0.5 mg</td>
<td>K2</td>
<td>07/12/2018</td>
</tr>
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3. Reassignment of Skin Substitute Product from the Low-Cost Group to the High Cost Group

The payment for skin substitute products that do not qualify for hospital Outpatient Prospective Payment System (OPPS) pass-through status are packaged into the OPPS payment for the associated skin substitute application procedure. This policy is also implemented in the ASC payment system. The skin substitute products are divided into two groups: 1) high cost skin substitute products and 2) low cost skin substitute products for packaging purposes. Table 5 lists the skin substitute product and its assignment as either a high cost or a low-cost skin substitute product, when applicable. ASCs should not separately bill for packaged skin substitutes (ASC PI=N1). High cost skin substitute products should only be used in combination with the performance of one of the skin application procedures described by CPT codes 15271-15278. Low cost skin substitute products should only be used in combination with the performance of one of the skin application procedures described by HCPCS code C5271-C5278. All OPPS pass-through skin substitute products (ASC PI=K2) should be billed in combination with one of the skin application procedures described by CPT code 15271-15278.

The skin substitute product listed in Table 5 has been reassigned from the low-cost skin substitute group to the high cost skin substitute group based on updated pricing information. Please note that this skin substitute product is packaged and should not be separately billed by ASCs.

Table 5 — Reassignment of Skin Substitute Product from the Low-Cost Group to the High Cost Group

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>ASC PI</th>
<th>Low/High Cost Skin Substitute</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q4181</td>
<td>Amnio wound, per square cm</td>
<td>N1</td>
<td>High</td>
</tr>
</tbody>
</table>

4. Coverage Determinations

The fact that a drug, device, procedure or service is assigned a HCPCS code and a payment rate under the ASC payment system does not imply coverage by the Medicare program, but indicates only how the product, procedure, or service may be paid if covered by the program. 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 questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

DOCUMENT HISTORY

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MLN Matters Number: MM10970  Related Change Request (CR) Number: 10970
Related CR Release Date: October 12, 2018  Effective Date: January 1, 2019
Related CR Transmittal Number: R2151OTN  Implementation Date: January 7, 2019

PROVIDER TYPES AFFECTED

This MLN Matters Article is intended for organizations enrolled as Medicare Diabetes Prevention Program (MDPP) suppliers billing Medicare Administrative Contractors (MACs) for MDPP services provided to Medicare beneficiaries.

WHAT YOU NEED TO KNOW

Change Request (CR) 10970 contains instructions for MACs and the Railroad Specialty MAC to update the MDPP Expanded Model payment rates for CY 2019. Make sure your billing staffs are aware of the update.

BACKGROUND

The MDPP Expanded Model is an expansion of the Centers for Medicare & Medicaid Services (CMS) Diabetes Prevention Program (DPP) model test, which was tested from 2012-2015 under the authority of Section 1115A(b) of the Social Security Act (the Act).

In March of 2016, the Secretary of Health and Human Services determined the DPP model test met the criteria for expansion in duration and scope under the authority of Section 1115A(c) of the Act. Following this determination, the Center for Medicare and Medicaid Innovation (CMMI) expanded the model nationwide through the CY 2017 and 2018 Medicare Physician Fee Schedule (PFS) final rules.

MDPP suppliers began enrolling in Medicare on January 1, 2018, and began furnishing MDPP services and billing Medicare for MDPP services on April 1, 2018. The MDPP Expanded Model is intended to prevent Medicare beneficiaries with an indication of prediabetes from developing diabetes. Prevention of diabetes among this high-risk group of Medicare beneficiaries is expected to result in significant cost savings to the Medicare program.

CMS pays MDPP suppliers using a performance-based payment method that is based on
beneficiary achievement of weight loss and attendance goals. CMS also offers a one-time “bridge payment” to MDPP suppliers when a beneficiary begins receiving services from them but previously received services from a different MDPP supplier. For more information on MDPP payments, please visit https://go.cms.gov/mdpp.

The CY 2018 MDPP payment rates were established in the CY 2018 Medicare Physician Fee Schedule final rule. This rule also stipulates that the MDPP performance payments and bridge payment will be adjusted each calendar year by the percent change in the Consumer Price Index for All Urban Consumers (CPI-U) (U.S. city average) for the 12-month period ending June 30th of the year preceding the update year. The percent change update will be calculated based on the level of precision of the index as published by the Bureau of Labor Statistics and applied based on one decimal place of precision. Payment rates will be in effect each year from January 1st through December 31st.

CMS intends to calculate the payment rates for each calendar year and instruct the MACs and the Railroad Specialty MAC to update the MDPP payment rates each year through a change request (CR). The annual rates each year will be published by CMS transmittal.

CR10970 contains instructions to MACs and the Railroad Specialty MAC to update the MDPP Expanded Model payment rates for CY 2019. CMS has calculated the MDPP payment rates for CY 2019, which are displayed in the following table. The rates below will be in effect for dates of service January 1, 2019 through December 31, 2019.

Table: MDPP Expanded Model HCPCS G-Codes CY 2019

<table>
<thead>
<tr>
<th>HCPCS G-Code</th>
<th>Long Descriptor</th>
<th>2019 Payment Amount</th>
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<tr>
<td>G9873</td>
<td>First Medicare Diabetes Prevention Program (MDPP) core session was attended by an MDPP beneficiary under the MDPP Expanded Model (EM). A core session is an MDPP service that: (1) is furnished by an MDPP supplier during months 1 through 6 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for core sessions.</td>
<td>$26</td>
</tr>
<tr>
<td>G9874</td>
<td>Four total Medicare Diabetes Prevention Program (MDPP) core sessions were attended by an MDPP beneficiary under the MDPP Expanded Model (EM). A core session is an MDPP service that: (1) is furnished by an MDPP supplier during months 1 through 6 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for core sessions.</td>
<td>$51</td>
</tr>
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| HCPCS  
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<th>G-Code</th>
<th>Long Descriptor</th>
<th>2019 Payment Amount</th>
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<tbody>
<tr>
<td>G9875</td>
<td>Nine total Medicare Diabetes Prevention Program (MDPP) core sessions were attended by an MDPP beneficiary under the MDPP Expanded Model (EM). A core session is an MDPP service that: (1) is furnished by an MDPP supplier during months 1 through 6 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for core sessions.</td>
<td>$93</td>
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<tr>
<td>G9876</td>
<td>Two Medicare Diabetes Prevention Program (MDPP) core maintenance sessions (MS) were attended by an MDPP beneficiary in months (mo.) 7-9 under the MDPP Expanded Model (EM). A core maintenance session is an MDPP service that: (1) is furnished by an MDPP supplier during months 7 through 12 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for maintenance sessions. The beneficiary did not achieve at least 5% weight loss (WL) from his/her baseline weight, as measured by at least one in-person weight measurement at a core maintenance session in months 7-9.</td>
<td>$15</td>
</tr>
<tr>
<td>G9877</td>
<td>Two Medicare Diabetes Prevention Program (MDPP) core maintenance sessions (MS) were attended by an MDPP beneficiary in months (mo) 10-12 under the MDPP Expanded Model (EM). A core maintenance session is an MDPP service that: (1) is furnished by an MDPP supplier during months 7 through 12 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for maintenance sessions. The beneficiary did not achieve at least 5% weight loss (WL) from his/her baseline weight, as measured by at least one in-person weight measurement at a core maintenance session in months 10-12.</td>
<td>$15</td>
</tr>
<tr>
<td>G9878</td>
<td>Two Medicare Diabetes Prevention Program (MDPP) core maintenance sessions (MS) were attended by an MDPP beneficiary in months (mo) 7-9 under the MDPP Expanded Model (EM). A core maintenance session is an MDPP service that: (1) is furnished by an MDPP supplier during months 7 through 12 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for maintenance sessions. The beneficiary achieved at least 5% weight loss (WL) from his/her baseline weight, as measured by at least one in-person weight measurement at a core maintenance session in months 7-9.</td>
<td>$62</td>
</tr>
<tr>
<td>G9879</td>
<td>Two Medicare Diabetes Prevention Program (MDPP) core maintenance sessions (MS) were attended by an MDPP beneficiary in months (mo) 10-12 under the MDPP Expanded Model (EM). A core maintenance session is an MDPP service that: (1) is furnished by an MDPP supplier during months 7 through 12 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for maintenance sessions.</td>
<td>$62</td>
</tr>
</tbody>
</table>
The beneficiary achieved at least 5% weight loss (WL) from his/her baseline weight, as measured by at least one in-person weight measurement at a core maintenance session in months 10-12.

<table>
<thead>
<tr>
<th>HCPCS G-Code</th>
<th>Long Descriptor</th>
<th>2019 Payment Amount</th>
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<tbody>
<tr>
<td>G9880</td>
<td>The MDPP beneficiary achieved at least 5% weight loss (WL) from his/her baseline weight in months 1-12 of the MDPP services period under the MDPP Expanded Model (EM). This is a one-time payment available when a beneficiary first achieves at least 5% weight loss from baseline as measured by an in-person weight measurement at a core session or core maintenance session.</td>
<td>$165</td>
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<tr>
<td>G9881</td>
<td>The MDPP beneficiary achieved at least 9% weight loss (WL) from his/her baseline weight in months 1-24 under the MDPP Expanded Model (EM). This is a one-time payment available when a beneficiary first achieves at least 9% weight loss from baseline as measured by an in-person weight measurement at a core session, core maintenance session, or ongoing maintenance session.</td>
<td>$26</td>
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<tr>
<td>G9882</td>
<td>Two Medicare Diabetes Prevention Program (MDPP) ongoing maintenance sessions (MS) were attended by an MDPP beneficiary in months (mo) 13-15 under the MDPP Expanded Model (EM). An ongoing maintenance session is an MDPP service that: (1) is furnished by an MDPP supplier during months 13 through 24 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for maintenance sessions. The beneficiary maintained at least 5% weight loss (WL) from his/her baseline weight, as measured by at least one in-person weight measurement at an ongoing maintenance session in months 13-15.</td>
<td>$51</td>
</tr>
<tr>
<td>G9883</td>
<td>Two Medicare Diabetes Prevention Program (MDPP) ongoing maintenance sessions (MS) were attended by an MDPP beneficiary in months (mo) 16-18 under the MDPP Expanded Model (EM). An ongoing maintenance session is an MDPP service that: (1) is furnished by an MDPP supplier during months 13 through 24 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for maintenance sessions. The beneficiary maintained at least 5% weight loss (WL) from his/her baseline weight, as measured by at least one in-person weight measurement at an ongoing maintenance session in months 16-18.</td>
<td>$51</td>
</tr>
<tr>
<td>G9884</td>
<td>Two Medicare Diabetes Prevention Program (MDPP) ongoing maintenance sessions (MS) were attended by an MDPP beneficiary in months (mo) 19-21 under the MDPP Expanded Model (EM). An ongoing maintenance session is an MDPP service that: (1) is furnished by an MDPP supplier during months 13 through 24 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for maintenance sessions.</td>
<td>$51</td>
</tr>
</tbody>
</table>
The beneficiary maintained at least 5% weight loss (WL) from his/her baseline weight, as measured by at least one in-person weight measurement at an ongoing maintenance session in months 19-21.

Two Medicare Diabetes Prevention Program (MDPP) ongoing maintenance sessions (MS) were attended by an MDPP beneficiary in months (mo) 22-24 under the MDPP Expanded Model (EM). An ongoing maintenance session is an MDPP service that: (1) is furnished by an MDPP supplier during months 13 through 24 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for maintenance sessions.

The beneficiary maintained at least 5% weight loss (WL) from his/her baseline weight, as measured by at least one in-person weight measurement at an ongoing maintenance session in months 22-24.

Bridge Payment: A one-time payment for the first Medicare Diabetes Prevention Program (MDPP) core session, core maintenance session, or ongoing maintenance session furnished by an MDPP supplier to an MDPP beneficiary during months 1-24 of the MDPP Expanded Model (EM) who has previously received MDPP services from a different MDPP supplier under the MDPP Expanded Model. A supplier may only receive one bridge payment per MDPP beneficiary.

MDPP session reported as a line-item on a claim for a payable MDPP Expanded Model (EM) HCPCS code for a session furnished by the billing supplier under the MDPP Expanded Model and counting toward achievement of the attendance performance goal for the payable MDPP Expanded Model HCPCS code. (This code is for reporting purposes only).

### ADDITIONAL INFORMATION


If you have questions, your MACs may have more information. Find their website at [http://go.cms.gov/MAC-website-list](http://go.cms.gov/MAC-website-list).
WPS GHA PROVIDER SERVICES

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

### J5 MAC (IA, KS, MO, NE, AND NATIONAL)

<table>
<thead>
<tr>
<th>Iowa</th>
<th>Kansas</th>
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<tbody>
<tr>
<td>WPS GHA</td>
<td>WPS GHA</td>
</tr>
<tr>
<td>General Correspondence</td>
<td>General Correspondence</td>
</tr>
<tr>
<td>P.O. Box 7665</td>
<td>P.O. Box 7576</td>
</tr>
<tr>
<td>Madison, WI 53707-7665</td>
<td>Madison, WI 53707-7576</td>
</tr>
<tr>
<td>(866) 518-3285</td>
<td>(866) 518-3285</td>
</tr>
<tr>
<td>Missouri</td>
<td>Nebraska</td>
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<tr>
<td>General Correspondence</td>
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<tr>
<td>P.O. Box 8890</td>
<td>P.O. Box 8799</td>
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<tr>
<td>Madison, WI 53708-8890</td>
<td>Madison, WI 53708-8799</td>
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<tr>
<td>(866) 518-3285</td>
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<td>National</td>
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<td>P.O. Box 7861</td>
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<tr>
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<tr>
<td>(866) 518-3285</td>
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### J8 MAC (IN, MI)

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<th>Michigan</th>
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<tr>
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</tr>
<tr>
<td>P.O. Box 8602</td>
<td>P.O. Box 8604</td>
</tr>
<tr>
<td>Madison, WI 53708-8602</td>
<td>Madison, WI 53708-8604</td>
</tr>
<tr>
<td>(866) 234-7331</td>
<td>(866) 234-7331</td>
</tr>
</tbody>
</table>

VISIT [WPSGHA.COM](http://www.wpsgha.com/) FOR ALL YOUR MEDICARE NEEDS

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

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