NOTE: Should you have landed here as a result of a search engine (or other) link, be advised that these files contain material that is copyrighted by the American Medical Association. You are forbidden to download the files unless you read, agree to, and abide by the provisions of the copyright statement. Read the copyright statement now and you will be linked back to here.
What’s Inside...

**Administration**

- 2018 MAC Satisfaction Indicator (MSI) - Evaluate Our Services! ...........................................2
- CMS Quarterly Provider Update ............................................................................................4
- Going Beyond Diagnosis .......................................................................................................4
- Get Your Medicare News Electronically ................................................................................5
- Form CMS-855O Processing Guide ......................................................................................7
- Reinstating the Qualified Medicare Beneficiary Indicator in the Medicare Fee-For-Service Claims Processing System from CR9911.................................................................9
- Adjustments to Qualified Medicare Beneficiary (QMB) Claims ..............................................12
- Prohibition Billing Dually Eligible Individuals Enrolled in the Qualified Medicare Beneficiary (QMB) Program ..........................................................14

**Drugs and Biologicals**

Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes - April 2018 Update ..........................................................19

**Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)**

April Quarterly Update for 2018 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule .................................................................21

**Education**

Educational Events Where You Can Ask Questions and Get Answers from Palmetto GBA ...................................................................................................................25

**Medicine**

NCD Coding Review: CR 10318-ICD-10 and Other Coding Revisions to NCDs.............27
- ICD-10 and Other Coding Revisions to National Coverage Determinations (NCDs) ........28

**Ambulatory Surgical Center (ASC)**

April 2018 Update of the Ambulatory Surgical Center (ASC) Payment System .............30

Continued >>

The JM Part B Medicare Advisory contains coverage, billing and other information for Part B. This information is not intended to constitute legal advice. It is our official notice to those we serve concerning their responsibilities and obligations as mandated by Medicare regulations and guidelines. This information is readily available at no cost on the Palmetto GBA website. It is the responsibility of each facility to obtain this information and to follow the guidelines. The JM Part B Medicare Advisory includes information provided by the Centers for Medicare & Medicaid Services (CMS) and is current at the time of publication. The information is subject to change at any time. This bulletin should be shared with all health care practitioners and managerial members of the provider staff. Bulletins are available at no-cost from our website at https://www.PalmettoGBA.com/JMB.

CPT only copyright 2017 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association. Applicable FARS/DFARS Restrictions Apply to Government Use. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, and are not part of CPT®, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein. The Code on Dental Procedures and Nomenclature is published in Current Dental Terminology (CDT), Copyright © 2017 American Dental Association (ADA). All rights reserved.
2018 MAC Satisfaction Indicator (MSI) - Evaluate Our Services!

The 2018 MAC Satisfaction Indicator (MSI), a survey administered by the Centers for Medicare & Medicaid Services (CMS), is now available. The MSI measures your satisfaction with our processes and service delivery so we can gain valuable insights and determine process improvements.

The MAC Satisfaction Indicator (MSI) is the best way to share your opinions directly with the Centers for Medicare & Medicaid Services (CMS) about your experience with us. These survey results will help us gain valuable insights and determine process improvements.

Take the survey today: https://cfigroup.qualtrics.com/jfe/form/SV_0iaaiJ6oOWShLIF?MAC_BRNC=11&MAC=JM–Palmetto

Thank you for the feedback provided to us throughout 2017. We made a lot of improvements to our services and have more planned in the coming months. In response to the provider feedback we created the following educational resources and enhancements:

• Offered more frequent webcast educational opportunities in response to your feedback
• Offered more education focused on clinical documentation instruction as well as billing guidance
• Developed additional web-based training modules
• Expanded our eServices online portal offerings
• Added better communication in our provider enrollment letters and email responses in relation to specific reasons for denial
Want to stay informed about the latest changes to the Medicare Program? Get connected with the Medicare Learning Network® (MLN) – the home for education, information, and resources for health care professionals.

The Medicare Learning Network® is a registered trademark of the Centers for Medicare & Medicaid Services (CMS) and the brand name for official CMS education and information for health care professionals. It provides educational products on Medicare-related topics, such as provider enrollment, preventive services, claims processing, provider compliance, and Medicare payment policies. MLN products are offered in a variety of formats, including training guides, articles, educational tools, booklets, fact sheets, web-based training courses (many of which offer continuing education credits) – all available to you free of charge!

The following items may be found on the CMS web page at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/index.html

- **MLN Catalog:** is a free interactive downloadable document that lists all MLN products by media format. To access the catalog, scroll to the “Downloads” section and select “MLN Catalog.” Once you have opened the catalog, you may either click on the title of a product or you can click on the type of “Formats Available.” This will link you to an online version of the product or the Product Ordering Page.
- **MLN Product Ordering Page:** allows you to order hard copy versions of various products. These products are available to you for free. To access the MLN Product Ordering Page, scroll to the “Related Links” and select “MLN Product Ordering Page.”
- **MLN Product of the Month:** highlights a Medicare provider education product or set of products each month along with some teaching aids, such as crossword puzzles, to help you learn more while having fun!

**Other resources:**
- **MLN Publications List:** contains the electronic versions of the downloadable publications. These products are available to you for free. To access the MLN Publications go to: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications.html. You will then be able to use the “Filter On” feature to search by topic or key word or you can sort by date, topic, title, or format.

**MLN Educational Products Electronic Mailing List**
To stay up-to-date on the latest news about new and revised MLN products and services, subscribe to the MLN Educational Products electronic mailing list! This service is free of charge. Once you subscribe, you will receive an e-mail when new and revised MLN products are released.

To subscribe to the service:
1. Go to https://list.nih.gov/cgi-bin/wa.exe?A0=mln_education_products-l and select the ‘Subscribe or Unsubscribe’ link under the ‘Options’ tab on the right side of the page.
2. Follow the instructions to set up an account and start receiving updates immediately – it’s that easy!

If you would like to contact the MLN, please email CMS at MLN@cms.hhs.gov.

CPT codes, descriptors and other data only are copyright 2017 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2017 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.
CMS 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 a listing of all non-regulatory changes to Medicare including program memoranda, manual changes and any other instructions that could affect providers. Regulations and instructions published in the previous quarter are also included in the update. The purpose of the Quarterly Provider Update is to:

• Inform providers about new developments in the Medicare program
• Assist providers in understanding CMS programs and complying with Medicare regulations and instructions
• Ensure that providers have time to react and prepare for new requirements
• Announce new or changing Medicare requirements on a predictable schedule
• Communicate the specific days that CMS business will be published in the ‘Federal Register’

To receive notification when regulations and program instructions are added throughout the quarter, sign up for the Quarterly Provider Update listserv (electronic mailing list) at https://public.govdelivery.com/accounts/USCMS/subscriber/new?pop=t&qsp=566.

We encourage you to bookmark the Quarterly Provider Update Web site at www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/index.html and visit it often for this valuable information.

Going Beyond Diagnosis
Preventing Payment Errors by Improving Provider-Payer Communication

A failure to communicate is the number one cause of Medicare claims denials. Palmetto GBA’s Going Beyond Diagnosis (GBD) process helps reduce Medicare denials by supporting the dissemination of best practices and process improvements. The GBD Blog was established to provide a platform for discussing the challenges and complexities of communicating health care encounters and to provide potential solutions to identify the root causes for specific communication errors.

The GBD Blog and Twitter ID @BeyondDx are part of Palmetto GBA’s innovative strategy for increasing the capacity of Medicare providers to improve the quality of healthcare records and effectively decrease the claims payment error rate. The success of this social media approach to communicating with healthcare stakeholders depends on your active participation.

True innovation requires collaboration. Please join the on-line GBD community by visiting the GBD Blog at http://palmgba.com/gbd/ or signing-up to follow us on Twitter @BeyondDx.
Get Your Medicare News Electronically

The Palmetto GBA Medicare listserv is a wonderful communication tool that offers its members the opportunity to stay informed about:

- Medicare incentive programs
- New legislation concerning Medicare
- Fee Schedule changes
- And so much more!

How to register to receive the Palmetto GBA Medicare Listserv:
Go to http://tinyurl.com/PalmettoGBAListserv and select “Register Now.” Complete and submit the online form. Be sure to select the specialties that interest you so information can be sent.

Note: Once the registration information is entered, you will receive a confirmation/welcome message informing you that you’ve been successfully added to our listserv. You must acknowledge this confirmation within 3 days of your registration.

We’d Love Your Feedback!

Palmetto GBA is committed to continuously improve your customer experience. We welcome your feedback on your experiences with the PalmettoGBA.com website and the eServices portal. As a visitor to the Palmetto GBA's website, you may be presented with an opportunity to take the website satisfaction survey.

The next time the survey is offered to you, please agree to participate and provide us with your feedback. You have the opportunity to explain your comments, share your honest opinions, and tell us what you like and what you would like to see us improve. If you find a feature or tool specifically helpful, let us know including any suggestions for making them simpler to use.

We continuously analyze your feedback and develop enhancements plans to better assist you with your experience. We value your opinion and look forward to hearing from you.
EDI Enrollment Instructions Guide Module

Do you need help completing your EDI Enrollment packet? This interactive guide will give you all the information you need to get started, including which forms to complete, and the fields that must be completed on each form. Access the EDI Enrollment Instructions Guide Module under Forms/Tools on the home page.

CPT codes, descriptors and other data only are copyright 2017 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2017 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.
MLN Matters Number: MM10355  
Related CR Release Date: February 23, 2018  
Related CR Transmittal Number: R773PI  
Related Change Request (CR) Number: 10355  
Effective Date: March 23, 2018  
Implementation Date: March 23, 2018

**PROVIDER TYPE AFFECTED**  
This MLN Matters Article is intended for eligible ordering, certifying physicians, and other eligible professionals who order or certify items or services for Medicare beneficiaries.

**PROVIDER ACTION NEEDED**  
Change Request (CR) 10355 adds, to the Medicare Program Integrity Manual, a supplementary guide that educates physicians and other eligible professionals on the preparation and submission of the Centers for Medicare & Medicaid Services form (CMS)-855O. The CR does not involve any legislative or regulatory policies.

**BACKGROUND**  
Most physicians and eligible professionals (as defined in section 1848(K)(3)(B) of the Social Security Act) enroll in the Medicare program to be reimbursed for the covered services they furnish to Medicare beneficiaries. However, with the implementation of Section 6405 of the Affordable Care Act, the Centers for Medicare & Medicaid Services (CMS) requires certain physicians and eligible professionals to enroll in the Medicare program not for reimbursement for furnishing services, but rather for the sole purpose of ordering, or certifying, items or services for Medicare beneficiaries.

The providers who may enroll in Medicare solely for the purpose of ordering and certifying include those who are:

- Doctors of Medicine or Osteopathy
- Doctors of Dental Medicine
- Doctors of Dental Surgery
- Doctors of Podiatric Medicine
- Doctors of Optometry
- Physician Assistants
- Certified Clinical Nurse Specialists
- Nurse Practitioners
- Clinical Psychologists
- Certified Nurse Midwives
- Clinical Social Workers
- Licensed Residents (as defined in 42 C.F.R. section 413.75(b)) in an approved medical residency program
- Retired Physicians who are licensed

Continued >>
These providers can enroll for the sole purpose of ordering or certifying items or services for Medicare beneficiaries by completing the Form CMS-855O via paper or the Internet-based Provider Enrollment, Chain and Ownership System (PECOS) process. To obtain additional information on Internet-based PECOS, refer to [http://www.cms.gov/Medicare/Provider-Enrollment-and-Certiﬁcation/MedicareProviderSupEnroll/InternetbasedPECOS.html](http://www.cms.gov/Medicare/Provider-Enrollment-and-Certiﬁcation/MedicareProviderSupEnroll/InternetbasedPECOS.html).

CR10355 adds a new supplemental guide to the Medicare Program Integrity Manual titled: Processing the CMS-855O Medicare Enrollment Application – Enrollment for Eligible Ordering, Certifying Physicians, and Other Eligible Professionals. This supplementary guide has been developed to educate providers and suppliers on the preparation and submission of the form CMS-855O.

**ADDITIONAL INFORMATION**


**DOCUMENT HISTORY**

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>February 23, 2018</td>
<td>Initial article released</td>
</tr>
</tbody>
</table>

---

eServices Makes Asking a Medicare Question Easier!

The eServices Secure eChat option allows providers to interact with designated Palmetto GBA staff so they can receive real-time assistance locating information on any topics or specialties they are searching for on the Palmetto GBA website or within the eServices online portal. The Secure eChat feature also allows users to dialogue with an online operator who can assist with patient or provider specific inquiries or address questions that require the sharing of PHI information! Using Secure eChat is simple! This free portal is available to all Medicare providers as long as you have a signed Electronic Data Interchange (EDI) Enrollment Agreement and a processed claim history. Once in the eServices portal, from the bottom right corner select either Medicare Inquiries or eServices Help. If you do not have an eServices account, you can get started by clicking this eServices link [https://www.onlineproviderservices.com/ecx_improvev2/](https://www.onlineproviderservices.com/ecx_improvev2/). The Secure eChat feature is available during business hours to assist providers.
Reinstating the Qualified Medicare Beneficiary Indicator in the Medicare Fee-For-Service Claims Processing System from CR9911

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

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

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

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

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

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

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

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

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

Additionally, CR 9911 changed the display of patient responsibility on the RA by replacing Claim Adjustment Group Code “Patient Responsibility” (PR) with Group Code “Other Adjustment” (OA). CMS zeroed out the deductible and coinsurance amounts associated with Claim Adjustment Reason Code (CARC) 1 (deductible) and/or 2 (coinsurance) and used CARC 209 – (“Per regulatory or other agreement, the provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to the patient if collected. (Use only with Group code OA).”)

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

To address these issues, on December 8, 2017, CMS suspended the CR 9911 system changes causing the claims processing systems to suspend the RA and MSN changes for QMB claims under CR 9911.

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

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

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

All Medicare’s FFS systems will discontinue the practice of outputting Claim Adjustment Group Code OA with CARC 209 in place of CARCs 1 and 2, as well as CARCs 66, 247, and 248, on the ERAs and on SPRs, as applicable.
The shared systems shall include the revised Alert RARCs N781 and N782 in association with CARCs 1 and or 2 on the RA. These RARCs designate that the beneficiary is enrolled in the QMB program and may not be billed for Medicare cost sharing amounts. Additionally, for QMB claims, the Part A and B shared systems shall include the revised Alert RARC N781 in association with CARC 66 (blood deductible). The revised Alert RARCs are as follows:

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

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

**ADDITIONAL INFORMATION**

**DOCUMENT HISTORY**

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 13, 2018</td>
<td>This article was revised to reflect an updated CR. That CR added CARCs 66, 247, and 248 (page 3 above). DME MACs were added to the “Providers Affected” section and the QMB enrollment numbers were also updated on page 2 to reflect 2016 statistics. Pharmacies were also included in the “Background” section. The CR date, transmittal number and link to the transmittal also changed. All other information is unchanged</td>
</tr>
<tr>
<td>February 28, 2018</td>
<td>This article was revised to correct a date in the “What you Need to Know” Section. The date should have been December 8, 2017.” All other information is unchanged.</td>
</tr>
<tr>
<td>February 2, 2018</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>
Adjustments to Qualified Medicare Beneficiary (QMB) Claims

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

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

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

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

To address these issues, on December 8, 2017, the Centers for Medicare & Medicaid Services (CMS) temporarily suspended the CR9911 claims processing system modifications. See “QMB Remittance Advice Issue” at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination-Ofﬁce/Downloads/MM9911Update112017.pdf.

Through CR10433, CMS will reintroduce QMB information in the RA starting July 2018 and modify CR9911 to avoid disrupting claims processing by secondary payers. CR10433 will be effective for claims processed on or after July 2, 2018. A related article is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm10433.pdf.

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

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

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

Make sure your billing staff is aware of these changes.

**ADDITIONAL INFORMATION**

**DOCUMENT HISTORY**

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 22, 2018</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>
Prohibition Billing Dually Eligible Individuals Enrolled in the Qualified Medicare Beneficiary (QMB) Program

MLN Matters Number: SE1128 Revised
Related CR Release Date: March 22, 2018
Related CR Transmittal Number: N/A
Related Change Request (CR) Number: N/A
Effective Date: N/A
Implementation Date: N/A

Note: This article was revised on March 22, 2018 to include updated information about the Remittance Advice (RA) and Medicare Summary Notice (MSN) for all Medicare Fee-For-Service (FFS) QMB claims. It also includes new statistics on the number of beneficiaries enrolled in QMB. All other information remains the same.

PROVIDER TYPE AFFECTED
This article pertains to all Medicare providers and suppliers, including pharmacies that serve beneficiaries enrolled in Original Medicare or a Medicare Advantage (MA) plan.

PROVIDER ACTION NEEDED
This Special Edition MLN Matters® Article from the Centers for Medicare & Medicaid Services (CMS) reminds all Medicare providers and suppliers, including pharmacies, that they may not bill beneficiaries enrolled in the QMB program for Medicare cost-sharing. Medicare beneficiaries enrolled in the QMB program have no legal obligation to pay Medicare Part A or Part B deductibles, coinsurance, or copays for any Medicare-covered items and services.

Implement key measures to ensure compliance with QMB billing requirements. Use HIPAA Eligibility Transaction System (HETS) (effective November 2017), CMS’ eligibility-verification system, and the provider RA (July 2018) to identify beneficiaries’ QMB status and exemption from cost-sharing prior to billing. Starting July 2018, look for QMB alerts messages in the Remittance Advice for FFS claims to verify QMB after claims processing. Refer to the Background and Additional Information Sections below for further details and important steps to promote compliance.

BACKGROUND
All Original Medicare and MA providers and suppliers—not only those that accept Medicaid—must not charge individuals enrolled in the QMB program for Medicare cost-sharing. Providers who inappropriately bill individuals enrolled in QMB are subject to sanctions. Providers and suppliers may bill State Medicaid programs for these costs, but States can limit Medicare cost-sharing payments under certain circumstances.

Billing of QMBs Is Prohibited by Federal Law
Federal law bars Medicare providers and suppliers from billing an individual enrolled in the QMB program for Medicare Part A and Part B cost-sharing under any circumstances (see Sections 1902(n)(3)(B), 1902(n)(3)(C), 1905(p)(3), 1866(a)(1)(A), and 1848(g)(3)(A) of the Social Security Act [the Act]). The QMB program is a State Medicaid benefit that assists low-income Medicare beneficiaries with Medicare Part A and Part B

Continued >>
premiums and cost-sharing, including deductibles, coinsurance, and copays. In 2016, 7.5 million individuals (more than one out of eight beneficiaries) were enrolled in the QMB program.

Providers and suppliers may bill State Medicaid agencies for Medicare cost-sharing amounts. However, as permitted by Federal law, States can limit Medicare cost-sharing payments, under certain circumstances. Regardless, persons enrolled in the QMB program have no legal liability to pay Medicare providers for Medicare Part A or Part B cost-sharing. Medicare providers who do not follow these billing prohibitions are violating their Medicare Provider Agreement and may be subject to sanctions (see Sections 1902(n)(3)(C), 1905(p)(3), 1866(a)(1)(A), and 1848(g)(3)(A) of the Act).

Note that certain types of providers may seek reimbursement for unpaid Medicare deductible and coinsurance amounts as a Medicare bad debt. For more information about bad debt, refer to Chapter 3 of the Provider Reimbursement Manual (Pub.15-1) (https://www.cms.gov/Regulations-and-Guidance/Guidance/ Manuals/Paper-Based-Manuals-Items/CMS021929.html).

Refer to the Important Reminders Concerning QMB Billing Requirements Section below for key policy clarifications.

**Inappropriate Billing of QMB Individuals Persists**

Despite Federal law, providers and suppliers continue to improperly bill individuals enrolled in the QMB program. Many beneficiaries are unaware of the billing restrictions (or concerned about undermining provider relationships) and simply pay the cost-sharing amounts. Others may experience undue distress when unpaid bills are referred to collection agencies. For more information, refer to Access to Care Issues Among Qualified Medicare Beneficiaries (QMB), Centers for Medicare & Medicaid Services July 2015 (https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination- Office/Downloads/Access_to_Care_Issues_Among_Qualified_Medicare_Beneficiaries.pdf).

**Ways to Promote Compliance with QMB Billing Rules**

Take the following steps to ensure compliance with QMB billing prohibitions:

1. Establish processes to routinely identify the QMB status of Medicare beneficiaries prior to billing for items and services.
   - Use Medicare eligibility data provided to Medicare providers, suppliers, and their authorized billing agents (including clearinghouses and third party vendors) by CMS’ HETS (effective November 2017) to verify a beneficiary’s QMB status and exemption from cost-sharing charges. Ask your third party eligibility-verification vendors how their products reflect the new QMB information from HETS. For more information on HETS, visit https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/index.html.
   - In July 2018, CMS will reintroduce QMB information in the Medicare RA that Original Medicare providers and suppliers can use to identify the QMB status of beneficiaries. Refer to the Additional Information section below for educational materials on recent changes that impact RAs for Medicare FFS QMB claims.
   - MA providers and suppliers should also contact the MA plan to learn the best way to identify the QMB status of plan members both before and after claims submission.
2. Providers and suppliers may also verify beneficiaries’ QMB status through automated Medicaid eligibility-verification systems in the State in which the person is a resident or by asking beneficiaries for other proof, such as their Medicaid identification card or documentation of their QMB status. Ensure that billing procedures and third-party vendors exempt individuals enrolled in the QMB program from Medicare charges and that you remedy billing problems should they occur. If you have erroneously billed individuals enrolled in the QMB program, recall the charges (including referrals to collection agencies) and refund the invalid charges they paid.

3. Determine the billing processes that apply to seeking payment for Medicare cost-sharing from the States in which the beneficiaries you serve reside. Different processes may apply to Original Medicare and MA services provided to individuals enrolled in the QMB program. For Original Medicare claims, nearly all States have electronic crossover processes through the Medicare Benefits Coordination & Recovery Center (BCRC) to automatically receive Medicare-adjudicated claims.

If a claim is automatically crossed over to another payer, such as Medicaid, it is customarily noted on the Medicare RA.

States require all providers, including Medicare providers, to enroll in their Medicaid system for provider claims review, processing, and issuance of the Medicaid RA. Providers should contact the State Medicaid Agency for additional information regarding Medicaid provider enrollment.

**Important Reminders Concerning QMB Billing Requirements**

Be aware of the following policy clarifications on QMB billing requirements:

1. All Original Medicare and MA providers and suppliers—not only those that accept Medicaid—must not charge individuals enrolled in the QMB program for Medicare cost-sharing.

2. Individuals enrolled in the QMB program keep their protection from billing when they cross State lines to receive care. Providers and suppliers cannot charge individuals enrolled in QMB even if their QMB benefit is from a different State than the State where they get care.

3. Note that individuals enrolled in QMB cannot elect to pay Medicare deductibles, coinsurance, and copays. However, a QMB who also receives full Medicaid may have a small Medicaid copay.

**ADDITIONAL INFORMATION**

For more information on this process, refer to Section HI 00801.140 of the Social Security Administration Program Operations Manual System (https://secure.ssa.gov/apps10/poms.nsf/lnx/0600801140).

Refer to these educational materials for information on recent changes that impact RAs and MSNs for Medicare FFS QMB claims:


- On December 8, 2017, the claims processing system modifications made on October 2, 2017, were temporarily suspended due to unintended issues that affected processing QMB cost-sharing claims by States and other payers secondary to Medicare. For more information, refer to QMB Remittance Advice Issue ([https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MM9911Update112017.pdf](https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MM9911Update112017.pdf)).
• MLN Matters Article 10494 (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10494.pdf) describes how Medicare Administrative Contractors (MACs) will issue replacement RAs for QMB claims paid on or after October 2, 2017, through December 31, 2017, that have not been voided or replaced. MACs will issue replacement RAs by December 20, 2018, for Part B claims and by September 20, 2018, for Part A/Durable Medical Equipment claims.

• MLN Matters Article MM10433 (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10433.pdf) discusses how CMS will reintroduce QMB information in the RA starting July 2018 and modify to CR 9911 to avoid disrupting claims processing by secondary payers.


For general Medicaid information, please visit http://www.medicaid.gov/index.html.

**DOCUMENT HISTORY**

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 22, 2018</td>
<td>The article was revised to indicate that CMS will reintroduce QMB information in the Medicare Remittance Advice (RA) and Medicare Summary Notice (MSN) for all claims processed on or after July 2, 2018. CMS initially included QMB information in RAs and MSNs for claims processed on or after October 2, 2017, but suspended those changes on December 8, 2017, to address unforeseen issues preventing the processing of QMB cost-sharing claims by States and other secondary payers outside of the Coordination of Benefits Agreement (COBA) process. All other information remains the same.</td>
</tr>
<tr>
<td>December 4, 2017</td>
<td>The article was revised to indicate that on December 8, 2017, CMS will suspend modifications to the Provider Remittance Advice and the Medicare Summary Notice for QMB claims made on October 2, 2017. The article was also revised to show the HETS QMB release was implemented in November 2017. Finally, the article was changed to clarify that QMBs cannot elect to pay Medicare cost-sharing but may need to pay a small Medicaid copay in certain circumstances. All other information remains the same.</td>
</tr>
<tr>
<td>November 3, 2017</td>
<td>Article revised to show the HETS QMB release will be in November 2017. All other information remains the same.</td>
</tr>
<tr>
<td>October 18, 2017</td>
<td>The article was revised to indicate that the Provider Remittance Advice and the Medicare Summary Notice for beneficiaries identifies the QMB status of beneficiaries and exemption from cost-sharing for Part A and B claims processed on or after October 2, 2017, and to recommend how providers can use these and other upcoming system changes to promote compliance with QMB billing requirements. All other information remains the same.</td>
</tr>
</tbody>
</table>

**Continued >>**
<table>
<thead>
<tr>
<th>Date</th>
<th>Revision Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>August 23, 2017</td>
<td>The article was revised to highlight upcoming system changes that identify the QMB status of beneficiaries and exemption from Medicare cost-sharing, recommend key ways to promote compliance with QMB billing rules, and remind certain types of providers that they may seek reimbursement for unpaid deductible and coinsurance amounts as a Medicare bad debt.</td>
</tr>
<tr>
<td>May 12, 2017</td>
<td>This article was revised on May 12, 2017, to modify language pertaining to billing beneficiaries enrolled in the QMB program. All other information is the same.</td>
</tr>
<tr>
<td>January 12, 2017</td>
<td>This article was revised to add a reference to MLN Matters article MM9817, which instructs Medicare Administrative Contractors to issue a compliance letter instructing named providers to refund any erroneous charges and recall any existing billing to QMBs for Medicare cost sharing.</td>
</tr>
<tr>
<td>February 4, 2016</td>
<td>The article was revised on February 4, 2016, to include updated information for 2016 and a correction to the second sentence in paragraph 2 under Important Clarifications Concerning QMB Balance Billing Law on page 3.</td>
</tr>
<tr>
<td>February 1, 2016</td>
<td>The article was revised to include updated information for 2016 and a clarifying note regarding eligibility criteria in the table on page 4.</td>
</tr>
<tr>
<td>March 28, 2014</td>
<td>The article was revised on to change the name of the Coordination of Benefits Contractor (COBC) to BCRC.</td>
</tr>
</tbody>
</table>

CPT codes, descriptors and other data only are copyright 2017 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2017 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.
MLN Matters Number: MM10454 Revised
Related CR Release Date: March 7, 2018
Related CR Transmittal Number: R3997CP
Related Change Request (CR) Number: 10454
Effective Date: April 1, 2018
Implementation Date: April 2, 2018

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

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

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

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

Effective for services as of April 1, 2018, The April 2018 HCPCS file includes these revised/new HCPCS codes:
- **HCPCS Code: Q5101**
  - Short Description: Injection, zarxio
  - Long Description: Injection, filgrastim-sndz, biosimilar, (zarxio), 1 microgram

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

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

Continued >>
HCPCS Code: Q2041
- Short Description: Axicabtagene ciloleucel car+
- Long Description: Axicabtagene Ciloleucel, up to 200 million autologous Anti-CD19 CAR T Cells, Including leukapheresis and dose preparation procedures, per infusion
- TOS Code: 1
- MPFSDB Status Indicator: E

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

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

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

**ADDITIONAL INFORMATION**

**DOCUMENT HISTORY**

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 8, 2018</td>
<td>This article was revised to reflect an updated CR. That CR provided additional instructions for the MACs, regarding use of the long descriptors. The CR date, transmittal number and link to the transmittal also changed. All other information is unchanged</td>
</tr>
<tr>
<td>February 2, 2018</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>
PROVIDER TYPE AFFECTED
This MLN Matters® Article is intended for providers and suppliers submitting claims to Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) items or services paid under the DMEPOS fee schedule.

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

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

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

BACKGROUND
Section 1834(a), (h), and (i) of the Social Security Act (the Act) require payment for Durable Medical Equipment (DME), prosthetic devices, orthotics, prosthetics and surgical dressings be completed on a fee schedule basis. Further, payment on a fee schedule basis is a regulatory requirement at 42 Code of Federal Regulations (CFR) §414.102s, for parenteral and enteral nutrition, splints, casts and Intraocular Lenses (IOLs) inserted in a physician’s office.

Additionally, Section 1834(a)(1)(F)(ii) of the Act mandates adjustments to the fee schedule amounts for certain items furnished on or after January 1, 2016, in areas that are not competitive bid areas, based on information from Competitive Bidding Programs (CBPs) for DME. Section 1842(s)(3)(B) of the Act provides authority for making adjustments to the fee schedule amount for enteral nutrients, equipment and supplies (enteral nutrition) based on information from CBPs.

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


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

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

K0903

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

Oxygen Volume Adjustments

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

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

Continued >>
50 percent of the stationary payment amount (HCPCS codes E0424, E0439, E1390, or E1391); or

The portable oxygen add-on amount (HCPCS codes E0431, E0433, E0434, E1392 or K0738); and

Never both.

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

CR 10503 provides that effective April 1, 2018:

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

Specifically (effective April 1, 2018), the modifier ‘QB’ should be used in conjunction with claims submitted for stationary oxygen (codes E0424, E0439, E1390, or E1391) and portable oxygen (codes E0431, E0433, E0434, E1392, or K0738) when the prescribed amount of oxygen for daytime and nighttime differ and the average of the two amounts is greater than 4 liters per minute (LPM) and portable oxygen is prescribed.

For more information on April 1, 2018, changes to the pricing modifiers for oxygen flow rate, please refer to MLN Matters Article MM10158 (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10158.pdf), titled ‘Revised and New Modifiers for Oxygen Flow Rate.”

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

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

To facilitate this payment calculation, CR 10503 adds the ‘QB’ modifier (effective April 1, 2018) to the DMEPOS fee schedule file, for both stationary and portable oxygen.
The stationary oxygen ‘QB’ modifier fee schedule amounts represent 100 percent of the stationary oxygen fee schedule amount. The portable oxygen ‘OB’ fee schedule amounts represent the higher of 1) 50 percent of the monthly stationary oxygen payment amount or 2) the fee schedule amount for the portable oxygen add-on amount.

ADDITIONAL INFORMATION

DOCUMENT HISTORY

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

New Targeted Probe & Educate (TPE) Process Module

Have questions about TPE? This interactive module will give you an overview of the Targeted Probe & Educate Process and link you to additional TPE resources on the Centers for Medicare & Medicare Services website. Access the Targeted Probe & Educate Process Module and other TPE resources on our Medical Review Targeted Probe and Educate page at https://tinyurl.com/JMBTPE.
Educational Events Where You Can Ask Questions and Get Answers from Palmetto GBA

Don’t Miss this Wonderful Opportunity!

If you are in search of an opportunity to interact with and get answers to your Medicare billing, coverage and documentation questions from Palmetto GBA’s Provider Outreach and Education (POE) department, please see these educational offerings which have a question and answer session:

<table>
<thead>
<tr>
<th>Event Title</th>
<th>Date/Time</th>
<th>Address (or link if Webinar)</th>
</tr>
</thead>
<tbody>
<tr>
<td>JJ/JM Part B Claims Payment Issues Log Webcast</td>
<td>April 24, 2018, 11:00am, ET</td>
<td><a href="https://event.on24.com/wcc/r/1641510/69D267DA728CFE31CF1B44BD9038FD">https://event.on24.com/wcc/r/1641510/69D267DA728CFE31CF1B44BD9038FD</a></td>
</tr>
<tr>
<td>JJ/JM June Medicare Part B Updates, Changes and Reminders</td>
<td>June 6, 2018, 10:00am, ET</td>
<td><a href="https://event.on24.com/wcc/r/1585285/C35C73FBCA519D39FDE01D8FAE4C326A">https://event.on24.com/wcc/r/1585285/C35C73FBCA519D39FDE01D8FAE4C326A</a></td>
</tr>
<tr>
<td>JJ/JM Part B Ask the Contractor Teleconference: Topic TBD</td>
<td>June 12, 2018, 11:00am, ET</td>
<td>Dial in Number: 866-745-0425 Access Code: 4298248</td>
</tr>
</tbody>
</table>

Check out these resources

<table>
<thead>
<tr>
<th>Quarterly Ask the Contractor Teleconferences (ACTs)</th>
<th><a href="http://tinyurl.com/jkb4458">http://tinyurl.com/jkb4458</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>ACTs are intended to open the communication channels between providers and Palmetto GBA, which allows for timely identification of problems and information-sharing in an informal and interactive atmosphere. These teleconferences will be held at least quarterly via teleconference.</td>
<td></td>
</tr>
</tbody>
</table>

Proceeding the presentation, providers are given an opportunity to ask questions both on the topics discussed as well as any other question they may have. While we encourage providers to submit questions prior to the call, this is not required. Just fill out the Ask the Contractor Teleconference (ACT): Submit A Question form (http://tinyurl.com/hjq84dg). Once the form is completed, please fax it to (803) 935-0140, Attention: Ask-the-Contractor Teleconference.

<table>
<thead>
<tr>
<th>Quarterly Updates Webcasts</th>
<th><a href="http://tinyurl.com/gsr8gt">http://tinyurl.com/gsr8gt</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>The Quarterly Update Webcasts are intended to provide ongoing, scheduled opportunities for providers to stay up to date on Medicare requirements.</td>
<td></td>
</tr>
</tbody>
</table>

Providers are able to type a question and have it responded to by the POE department throughout the webcast. At the end of the presentation the moderator will also read and respond to questions submitted by attendees in order to share the responses with the group at large.

Continued >>
<table>
<thead>
<tr>
<th>Event Registration Portal</th>
<th>Visit our Event Registration Portal to find information on upcoming educational events and seminars.</th>
</tr>
</thead>
<tbody>
<tr>
<td><a href="http://tinyurl.com/gsrb8gt">http://tinyurl.com/gsrb8gt</a></td>
<td>This is a complete listing of both our face-to-face outreach opportunities as well as our teleconference and webcast listings. Providers are able to dialogue with POE and get answers to their questions at all of these educational events.</td>
</tr>
</tbody>
</table>

If you have a question that you need an answer to today or a claims specific question which requires the disclosure of PII or PHI for response, please contact the Provider Contact Center (PCC) at 1-855-696-0705.
NCD Coding Review: CR 10318-ICD-10 and Other Coding Revisions to NCDs

On January 18, 2018, CMS released Change Request (CR) 10318, Transmittal 2005 titled, “ICD-10 and Other Coding Revisions to National Coverage Determinations (NCDs)”; it contains the latest coding instructions for CMS NCDs. We are bringing the following NCDs to your attention.

NCD 110.21 Erythropoiesis Stimulating Agents (ESAs) in Cancer
Business requirement (BR) 10318.10 specifically addresses coding changes and is in process of CMS’ review. Until this review is complete and CMS makes a final determination, the A/B MACs will not implement the edits contained in this CR. The A/B MACs will also reprocess any claims that were processed in error from January 1, 2018, that were processed with the additional codes included in CR 10318 as not payable with the EC modifier.

NCD 80.11 Vitrectomy
BRs 10318.21, 10318.21.1 and 10318.21.2 contain coding instructions for the vitrectomy NCD. CMS carefully reviews all coding revisions. While the review of the vitrectomy NCD is no exception, we realize that a large number of codes were removed and that has caused some concern among stakeholders. We appreciate all the stakeholders’ comments that notified CMS of the effect of the coding changes. As a result, CMS is in the process of a subsequent review of the codes marked for removal in CR 10318.

In the interim, codes included in the covered diagnosis list prior to CR 10318 are coverable. Any claims you and/or the MACs believe were processed in error as a result of CR 10318 will be reprocessed. Further, if you were advised by a MAC to hold NCD 80.11 claims until further notice, please be assured you can submit those claims and they will be processed without regard to CR 10318.

Once CMS has completed their review of coding for NCD 80.11 and if changes to CR 10318 are warranted, a subsequent CR will be released as well as directions to MACs indicating that decision, complete with specific implementation instructions.

If you are seeing problems with the Medicare Advantage plans concerning this please contact the Atlanta Regional office at 404-562-7500 or Part C/D complaints can be directed to: PARTDCOMPLAINTS_RO4@CMS.HHS.GOV

CPT codes, descriptors and other data only are copyright 2017 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2017 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.
ICD-10 and Other Coding Revisions to National Coverage Determinations (NCDs)

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

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

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

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

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

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

NOTE: The translations from ICD-9 to ICD-10 are not consistent one-to-one matches, nor are all ICD-10 codes appearing in a complete General Equivalence Mappings (GEMs) mapping guide or other mapping guides appropriate when reviewed against individual NCD policies. In addition, for those policies that expressly allow MAC discretion, there may be changes to those NCDs based on current review of those NCDs against ICD-10

Continued >>
coding. For these reasons, there may be certain ICD-9 codes that were once considered appropriate prior to ICD-10 implementation that are no longer considered acceptable.

CR10473 makes coding and clarifying adjustments to the following NCDs:
1. NCD20.5 Extracorporeal Immunoadsorption (ECI) Using Protein A Columns
2. NCD110.18 Aprepitant
3. NCD110.21 Erythropoiesis Stimulating Agents (ESAs)
4. NCD150.3 Bone Mineral Density Studies
5. NCD190.1 Histocompatibility Testing
6. NCD190.11 PT/INR
7. NCD210.3 Colorectal Cancer Screening
8. NCD210.4.1 Counseling to Prevent Tobacco Use
9. NCD210.6 Hepatitis B Virus Screening
10. NCD220.4 Mammograms
11. NCD220.6.17 PET for Solid Tumors
12. NCD250.4 Actinic Keratosis (AKs)

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

ADDITIONAL INFORMATION

DOCUMENT HISTORY

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 1, 2018</td>
<td>This article was revised to reflect an updated CR. That CR corrected instructions in business requirement 7 (NCD210.3), including the spreadsheet for MACs. The CR release date, transmittal number and link to the transmittal also changed.</td>
</tr>
<tr>
<td>February 21, 2018</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>
April 2018 Update of the Ambulatory Surgical Center (ASC) Payment System

MLN Matters Number: MM10530
Related CR Release Date: March 9, 2018
Related CR Transmittal Number: R3996CP
Related Change Request (CR) Number: 10530
Effective Date: April 1, 2018
Implementation Date: April 2, 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.

WHAT YOU NEED TO KNOW
Change Request (CR) 10530 informs MACs about updates to the ASC payment system for January 2018. Be sure your billing staffs are aware of these changes.

BACKGROUND
CR10530 describes changes to billing instructions for various payment policies implemented in the April 2018 ASC payment system update and also includes updates to the Healthcare Common Procedure Coding System (HCPCS).

This notification includes 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. CMS is also including April 2018 ASC payment rates for covered surgical and ancillary services (ASCFS) update file. No ASC Code Pair file is being issued.

The changes in CR10530 are as follows:

1. New Separately Payable Procedure Code Effective April 1, 2018
Effective April 1, 2018, new HCPCS code C9749 has been created as described in the Table 1.

Table 1 - New Separately Payable Procedure Code Effective April 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>C9749</td>
<td>Repair nasal stenosis w/imp</td>
<td>Repair of nasal vestibular lateral wall stenosis with implant(s)</td>
<td>J8</td>
</tr>
</tbody>
</table>

2. Drugs, Biologicals, and Radiopharmaceuticals
a. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective April 1, 2018
For CY 2018, payment for non-pass-through drugs, biologicals and therapeutic radiopharmaceuticals 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, biological or therapeutic radiopharmaceutical. In addition, in CY 2018, a single payment of ASP + 6 percent continues to be made for pass-through drugs, biologicals and radiopharmaceuticals to provide payment for both the acquisition cost and pharmacy overhead costs of these

Continued >>
pass-through items. Payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. Updated payment rates effective April 1, 2018, and drug price restatements, can be found in the April 2018 update of ASC Addendum BB at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html.

b. April 2018 HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Radiopharmaceuticals Effective April 1, 2018
Several new HCPCS codes have been created for reporting drugs and biologicals in the ASC payment system effective April 1, 2018, where there have not previously been specific codes available. These new codes are listed in Table 2.

Table 2 - April 2018 HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Radiopharmaceuticals Effective April 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>C9462</td>
<td>Injection, delafloxacin</td>
<td>Injection, delafloxacin, 1 mg</td>
<td>K2</td>
</tr>
<tr>
<td>C9463</td>
<td>Injection, aprepitant</td>
<td>Injection, aprepitant, 1 mg</td>
<td>K2</td>
</tr>
<tr>
<td>C9464</td>
<td>Injection, rolapitant</td>
<td>Injection, rolapitant, 0.5 mg</td>
<td>K2</td>
</tr>
<tr>
<td>C9465</td>
<td>Injection, Durolane</td>
<td>Hyaluronan or derivative, Durolane, for intra-articular injection, per dose</td>
<td>K2</td>
</tr>
<tr>
<td>C9466</td>
<td>Injection, benralizumab</td>
<td>Injection, benralizumab, 1 mg</td>
<td>K2</td>
</tr>
<tr>
<td>C9467</td>
<td>Inj rituximab hyaluronidase</td>
<td>Injection, rituximab and hyaluronidase, 10 mg</td>
<td>K2</td>
</tr>
<tr>
<td>C9468</td>
<td>Inj, factor ix, Rebinyn</td>
<td>Injection, factor ix (antihemophilic factor, recombinant), glycopegylated, Rebinyn, 1 i.u..</td>
<td>K2</td>
</tr>
<tr>
<td>C9469</td>
<td>Inj triamcinolone acetonide</td>
<td>Injection, triamcinolone acetonide, preservative-free, extended-release, microsphere formulation, 1 mg</td>
<td>K2</td>
</tr>
</tbody>
</table>

c. 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 payments rates will be accessible on the CMS Web site on the first date of the quarter at http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/index.html.

Suppliers who think they may have received an incorrect payment for drugs and biologicals impacted by these corrections may request MACs to adjust previously processed claims.

d. Changes to Biosimilar Biological Product HCPCS Codes and Modifiers
Effective April 1, 2018, CMS is revising the long and short descriptors for HCPCS code Q5101. Table 3 displays the revised descriptors.

Continued >>

CPT codes, descriptors and other data only are copyright 2017 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2017 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.
Table 3 - Revised Descriptors for Q5101

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>ASC PI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5101</td>
<td>Injection, zarxio</td>
<td>Injection, filgrastim-sndz, biosimilar, (zarxio), 1 microgram</td>
<td>K2</td>
</tr>
</tbody>
</table>

In addition, effective April 1, 2018, HCPCS codes Q5103, Injection, infliximab-dyyb, biosimilar, (inflectra), 10 mg, and Q5104 (Injection, infliximab-abda, biosimilar, (renflexis), 10 mg) will replace HCPCS code Q5102 (Inj., infliximab biosimilar). Table 4, describes coding changes, the ASC payment indicator, and effective dates for biosimilar biological product HCPCS codes.

Table 4 - Changes to Biosimilar Biological Product HCPCS Codes

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>ASC PI</th>
<th>Added Date</th>
<th>Termination Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5102*</td>
<td>Inj., infliximab biosimilar</td>
<td>Injection, infliximab, biosimilar, 10 mg</td>
<td>K2</td>
<td>07/01/2016</td>
<td>03/31/2018</td>
</tr>
<tr>
<td>Q5103</td>
<td>Injection, inflectra</td>
<td>Injection, infliximab-dyyb, biosimilar, (inflectra), 10 mg</td>
<td>K2</td>
<td>04/01/2018</td>
<td></td>
</tr>
<tr>
<td>Q5104</td>
<td>Injection, renflexis</td>
<td>Injection, infliximab-abda, biosimilar, (renflexis), 10 mg</td>
<td>K2</td>
<td>04/01/2018</td>
<td></td>
</tr>
</tbody>
</table>

*Note on Q5102: Q5102 was added 7/01/2016, and effective 4/5/2016.

The new biosimilar payment policy also makes the use of modifiers that describe the manufacturer of a biosimilar product unnecessary. Therefore, modifiers ZA, ZB, and ZC will be discontinued for dates of service on or after April 1, 2018. Beginning April 1, 2018, Q5101, when performed, would no longer be required to be billed with a modifier. However, please note that both HCPCS codes Q5101 and Q5102, and the requirement to use applicable biosimilar modifiers remain in effect for dates of service prior to April 1, 2018.

3. 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

DOCUMENT HISTORY

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 12, 2018</td>
<td>Initial article released</td>
</tr>
</tbody>
</table>
Quarterly Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment

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

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

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

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

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

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

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

New Codes
• The following new codes will be MAC priced, until they are addressed at the annual Clinical Laboratory

Continued >>

CPT codes, descriptors and other data only are copyright 2017 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2017 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.
Public Meeting, which will take place in July, 2018. The following “U” codes shall have HCPCS Pricing Indicator Code - 22 = Price established by A/B MACs Part B (e.g., gap-fills, A/B MACs Part B established panels) instead of Pricing Indicator - 21 = Price Subject to National Limitation Amount. (Code, Long Descriptor, Short Descriptor, Effective Date, Type of Service (TOS))

- 0024U Glycosylated acute phase proteins (GlycA), nuclear magnetic resonance spectroscopy, quantitative GLYCA NUC MR SPECTRSC QUAN 1/1/2018 5
- 0025U Tenofovir, by liquid chromatography with tandem mass spectrometry (LC-MS/MS), urine, quantitative TENOFOVIR LIQ CHROM UR QUAN 1/1/2018 5
- 0026U Oncology (thyroid), DNA and mRNA of 112 genes, next-generation sequencing, fine needle aspirate of thyroid nodule, algorithmic analysis reported as a categorical result (“Positive, high probability of malignancy” or “Negative, low probability of malignancy”) ONC THYR DNA&MRNA 112 GENES 1/1/18 5
- 0027U JAK2 (Janus kinase 2) (eg, myeloproliferative disorder) gene analysis, targeted sequence analysis exons 12-15 JAK2 GENE TRGT SEQ ALYS 1/1/18 5
- 0028U CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism) gene analysis, copy number variants, common variants with reflex to targeted sequence analysis CYP2D6 GENE CPY NMR CMN VRNT 1/1/18 5
- 0029U Drug metabolism (adverse drug reactions and drug response), targeted sequence analysis (ie, CYP1A2, CYP2C19, CYP2C9, CYP2D6, CYP3A4, CYP3A5, CYP4F2, SLCO1B1, VKORC1 and rs12777823) RX METAB ADVRS TRGT SEQ ALYS 1/1/18 5
- 0030U Drug metabolism (warfarin drug response), targeted sequence analysis (ie, CYP2C9, CYP4F2, VKORC1, rs12777823) RX METAB WARF TRGT SEQ ALYS 1/1/18 5
- 0031U CYP1A2 (cytochrome P450 family 1, subfamily A, member 2) (eg, drug metabolism) gene analysis, common variants (ie, *1F, *1K, *6, *7) CYP1A2 GENE 1/1/18 5
- 0032U COMT (catechol-O-methyltransferase)(drug metabolism) gene analysis, c.472G>A (rs4680) variant COMT GENE 1/1/18 5
- 0033U HTR2A (5-hydroxytryptamine receptor 2A), HTR2C (5-hydroxytryptamine receptor 2C) (eg, citalopram metabolism) gene analysis, common variants (ie, HTR2A rs7997012 [c.614-2211T>C], HTR2C rs3813929 [c.-759C>T] and rs1414334 [c.551-3008C>G]) HTR2A HTR2C GENES 1/1/18 5

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

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

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

Continued >>
ADDITIONAL INFORMATION

DOCUMENT HISTORY

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 15, 2018</td>
<td>The article was revised to reflect an updated CR. That CR removed the list of new codes with a QW modifier that were effective as of April 1, 2018 from the policy section.</td>
</tr>
<tr>
<td>February 9, 2018</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>

eServices Eligibility

eServices, by Palmetto GBA, allows you to search for patient eligibility, which is a functionality of HETS. HETS requires you to enter beneficiary last name and HICN, in addition to either the birth date or first name. See options below:

- HICN, Last Name, First Name, Birth Date
- HICN, Last Name, Birth Date
- HICN, Last Name, First Name

For more information about eServices and the many services it offers, please visit our website at http://www.PalmettoGBA.com/eServices.
PROVIDER TYPE AFFECTED
This MLN Matters Article is intended for physicians, facilities and other practitioners billing Part B services to Medicare Administrative Contractors (MACs) for advanced diagnostic imaging provided to Medicare beneficiaries.

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

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

A consultation must take place for an applicable imaging service ordered by an ordering professional that would be furnished in an applicable setting and paid under an applicable payment system. Please note that the applicable setting is where the imaging service is furnished, not the setting where the imaging service is ordered.

Applicable settings include physician offices, hospital outpatient departments (including emergency departments), ambulatory surgical centers, and any other provider-led outpatient setting determined appropriate by the Secretary of Health and Human Services (at this time, no other settings have been identified). Applicable payment systems include the physician fee schedule (PFS), the hospital outpatient prospective payment system (OPPS), and the ambulatory surgical center payment system.
When this program is more fully implemented (expected January 1, 2020), consultation with a qualified CDSM will be required and detailed information regarding the ordering professional’s consultation must be appended to the furnishing professional’s claim. This includes the ordering practitioner’s National Provider Identifier (NPI) and documenting which CDSM was consulted (there are multiple qualified CDSMs available). The Centers for Medicare and Medical Services (CMS) does not have guidance at this time regarding what the claims-based reporting requirements will be in 2020. In addition, this program will include exceptions to consulting CDSMs that include:

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

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

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

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

- Used when the furnishing professional is aware of the result of the ordering professional’s consultation with a CDSM for that patient,
- Reported on the same claim line as the CPT code for an advanced diagnostic imaging service furnished in an applicable setting and paid for under an applicable payment system, and,
- Reported on both the facility and professional claim.

You should be aware that, effective for claims with dates of service on or after July 1, 2018, your MACs will accept the new QQ modifier on the same claim line as any CPT codes that fall within the ranges shown below.

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

**Magnetic Resonance Imaging**

70336, 70540, 70542, 70543, 70544, 70545, 70546, 70547, 70548, 70549, 70551, 70552, 70553, 70554, 70555, 71550, 71551, 71552, 71555, 72141, 72142, 72146, 72147, 72148, 72149, 72156, 72157, 72158, 72159, 72195, 72196, 72197, 72198, 73218, 73219, 73220, 73221, 73222, 73223, 73225, 73718, 73719, 73720, 73721, 73722, 73723, 73725, 74181, 74182, 74183, 74185, 75557, 75559, 75561, 75563, 75565, 76498

**Computerized Tomography**

70450, 70460, 70470, 70480, 70481, 70482, 70486, 70487, 70488, 70490, 70491, 70492, 70496, 70498, 71250, 71260, 71270, 71275, 71285, 71286, 71287, 71289, 7130, 71310, 71313, 71323, 72191, 72192, 72193,
Receive ADRs Electronically:
Go Green via eServices

Providers can opt to receive Additional Documentation Requests (ADRs) through eServices. If your claim is selected for review, you can receive your request as it is generated – instead of by mail (which decreases the amount of time you have to respond).

This process is free, secure and easy to use. Our messaging function in eServices will send an inbox message to let users know that an ‘eLetter’ is now available. This new process delivers the electronic document as a link within the secure message once you sign into eServices.

For more information about eServices and the many services it offers, please visit our website at www.PalmettoGBA.com/eServices.
Internet Only Manual Updates to Pub. 100-01, 100-02 and 100-04 to Correct Errors and Omissions (SNF) (2018)

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

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

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

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

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

CR10512 Changes
Medicare General Information, Eligibility and Entitlement Manual,
Chapter 4: Physician Certification and Recertification of Services
Pub 100-01, Chapter 4, §40.1
This section is revised by adding an appropriate cross-reference.

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

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

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

Medicare Benefit Policy Manual
Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance
Pub 100-02, Chapter 8, §20.2.3
This section is revised by modifying the language that describes the starting point of the applicable 30-day period, so that it more accurately tracks that of the corresponding statutory authority in §1861(i) of the Social Security Act and the implementing regulations at 42 CFR 409.36.

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

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

Pub 100-02, Chapter 8, §50.3
This section is revised to correct some cross-references, and to clarify the language describing the nonparticipating portion of the same institution that also includes a participating distinct part.

Pub 100-02, Chapter 8, §50.8.2
This section is revised to correct a cross-reference.

Pub 100-02, Chapter 8, §70.4
The first paragraph of this section is revised to clarify the scope of services for which SNFs can make arrangements with outside sources, and also by adding an appropriate cross-reference.

Medicare Claims Processing Manual
Chapter 1 - General Billing Requirements
Pub 100-04, Chapter 1, §30.1.1.1
This section is revised by updating the existing citation to the regulations at 42 CFR 483.10(b)(5)-(6), in order to reflect their revision and redesignation at 42 CFR 483.10(g)(17)-(18) in the long-term care facility requirements reform final rule (81 FR 68825, 68854, October 4, 2016).
Chapter 6 - SNF Inpatient Part A Billing and SNF Consolidated Billing

Pub 100-04, Chapter 6, §10.1
This section is revised to expand and clarify the discussion of a beneficiary’s status as a SNF “resident” for consolidated billing purposes to conform more closely with the corresponding regulations at 42 CFR 411.15(p)(3), as well as by adding some appropriate cross-references, and by updating the existing citation to the regulations at 42 CFR 483.12(a)(2)(i)-(vi), in order to reflect their redesignation at 42 CFR 483.15(c)(1)(i)(A)-(F) in the long-term care facility requirements reform final rule (81 FR 68826, October 4, 2016).

Pub 100-04, Chapter 6, §10.4
This section is revised by updating the existing citation to the regulations at 42 CFR 483.75(h), in order to reflect their redesignation at 42 CFR 483.70(g) in the long-term care facility requirements reform final rule (81 FR 68830, October 4, 2016).

Pub 100-04, Chapter 6, §20.1.2
This section is revised to restore a minor edit that was agreed to during the internal review of CR 9748 but was then inadvertently omitted from the published version.

Pub 100-04, Chapter 6, §20.2.1
The final paragraph of this section is revised to reflect the statutory addition of acute dialysis to the scope of the Part B dialysis benefit and, by extension, to the scope of the dialysis exclusion from SNF consolidated billing as well.

Pub 100-04, Chapter 6, §20.3
This section is revised to clarify the language in a parenthetical phrase.

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

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

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

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

Continued >>

CPT codes, descriptors and other data only are copyright 2017 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2017 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.
Pub 100-04, Chapter 6, §40.3.5.2
This section is revised to clarify the language that describes the nonparticipating portion of the same institution that also includes a participating distinct part.

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

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

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

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

DOCUMENT HISTORY

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 16, 2018</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>
Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD)

MLN Matters Number: MM10295 Revised
Related CR Release Date: March 2, 2018
Related CR Transmittal Number: R205NCD and R3992CP
Related Change Request (CR) Number: 10295
Effective Date: May 25, 2017
Implementation Date: April 2, 2018 - MAC edits; July 2, 2018 - full implementation

Note: The article was revised on March 5, 2018, to reflect a revised CR. The MAC implementation date, CR release date, transmittal numbers and the Web addresses of the transmittals were revised. All other information remains the same.

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

PROVIDER ACTION NEEDED
Change Request (CR) 10295 informs MACs that effective May 25, 2017, the Centers for Medicare & Medicaid Services (CMS) issued a National Coverage Determination (NCD) to cover Supervised Exercise Therapy (SET) for beneficiaries with Intermittent Claudication (IC) for the treatment of symptomatic Peripheral Artery Disease (PAD). Make sure your billing staffs are aware of these changes.

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

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

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

The SET program must:
• Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication
• Be conducted in a hospital outpatient setting, or a physician’s office
• Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD

Continued >>
• Be under the direct supervision of a physician (as defined in Section 1861(r)(1)) of the Social Security Act (the Act), physician assistant, or nurse practitioner/clinical nurse specialist (as identified in Section 1861(aa) (5) of the Act)) who must be trained in both basic and advanced life support techniques.

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

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

**Coding Requirements for SET**

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

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

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

- Claim Adjustment Reason Code (CARC) 167 – This (these) diagnosis (es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- Remittance Advice Remark Code (RARC) N386: This decision was based on a National Coverage Determination 20.35 (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.

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

MACs will accept claims for CPT 93668 only when services are provided in Place of Service (POS) code 11, 19, or 22. MACs will deny claims for SET if services are not provided in POS 11, 19, or 22, using the following remittance messages:
• CARC 58: Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. NOTE: Refer to the 832 Healthcare Policy Identification Segment (loop 2110 Service payment Information REF), if present.
• RARC N386: This decision was based on a National Coverage Determination 20.35 (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.
• Group Code CO (Contractual Obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

Institutional claims for SET must be submitted on Type of Bills (TOB) 13X or 85X. MACs will deny line items on institutional claims that are not submitted on TOB 13X or 85X using the following messages:
• CARC 58: “Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. NOTE: Refer to the 832 Healthcare Policy Identification Segment (loop 2110 Service payment Information REF), if present.
• RARC N386: “This decision was based on a National Coverage Determination 20.35 (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.
• Group Code CO (Contractual Obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

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

Medicare will reject claims with CPT93668 which exceed 36 sessions within 84 days from the date of the first session when the KX modifier is not included on the claim line OR any SET session provided after 84 days from the date of the first session and the KX modifier is not included on the claim and use the following messages:
• CARC 96: Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
• RARC N640: Exceeds number/frequency approved/allowed within time period.
• Group Code CO (Contractual Obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.
• Group Code PR (Patient Responsibility) assigning financial liability to the beneficiary if a claim is received with a GA modifier indicating a signed ABN is on file.

Continued >>

CPT codes, descriptors and other data only are copyright 2017 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2017 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.
MACs will deny/reject claim lines for SET exceeding 73 sessions using the following codes:

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

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

**ADDITIONAL INFORMATION**


**DOCUMENT HISTORY**

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 5, 2018</td>
<td>The article was revised to reflect a revised CR. The MAC implementation date, CR release date, transmittal numbers and the Web addresses of the transmittals were revised. All other information remains the same.</td>
</tr>
<tr>
<td>February 6, 2018</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>

CPT codes, descriptors and other data only are copyright 2017 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2017 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.
Interactive Tools

These guides provide instruction on how to complete or interpret the following forms. They are available on the home page, under Forms/Tools.

Remittance Advice
EDI Agreement
EDI Application
EDI Provider Authorization

CMS 1500 Claim Form

CPT codes, descriptors and other data only are copyright 2017 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2017 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.
Medical Director’s Desk

Medical Affairs publishes Medicare Local Coverage Determination (LCDs) and medically related articles in this special section of the Medicare Advisory. We encourage you to help us maintain accurate LCDs. Please review LCDs and address your comments and concerns to your Carrier Advisory Committee specialty representative or contact the Medical Affairs Department.

Medical articles are published in the Medicare Advisory to provide education and alert Medicare providers of billing/coding issues. Remember, physicians and non-physician practitioners (NPPs) who bill Medicare are responsible for accurate service coding. Errors may result in overpayment requests or Recovery Auditor (RA) referrals. If you purchase a new device or need to submit claims for a new procedure, please review applicable service codes and descriptions in the current CPT and HCPCS manuals. If you question the recommended service procedures received from other sources such as manufacturers, send your inquiry and the device description to the Medical Affairs Department.

To contact the Medical Affairs Department:

e-mail: B.Policy@PalmettoGBA.com
Mail: JM Part B Medical Affairs
      Palmetto GBA
      PO Box 100190
      Columbia, SC 29202-3190

Continued >>
<table>
<thead>
<tr>
<th>Policy Title</th>
<th>LCD Revisions</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>3D Interpretation and Reporting of Imaging Studies L33416 Rev #5</td>
<td>Under CPT/HCPCS Codes Group 1: Paragraph deleted the verbiage. Under ICD-10 Codes That Support Medical Necessity added verbiage to the Group 1: Paragraph for clarification and revised the cited section to read Article Text-Coding Guidelines. The Sources of Information citations were moved to the Bibliography section of the LCD.</td>
<td>3/15/18</td>
</tr>
<tr>
<td>Brain Natriuretic Peptide (BNP) Level L33422 Rev #10</td>
<td>Under Sources of Information and Basis for Decision deleted “medically” in the first cited source. Deleted “who” from 42 CFR §410.32(a). Deleted the “s” from the cited Internet-Only Manual references X2. Under Associated Information-Documentation Requirements added “the” to the second sentence. Under Bibliography the full titles were added to several cited journal sources. A spelling error was corrected for Natriuretic, et al was deleted and three author names were added for the following: Morrison LK, Harrison A, Krishnaswamy P, et al. Utility of a rapid B-Natriuretic Peptide Assay in differentiating Congestive Heart Failure from lung disease in patients presenting with dyspnea. Jour Am Coll Cardiol. 2002;39(2):202-209. The journal title was italicized for the following: Shapiro BP, Chen HH, Burnett JC, Redfield MM. Use of Plasma Brain Natriuretic Peptide Concentration to Aid in the Diagnosis of Heart Failure. Mayo Clin Proc. 2003;78(4):481-6.</td>
<td>3/15/18</td>
</tr>
<tr>
<td>Chemodenervation L33458 Rev #18</td>
<td>Under CMS National Coverage Policy deleted the “s” from the cited Internet-Only Manual references X2. Throughout the LCD punctuation was corrected. Under Coverage Indications, Limitations and/or Medical Necessity #7 corrected the spelling of splenius. Throughout the LCD punctuation was corrected. Under Bibliography author initials were added to the author name WJ Binder and the spelling of the author name Heckmann was corrected.</td>
<td>3/15/18</td>
</tr>
<tr>
<td>Computerized Axial Tomography (CT), Thorax L33459 Rev #8</td>
<td>Under CMS National Coverage Policy added “Medicare” to the cited NCD manual reference and clarified the sections cited for CMS Internet-Only Manual, Pub 100-02, Medicare Benefit Policy Manual, Chapter 6, §§20.4.1 and 20.4.3-20.4.5. Under CPT/HCPCS Codes- Group 1: Paragraph deleted the verbiage. Under Bibliography corrected the title, url, amended date and accessed date for the first cited practice parameter and corrected the url, amended date and accessed date for the second cited practice parameter.</td>
<td>3/15/18</td>
</tr>
<tr>
<td>Repetitive Transcranial Magnetic Stimulation (rTMS) in Adults with Treatment Resistant Major Depressive Disorder L34868 Rev #8</td>
<td>Punctuation was corrected throughout the LCD. Under Associated Information-Utilization Guidelines in the third paragraph revised “addition” to now read “additional.” Under Bibliography 1. added “the” to the journal title and revised the access dates for the following citations: #5 and #11. The “url” title was corrected for citation #11 to read Repetitive Transcranial Magnetic Stimulation.</td>
<td>3/15/18</td>
</tr>
<tr>
<td>Coding and Billing External Components for Cochlear Implants A53708 Rev #6</td>
<td>Under CPT/HCPCS Group 1: Codes, added HCPCS code L7520.</td>
<td>4/1/18</td>
</tr>
</tbody>
</table>

Continued >>
<table>
<thead>
<tr>
<th>3D Interpretations and Reporting of Imaging Studies</th>
<th>Under <em>Article Text-Reasons for Denial</em> in the last bullet deleted “in” and added, “…. refer to the…”</th>
<th>3/15/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hemorrhoid Artery Ligation CPT Code 0249T Article A53006 Rev #4</td>
<td>Under CPT/HCPCS Codes added CPT codes included in the <em>Article Text</em>.</td>
<td>3/15/18</td>
</tr>
<tr>
<td>Medicare Preventive Coverage for Certain Vaccines A54767 Rev #14</td>
<td>Under <em>Article Text</em> added punctuation and bolded and italicized text in the last bullet. Under <em>Covered ICD-10 Codes Group 3: Paragraph- Covered ICD-10 codes for Tetanus</em> added the following ICD-10 codes that were inadvertently omitted: S78.011D, S78.011S, S78.021D, S78.021S, S78.111D, S78.111S, S78.121D, S78.121S, S78.911D, S78.911S, S78.921D, S78.921S, and S91.225D.</td>
<td>4/10/18</td>
</tr>
</tbody>
</table>

**A/B MAC Local Coverage Determinations**

<table>
<thead>
<tr>
<th>Policy Title</th>
<th>LCD Revisions</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac Rehabilitation L34412 Rev #17</td>
<td>Revisions were made to Cardiac Rehabilitation Local Coverage Determination (LCD) L34412. Under <em>CMS National Coverage Policy</em> Change Request 10199, Transmittal 3848 was deleted as this was manualized and is now found in the following manual citation: CMS Internet-Only Manual, Pub. 100-04, Medicare Claims Processing Manual, Chapter 32, §140.2.2.</td>
<td>3/8/18</td>
</tr>
<tr>
<td>Removal of Benign and Malignant Skin Lesions L33445 Rev #18</td>
<td>Under <em>ICD-10 Codes that Support Medical Necessity Group 1: Codes</em> added ICD-10 code D29.0 due to a reconsideration request. ICD code D29.0 is valid for CPT codes 11420, 11421, 11422, 11423, 11424 and 11426.</td>
<td>3/30/18</td>
</tr>
<tr>
<td>Rituximab (Rituxan®) L35026 Rev #18</td>
<td>Under <em>Coverage Indications, Limitations and/or Medical Necessity</em> added the ® symbol where indicated. Under <em>ICD-10 Codes That Support Medical Necessity Group 1: Codes</em> added ICD-10 code L10.1 due to a reconsideration request.</td>
<td>3/30/18</td>
</tr>
<tr>
<td>Polysomnography L36593 Rev #5</td>
<td>Under Coverage Indications, Limitations and/or Medical Necessity, Accreditation, Added bullets to first paragraph and deleted survey information. Added “at least” to the last sentence of the second paragraph, deleted numbers 1-7 and added 2 bullets. Under Bibliography, added The Joint Commission: New Requirement for Ambulatory Care Organizations Providing Sleep Center Services and Recent Revisions to Polysomnography and Sleep Study LCDs: Wisconsin Physician Services, CGS, and Noridian.</td>
<td>3/8/18</td>
</tr>
<tr>
<td>Cosmetic and Reconstructive Surgery L33428 Rev #14</td>
<td>Under CPT/HCPCS Codes Group 6: Paragraph Rhinoplasty changed the heading to read “Group 6: Paragraph Nasal Reconstruction and Rhinoplasty”, added CPT code 21235 and added ICD-10 codes C44.212, C44.219, C44.222, C44.229, C43.21, C43.22, D03.21, D03.22, D04.21 and D04.22. Under <em>ICD-10 Codes that Support Medical Necessity Group 7: Codes</em> added ICD-10 codes C44.311, C44.212, C44.219, C44.321, C44.222, C44.229, C43.21, C43.22, D03.21, D03.22, D04.21 and D04.22. These revisions are due to a reconsideration request.</td>
<td>4/5/18</td>
</tr>
</tbody>
</table>

Continued >>
Non-Covered Category III
CPT Codes
L34555
Rev # 23

Under **CPT/HCPCS Group 1: Codes**, deleted HCPCS code 0449T.

2/26/18

Ophthalmology: Extended Ophthalmoscopy and Fundus Photography
L33467
Rev #12

Under **CMS National Coverage Policy** in the first paragraph deleted the second and third sentence. Under **Bibliography-Fundus Photography** corrected the first three links for the cited practice guidelines including the year the articles were updated, as appropriate. Under **Bibliography-Extended Ophthalmoscopy** punctuation and spelling were corrected. Author initials and the supplement number were added to the following: Ho AC, Guyer DR, Fine SL. Clinical examination of the posterior segment of the eye. Retina-Vitreous Macula. Philadelphia, PA: WB Saunders Co;1999;1:21-28.

3/15/18

<table>
<thead>
<tr>
<th>Article Title</th>
<th>Articles</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Billing and Coding Instructions for Lemtrada® (alemtuzumab) When Used in the Treatment of Relapsing Multiple Sclerosis A55310 Rev #3</td>
<td>Under <strong>CPT/HCPCS Group 1: Codes</strong>, added HCPCS J0202.</td>
<td>4/1/18</td>
</tr>
<tr>
<td>Single Chamber and Dual Chamber Permanent Cardiac Pacemakers – Coding and Billing A54831 Rev #5</td>
<td>Under <strong>Article Text-Indications and Limitations Coverage</strong> the verbiage was italicized in sections B. <strong>Nationally Covered Indications</strong> and C. <strong>Nationally Non-Covered Indications</strong>.</td>
<td>3/15/18</td>
</tr>
</tbody>
</table>

**MolDX Local Coverage Determinations**

<table>
<thead>
<tr>
<th>Policy Title</th>
<th>LCD Revision</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infectious Disease Molecular Diagnostic Testing, L33433, Retire</td>
<td>The LCD is retired because many of the sections are no longer applicable and some sections are out-of-date.</td>
<td>3/1/18</td>
</tr>
</tbody>
</table>
| MolDX: GeneSight® Assay for Refractory Depression, L35633, #7 | Removed Documentation requirements and ICD-9 references. Added the following verbiage to the introductory paragraph and Note: in the LCD:

“Provider may have primary boards in internal medicine or neurology and also have boards in psychiatry or neuropsychiatry and the provider has a designated specialty in PECOS as IM/neurology. Palmetto GBA is allowing the GeneSight test to be ordered, when medically necessary, by these providers and they will affix a KX modifier attesting that they have psychiatry or neuropsychiatry boards. Assurex will maintain the certification and make it available upon request.”

At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy. | 3/8/18 |
<table>
<thead>
<tr>
<th>Document Title</th>
<th>Description</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Controlled Substance Monitoring and Drugs of Abuse Testing L35724, #14</td>
<td>Revised LCD to add M54.12 to ICD-10 Group 1: Codes. This code was inadvertently left off during the ICD-10 transition. The effective date of M54.12 is 10/1/15.</td>
<td>3/8/18</td>
</tr>
<tr>
<td>Controlled Substance Monitoring and Drugs of Abuse Testing L35724, #15</td>
<td>The effective date of M54.12 was erroneously stated as 10/1/15 in Revision History 14. The correct effective date is 1/1/17. DX coverage was not applied until dates of service on and after 1/1/17. The effective date of M54.12 is 1/1/17. Added M25.511 and M25.512 to ICD-10 Group 1: Codes. This code was inadvertently left off during the ICD-10 transition. The effective date of M25.511 and M25.512 is 1/1/17.</td>
<td>3/22/18</td>
</tr>
<tr>
<td>MolDX: APC and MUTYH Gene Testing L36827, #5</td>
<td>Added 81401 to CPT/HCPCS Codes Group 1. This code was inadvertently omitted from the LCD and is effective for DOS on or after 3/17/17.</td>
<td>3/8/18</td>
</tr>
<tr>
<td>Bladder/Urothelial Tumor Markers L33420, #11</td>
<td>Corrected numbering in the Sources of Information section.</td>
<td>3/8/18</td>
</tr>
<tr>
<td>MolDX: Decipher® Prostate Cancer Classifier Assay L35868, #6</td>
<td>Removed “CDD” from the title. Revised the second bullet in the Criteria for Coverage to remove “undetectable” PSA and change it to “at or below 0.2 ng/ml within 120 days” of RP surgery. Added 2 regulations to “CMS National Coverage Policy “ section: CMS Internet Online Manual Pub. 100-04 (Medicare Claims Processing Manual), Chapter 23 (Section 10) “Reporting ICD Diagnosis and Procedure Codes”. CMS On-Line Manual, Publication 100-02, Medicare Benefit Policy Manual,Chapter 15, §§80.0, 80.1.1, 80.2. Clinical Laboratory services.</td>
<td>3/8/18</td>
</tr>
<tr>
<td>MolDX: Prolaris™ Prostate Cancer Genomic Assay L35869, #6</td>
<td>Removed “CDD” from the title.</td>
<td>3/15/18</td>
</tr>
<tr>
<td>MolDX: Prometheus IBD sgi Diagnostic Policy L37260, #3</td>
<td>Corrected two typographical errors. Corrected the references superscript in the “Analysis of Evidence” section. Also, added the 5th inflammatory marker, CRP, omitted in the “Coverage Indications, Limitations and/or Medical Necessity” section.</td>
<td>3/8/18</td>
</tr>
</tbody>
</table>
MLN Connects™

MLN Connects contains a week’s worth of Medicare-related messages instead of many different messages being sent to you throughout the week. This notification process ensures planned, coordinated messages are delivered timely about Medicare-related topics.

MLN Connects™ for March 1, 2018

MLN Connects™ for March 8, 2018

MLN Connects™ for March 15, 2018

MLN Connects™ for March 22, 2018

Special Edition MLN Connects™ - Wednesday, February 28, 2018


On February 9, 2018, President Trump signed into law the Bipartisan Budget Act of 2018. This new law includes several provisions related to Medicare payment.

With regard to payment for outpatient therapy services, the law repeals application of the Medicare outpatient therapy caps but retains the former cap amounts as a threshold above which claims must include the KX modifier as a confirmation that services are medically necessary as justified by appropriate documentation in the medical record; and retains the targeted medical review process, but at a lower threshold amount. It also extends several recently expired Medicare legislative provisions affecting health care providers and beneficiaries, including the Medicare physician fee schedule work geographic adjustment floor, add-on payments for ambulance services and home health rural services, changes to the payment adjustment for low volume hospitals, and the Medicare dependent hospital program.

In addition, with regard to Section 53111 – Medicare Payment Update for Skilled Nursing Facilities, the Centers for Medicare & Medicaid Services has received questions from stakeholders about the impact of the FY 2019 Skilled Nursing Facility (SNF) update due to section 53111 of the BBA of 2018. To help answer these questions, we are providing information about the estimated market basket update for FY 2019 based on currently available data. This estimate may be updated in the Notice of Proposed Rulemaking for the FY 2019 SNF Prospective Payment System (PPS).

Read the full summary at: https://www.cms.gov/Center/Provider-Type/All-Fee-For-Service-Providers/Downloads/Medicare-Expired-Legislative-Provisions-Extended.pdf.

CPT codes, descriptors and other data only are copyright 2017 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2017 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.
CMS Offers FREE Medicare Training for Providers

**CMS Web Training**
The Centers for Medicare & Medicaid Services (CMS) has launched a series of education and training programs designed to leverage emerging Internet and satellite technologies to offer just-in-time training to Medicare providers and suppliers throughout the United States. Many of these programs include free, downloadable computer/Web based training courses. These courses are also available on CD-ROM.

https://www.cms.gov/MLNGenInfo

## Palmetto GBA Medicare Customer Information and Outreach

<table>
<thead>
<tr>
<th>Important Telephone Numbers</th>
<th>Training Available</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Provider Contact Center</strong></td>
<td>To request a Medicare Education meeting/seminar at no cost to you, complete and fax the form located on the</td>
</tr>
<tr>
<td><strong>Electronic Data Interchange (EDI)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Technical Support</strong></td>
<td></td>
</tr>
<tr>
<td>(855) 696-0705</td>
<td></td>
</tr>
<tr>
<td><strong>Medicare Beneficiary Call Center</strong></td>
<td></td>
</tr>
<tr>
<td>1-800-MEDICARE (1-800-633-4227)</td>
<td></td>
</tr>
<tr>
<td>TTY 1-877-486-2048</td>
<td></td>
</tr>
</tbody>
</table>

**Important Sources For You**
- https://www.cms.gov
- https://www.cms.gov/MLNGenInfo
- https://www.cms.gov/CMSforms/CMSforms/list.asp

**Attention: Billing Manager**