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PART B MEDICARE ADVISORY
Latest Medicare News for Part B

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The 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 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.

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**CMS Provider Minute Videos**

The Medicare Learning Network has a series of CMS Provider Minute Videos (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Multimedia.html) on a variety of topics, such as psychiatry, preventive services, lumbar spinal fusion, and much more. The videos offer tips and guidelines to help you properly submit claims and maintain sufficient supporting documentation. Check the site often as CMS adds new videos periodically to further help you navigate the Medicare program.
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.
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.
Multi-Factor Authentication (MFA) Enhancement

Palmetto GBA is excited to announce that starting February 1, 2018, providers will be able to use their MFA codes for up to eight hours! Currently, providers are required to request a new MFA code each time they signed into the eServices portal. The new enhancement allows providers to simply reuse the last valid code issued. MFA codes will expire eight hours from the time it was requested or when a new MFA code is generated.

Note: Providers will still have the ability to request a new MFA code in the event another one is needed.

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

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

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

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

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

The final rule, CMS-1676-F, also addresses public comments on Medicare payment policies proposed earlier this year. The final rule, “Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2018,” was published in the Federal Register on November 2, 2017. The key changes are as follows:

Overall Payment Update and Misvalued Code Target
The overall update to payments under the MPFS based on the finalized CY 2018 rates will be +0.41 percent. This update reflects the +0.50 percent update established under the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, reduced by 0.09 percent, due to the misvalued code target recapture amount, required under the Achieving a Better Life Experience (ABLE) Act of 2014.
After applying these adjustments and the budget neutrality adjustment to account for changes in Relative Resource Units (RVUs), all required by law, the final 2018 Physician Fee Schedule (PFS) conversion factor is $35.99, an increase to the 2017 PFS conversion factor of $35.89.

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

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

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

Telehealth originating site facility fee payment amount update

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

Medicare Telehealth Services

For CY 2018, CMS is finalizing the addition of several codes to the list of telehealth services, including:

- HCPCS code G0296 (visit to determine Low Dose Computed Tomography (LDCT) eligibility)
- CPT code 90785 (Interactive Complexity)
- CPT codes 96160 and 96161 (Health Risk Assessment)
- HCPCS code G0506 (Care Planning for Chronic Care Management)
- CPT codes 90839 and 90840 (Psychotherapy for Crisis)

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

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

- CMS is adopting CPT prefatory guidance that this code should be billed no more than once every 30 days.
- CMS is allowing CPT code 99091 to be billed once per patient during the same service period as chronic care management (CCM) (CPT codes 99487, 99489, and 99490), Transitional Care Management (TCM)

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(CPT codes 99495 and 99496), and behavioral health integration (BHI) services (CPT codes 99492, 99493, 99494, and 99484).

- CMS is requiring that the practitioner obtain advance beneficiary consent for the service and document this in the patient’s medical record.
- For new patients or patients not seen by the billing practitioner within one year prior to billing CPT code 99091, CMS requires initiation of the service during a face-to-face visit with the billing practitioner, such as an Annual Wellness Visit or Initial Preventive Physical Exam, or other face-to-face visit with the billing practitioner.

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

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

**Improvement of Payment Rates for Office-based Behavioral Health Services**
CMS is finalizing an improvement in the way MPFS rates are set that will positively impact office-based behavioral health services with a patient. The final policy will increase payment for these important services by better recognizing overhead expenses for office-based face-to-face services with a patient.

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

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

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

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

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

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

ADDITIONAL INFORMATION

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<td>December 26, 2017</td>
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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.
Suppression of the Standard Paper Remittance Advice (SPR) in 45 days if also Receiving Electronic Remittance Advice (ERA)

MLN Matters Number: MM10151 Revised
Related CR Release Date: December 28, 2017
Related CR Transmittal: R1994OTN
Related Change Request (CR) Number: 10151
Effective Date: January 1, 2018
Implementation Date: January 2, 2018

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

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

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

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

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

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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 inquires 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/. The Secure eChat feature is available during business hours to assist providers.
Proper Use of Modifier 59

MLN Matters® Number: SE1418
Related Change Request (CR) #: N/A
Article Release Date: January 3, 2018
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

Note: This article was revised on January 3, 2018, to conform with the latest Modifier 59 article on the NCCI website. The key update was the addition of information regarding the XE, XS, XP, and XU modifiers.

Provider Types Affected
This MLN Matters® Special Edition Article is intended for physicians and providers submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed
This special edition article is being provided by the Centers for Medicare & Medicaid Services (CMS) to clarify the proper use of Modifier 59. The article only clarifies existing policy. Make sure that your billing staffs are aware of the proper use of Modifier 59.

Background
The Medicare National Correct Coding Initiative (NCCI) includes Procedure-to-Procedure (PTP) edits that define when two Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes should not be reported together either in all situations or in most situations.

For PTP edits that have a Correct Coding Modifier Indicator (CCMI) of “0,” the codes should never be reported together by the same provider for the same beneficiary on the same date of service. If they are reported on the same date of service, the column one code is eligible for payment and the column two code is denied.

For PTP edits that have a CCMI of “1,” the codes may be reported together only in defined circumstances which are identified on the claim by the use of specific NCCI-associated modifiers. (Refer to the National Correct Coding Initiative Policy Manual for Medicare Services, Chapter 1, for general information about the NCCI program, PTP edits, CCMIs, and NCCI-associated modifiers. This manual is available in the download section at http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html)

One function of NCCI PTP edits is to prevent payment for codes that report overlapping services except in those instances where the services are “separate and distinct.” Modifier 59 is an important NCCI-associated modifier that is often used incorrectly.

The CPT Manual defines modifier 59 as follows:

“Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or

Continued >>
surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of
injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual.
However, when another already established modifier is appropriate, it should be used rather than modifier 59.
Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances,
should modifier 59 be used. Note: Modifier 59 should not be appended to an E/M service. To report a separate
and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.”

Modifier 59 and other NCCI-associated modifiers should NOT be used to bypass a PTP edit unless the proper
criteria for use of the modifier are met. Documentation in the medical record must satisfy the criteria required
by any NCCI-associated modifier that is used.

1. Modifier 59 is used appropriately for different anatomic sites during the same encounter only when
procedures which are not ordinarily performed or encountered on the same day are performed on
different organs, or different anatomic regions, or in limited situations on different, non-contiguous
lesions in different anatomic regions of the same organ.

One of the common uses of modifier 59 is for surgical procedures, non-surgical therapeutic procedures, or
diagnostic procedures that are performed at different anatomic sites, are not ordinarily performed or encountered
on the same day, and that cannot be described by one of the more specific anatomic NCCI-associated modifiers
– i.e., RT, LT, E1-E4, FA, F1-F9, TA, T1-T9, LC, LD, RC, LM, or RI. (See examples 1, 2, and 3.) From an
NCCI perspective, the definition of different anatomic sites includes different organs or, in certain instances,
different lesions in the same organ. However, NCCI edits are typically created to prevent the inappropriate
billing of lesions and sites that should not be considered to be separate and distinct. Modifier 59 should only
be used to identify clearly independent services that represent significant departures from the usual situations
described by the NCCI edit. The treatment of contiguous structures in the same organ or anatomic region does
not constitute treatment of different anatomic sites. For example:

• Treatment of the nail, nail bed, and adjacent soft tissue distal to and including the skin overlying the distal
interphalangeal joint on the same toe or finger constitutes treatment of a single anatomic site. (See example 4.)
• Treatment of posterior segment structures in the eye constitutes treatment of a single anatomic site. (See
example 5.)
• Arthroscopic treatment of structures in adjoining areas of the same shoulder constitutes treatment of a
single anatomic site. (See example 6.)

2. Modifier 59 is used appropriately when the procedures are performed in different encounters on the
same day.

Another common use of modifier 59 is for surgical procedures, non-surgical therapeutic procedures, or diagnostic
procedures that are performed during different patient encounters on the same day and that cannot be described
by one of the more specific NCCI-associated modifiers – i.e., 24, 25, 27, 57, 58, 78, 79, or 91. (See example
7) As noted in the CPT definition, modifier 59 should only be used if no other modifier more appropriately
describes the relationship of the two procedure codes.

3. Modifier 59 is used inappropriately if the basis for its use is that the narrative description of the two
codes is different.

One of the common misuses of modifier 59 is related to the portion of the definition of modifier 59 allowing
its use to describe a “different procedure or surgery.” The code descriptors of the two codes of a code pair edit
usually represent different procedures, even though they may be overlapping. The edit indicates that the two

Continued >>
procedures should not be reported together if performed at the same anatomic site and same patient encounter as those procedures would not be considered to be “separate and distinct.” The provider should not use modifier 59 for such an edit based on the two codes being “different procedures.” (See example 8.) However, if the two procedures are performed at separate anatomic sites or at separate patient encounters on the same date of service, modifier 59 may be appended to indicate that they are different procedures on that date of service. Additionally, there may be limited circumstances sometimes identified in the National Correct Coding Initiative Policy Manual for Medicare Services (available in the downloads section at https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html) when the two codes of an edit pair may be reported together with modifier 59 when performed at the same patient encounter or at the same anatomic site.

4. Other specific appropriate uses of modifier 59
There are three other limited situations in which two services may be reported as separate and distinct because they are separated in time and describe non-overlapping services even though they may occur during the same encounter, i.e.:

A. Modifier 59 is used appropriately for two services described by timed codes provided during the same encounter only when they are performed sequentially. There is an appropriate use for modifier 59 that is applicable only to codes for which the unit of service is a measure of time (e.g., per 15 minutes, per hour). If two timed services are provided in time periods that are separate and distinct and not interspersed with each other (i.e., one service is completed before the subsequent service begins), modifier 59 may be used to identify the services. (See example 9.)

B. Modifier 59 is used appropriately for a diagnostic procedure which precedes a therapeutic procedure only when the diagnostic procedure is the basis for performing the therapeutic procedure. When a diagnostic procedure precedes a surgical procedure or non-surgical therapeutic procedure and is the basis on which the decision to perform the surgical procedure is made, that diagnostic test may be considered to be a separate and distinct procedure as long as (a) it occurs before the therapeutic procedure and is not interspersed with services that are required for the therapeutic intervention; (b) it clearly provides the information needed to decide whether to proceed with the therapeutic procedure; and (c) it does not constitute a service that would have otherwise been required during the therapeutic intervention. (See example 10.) If the diagnostic procedure is an inherent component of the surgical procedure, it should not be reported separately.

C. Modifier 59 is used appropriately for a diagnostic procedure which occurs subsequent to a completed therapeutic procedure only when the diagnostic procedure is not a common, expected, or necessary follow-up to the therapeutic procedure. When a diagnostic procedure follows the surgical procedure or non-surgical therapeutic procedure, that diagnostic procedure may be considered to be a separate and distinct procedure as long as (a) it occurs after the completion of the therapeutic procedure and is not interspersed with or otherwise commingled with services that are only required for the therapeutic intervention, and (b) it does not constitute a service that would have otherwise been required during the therapeutic intervention. If the post-procedure diagnostic procedure is an inherent component or otherwise included (or not separately payable) post-procedure service of the surgical procedure or non-surgical therapeutic procedure, it should not be reported separately.
Use of Modifier 59 does not require a different diagnosis for each HCPCS/CPT coded procedure. Conversely, different diagnoses are not adequate criteria for use of modifier 59. The HCPCS/CPT codes remain bundled unless the procedures are performed at different anatomic sites or separate patient encounters or meet one of the other three scenarios described above.

Modifiers XE, XS, XP, and XU are effective January 1, 2015. These modifiers were developed to provide greater reporting specificity in situations where modifier 59 was previously reported and may be utilized in lieu of modifier 59 whenever possible. (Modifier 59 should only be utilized if no other more specific modifier is appropriate.) Although NCCI will eventually require use of these modifiers rather than modifier 59 with certain edits, providers may begin using them for claims with dates of service on or after January 1, 2015. The modifiers are defined as follows:

- **XE** – “Separate encounter, A service that is distinct because it occurred during a separate encounter” This modifier should only be used to describe separate encounters on the same date of service.
- **XS** – “Separate Structure, A service that is distinct because it was performed on a separate organ/structure”
- **XP** – “Separate Practitioner, A service that is distinct because it was performed by a different practitioner”
- **XU** – “Unusual Non-Overlapping Service, The use of a service that is distinct because it does not overlap usual components of the main service”

**Examples of Modifier 59 Usage**

Following are some examples developed to help guide physicians and providers on the proper use of Modifier 59 *(Please remember that Medicare policy is that Modifier 59 is used appropriately for different anatomic sites during the same encounter only when procedures which are not ordinarily performed or encountered on the same day are performed on different organs, or different anatomic regions, or in limited situations on different, non-contiguous lesions in different anatomic regions of the same organ.)*:

**Example 1: Column 1 Code / Column 2 Code - 17000/11100**

- CPT Code 17000 – Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettment), all benign or premalignant lesions (eg, actinic keratoses) other than skin tags or cutaneous vascular proliferative lesions; first lesion
- CPT Code 11100 – Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion

Modifier 59 may be reported with code 11100 if the procedures are performed at different anatomic sites on the same side of the body and a specific anatomic modifier is not applicable. If the procedures are performed on different sides of the body, modifiers RT and LT or another pair of anatomic modifiers should be used, not modifier 59.

**Example 2: Column 1 Code/Column 2 Code 47370/76942**

- CPT Code 47370 – Laparoscopy, surgical, ablation of one or more liver tumor(s); radiofrequency
- CPT Code 76942 – Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation

CPT code 76942 should not be reported and Modifier 59 should not be used if the ultrasonic guidance is for needle placement for the laparoscopic liver tumor ablation procedure. Code 76942 may be reported with modifier 59 if the ultrasonic guidance for needle placement is unrelated to the laparoscopic liver tumor ablation procedure.

*Continued >*

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Example 3: Column 1 Code/Column 2 Code 93453/76000
- CPT Code 93453 – Combined right and left heart catheterization including intraprocedural injections(s) for left ventriculography, imaging supervision and interpretation, when performed
- CPT Code 76000 – Fluoroscopy (separate procedure), up to one hour physician time, other than 71023 or 71034 (eg, cardiac fluoroscopy)

CPT code 76000 should not be reported and Modifier 59 should not be used for fluoroscopy that is used in conjunction with a cardiac catheterization procedure. Modifier 59 may be reported with code 76000 if the fluoroscopy is performed for a procedure unrelated to the cardiac catheterization procedure.

Example 4: Column 1 Code / Column 2 Code - 11055/11720
- CPT Code 11055 - Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); single lesion
- CPT Code 11720 – Debridement of nail(s) by any method(s); one to five

CPT codes 11720 and 11055 should not be reported together for services performed on skin distal to and including the skin overlying the distal interphalangeal joint of the same toe. Modifier 59 should not be used if a nail is debrided on the same toe on which a hyperkeratotic lesion of the skin on or distal to the distal interphalangeal joint is pared. Modifier 59 may be reported with code 11720 if one to five nails are debrided and a hyperkeratotic lesion is pared on a toe other than one with a debrided toenail or the hyperkeratotic lesion is proximal to the skin overlying the distal interphalangeal joint of a toe on which a nail is debrided.

Example 5: Column 1 Code / Column 2 code - 67210/67220
- CPT Code 67210 – Destruction of localized lesion of retina (eg, macular edema, tumors), 1 or more sessions; photocoagulation
- CPT Code 67220 – Destruction of localized lesion of choroid (eg, choroidal neovascularization); photocoagulation (eg, laser), 1 or more sessions

CPT code 67220 should not be reported and Modifier 59 should not be used if both procedures are performed during the same operative session because the retina and choroid are contiguous structures of the same organ.

Example 6: Column 1 Code / Column 2 Code - 29827/29820
- CPT Code 29827 – Arthroscopy, shoulder, surgical; with rotator cuff repair
- CPT Code 29820 – Arthroscopy, shoulder, surgical; synovectomy, partial

CPT code 29820 should not be reported and Modifier 59 should not be used if both procedures are performed on the same shoulder during the same operative session because the shoulder joint is a single anatomic structure. If the procedures are performed on different shoulders, modifiers RT and LT should be used, not Modifier 59.

Example 7: Column 1 Code / Column 2 Code - 93015/93040
- CPT Code 93015 – Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision, with interpretation and report
- CPT Code 93040 – Rhythm ECG, one to three leads; with interpretation and report

Continued >>
Modifier 59 may be reported if the rhythm ECG is performed at a different encounter than the cardiovascular stress test. If a rhythm ECG is performed during the cardiovascular stress test encounter, CPT code 93040 should not be reported and Modifier 59 should not be used. **Modifier 59 is used appropriately when the procedures are performed in different encounters on the same day.**

**Example 8: Column 1 Code/Column 2 code - 34833/34820**

- CPT code 34833 - Open iliac artery exposure with creation of conduit for delivery of endovascular prosthesis or for establishment of cardiopulmonary bypass, by abdominal or retroperitoneal incision, unilateral (List separately in addition to code for primary procedure)
- CPT code 34820 - Open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision, unilateral (List separately in addition to code for primary procedure)

CPT code 34833 is followed by a CPT Manual instruction that states: “(Do not report 34833 in conjunction with 33364, 33953, 33954, 33959, 33962, 33969, 33984, 34820 when performed on the same side).” Although the CPT code descriptors for 34833 and 34820 describe different procedures, they should not be reported together for the same side. Modifier 59 should not be appended to either code to report the two procedures for the same side of the body. If the two procedures were performed on different sides of the body, they may be reported with modifiers LT and RT as appropriate. **However, modifier 59 is used inappropriately if the basis for its use is that the narrative description of the two codes is different.**

**Example 9: Column 1 Code / Column 2 Code - 97140/97530**

- CPT Code 97140 – Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes
- CPT Code 97530 – Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes

Modifier 59 may be reported if the two procedures are performed in distinctly different 15 minute time blocks. For example, one service may be performed during the initial 15 minutes of therapy and the other service performed during the second 15 minutes of therapy. Alternatively, the therapy time blocks may be split. For example, manual therapy might be performed for 10 minutes, followed by 15 minutes of therapeutic activities, followed by another 5 minutes of manual therapy. CPT code 97530 should not be reported and modifier 59 should not be used if the two procedures are performed during the same time block. **Modifier 59 is used appropriately when two timed procedures are performed in different blocks of time on the same day.**

**Example 10: Column 1 Code / Column 2 Code - 37220/75710**

- CPT Code 37220 – Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty
- CPT Code 75710 – Angiography, extremity, unilateral, radiological supervision and interpretation.

Modifier 59 may be reported with CPT code 75710 if a diagnostic angiography has not been previously performed and the decision to perform the revascularization is based on the result of the diagnostic angiography. The CPT Manual defines additional circumstances under which diagnostic angiography may be reported with an interventional vascular procedure on the same artery. **Modifier 59 is used appropriately for a diagnostic**
procedure which precedes a therapeutic procedure only when the diagnostic procedure is the basis for performing the therapeutic procedure.

Additional Information
The CMS webpage on the National Correct Coding Initiative Edits is available at http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html on the CMS website. There is a modifier 59 article on this website also.

The CPT Manual includes the definition of Modifier 59, as well as CPT codes used with Modifier 59. The manual is available at http://www.ama-assn.org/ama on the American Medical Association (AMA) website.

You may want to review MLN Matters® article MM8863 (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8863.pdf) that alerts providers that CMS is establishing four new HCPCS Modifiers to define subsets of Modifier 59, Distinct Procedural Services.

Document History
• June 2, 2014 - Initial article released.
• May 27, 2015 - This article was revised to provide a reference to MLN Matters Article SE1503 that advises physicians, providers and suppliers submitting bills to Medicare that additional guidance and education on the appropriate use of the new X modifiers will be introduced in a gradual, controlled fashion by CMS and that providers may continue to use Modifier -59 after January 1, 2015, in any instance in which it was correctly used before January 1, 2015. All other information is unchanged.
• January 3, 2018 - Article updated to conform with latest Modifier 59 article on the NCCI website.
Medically Unlikely Edits (MUE) and Bilateral Surgical Procedures

MLN Matters® Number: SE1422 Revised
Related Change Request (CR) #: N/A
Article Release Date: January 17, 2018
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

**Note:** This article was revised with more details and examples and was re-issued on January 17, 2018. Providers who perform bilateral surgical procedures should review the entire article.

**Provider Types Affected**
This MLN Matters® Special Edition Article is intended for all Medicare Fee-For-Service (FFS) physicians, non-physician practitioners, providers, and other health care professionals who bill Medicare Administrative Contractors (MACs) for bilateral surgical procedures for Medicare beneficiaries using the Physician Fee Schedule (PFS).

**Provider Action Needed**
The purpose of this article is to inform providers that Medically Unlikely Edits (MUEs) may render certain claim lines for bilateral surgical procedures unpayable. Providers and suppliers billing using the PFS are reminded that Medicare billing instructions require claims for certain bilateral surgical procedures to be filed using a -50 modifier and One Unit of Service (UOS).

Make sure your billing staffs examine their process for filing claims for bilateral surgical procedures and services to ensure the -50 modifier is used in accordance with Medicare correct coding and claims submission instructions.

**Background**
Healthcare Common Procedure Coding System (HCPCS) coding for bilateral surgical procedures differs from CPT coding guidelines.

Coding claims for surgical procedures performed bilaterally depends on:
- The HCPCS code descriptor,
- The “Bilateral Indicator” assigned to the HCPCS code (that is, whether special payment rules apply), and
- The nature of the service.

The “National Correct Coding Initiative (NCCI)” manual specifies that modifier -50 is used to report bilateral surgical procedures as a single UOS. The NCCI manual warns that MUE edits based on established CMS policies may limit units of service and are predicated on the assumption that claims are coded in accordance with these Medicare instructions. Consequently, many bilateral procedures have an MUE value of 1.

Bilateral indicators only apply to the Physician Fee Schedule (PFS) and not to other Medicare payment systems.

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<table>
<thead>
<tr>
<th>Bilateral Indicator</th>
<th>What Does this Bilateral Indicator Mean?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td><strong>No bilateral payment adjustment</strong> 150% payment adjustment for bilateral procedures does not apply. If procedure is reported with modifier -50 or with modifiers RT and LT, base the payment for the two sides on the lower of: (a) the total actual charge for both sides and (b) 100% of the fee schedule amount for a single code. Example: The fee schedule amount for code XXXXX is $125. The physician reports code XXXXX-LT with an actual charge of $100 and XXXXX-RT with an actual charge of $100. Payment should be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200). The bilateral adjustment is inappropriate for codes in this category (a) because of physiology or anatomy, or (b) because the code description specifically states that it is a unilateral procedure and there is an existing code for the bilateral procedure.</td>
</tr>
<tr>
<td>1</td>
<td><strong>150% Bilateral payment adjustment</strong> 150% payment adjustment for bilateral procedures applies. If the code is billed with the bilateral modifier or is reported twice on the same day by any other means (e.g., with RT and LT modifiers, or with a 2 in the units field), base the payment for these codes when reported as bilateral procedures on the lower of: (a) the total actual charge for both sides or (b) 150% of the fee schedule amount for a single code. If the code is reported as a bilateral procedure and is reported with other procedure codes on the same day, apply the bilateral adjustment before applying any multiple procedure rules.</td>
</tr>
<tr>
<td>2</td>
<td><strong>Bilateral procedure</strong> 150% payment adjustment does not apply. RVUs are already based on the procedure being performed as a bilateral procedure. If the procedure is reported with modifier -50 or is reported twice on the same day by any other means (e.g., with RT and LT modifiers or with a 2 in the units field), base the payment for both sides on the lower of (a) the total actual charge by the physician for both sides, or (b) 100% of the fee schedule for a single code. Example: The fee schedule amount for code YYYYY is $125. The physician reports code YYYYY-LT with an actual charge of $100 and YYYYY-RT with an actual charge of $100. Payment should be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200). The RVUs are based on a bilateral procedure because (a) the code descriptor specifically states that the procedure is bilateral, (b) the code descriptor states that the procedure may be performed either unilaterally or bilaterally, or (c) the procedure is usually performed as a bilateral procedure.</td>
</tr>
<tr>
<td>3</td>
<td><strong>No bilateral payment adjustment</strong> The usual payment adjustment for bilateral procedures does not apply. If the procedure is reported with modifier -50 or is reported for both sides on the same day by any other means (e.g., with RT and LT modifiers or with a 2 in the units field), base the payment for each side or organ or site of a paired organ on the lower of (a) the actual charge for each side or (b) 100% of the fee schedule amount for each side. If the procedure is reported as a bilateral procedure and with other procedure codes on the same day, determine the fee schedule amount for a bilateral procedure before applying any multiple procedure rules. Services in this category are generally radiology procedures or other diagnostic tests which are not subject to the special payment rules for other bilateral surgeries.</td>
</tr>
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</table>
### Examples of Correct Coding for Bilateral Surgical Procedures for PFS

<table>
<thead>
<tr>
<th>Bilateral Indicator</th>
<th>Expected Units of Service if performed bilaterally</th>
<th>Modifier based on Laterality</th>
<th>HCPCS code descriptor and Explanation of Correct Coding</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
<td>50</td>
<td>23515 Open treatment of clavicular fracture, includes internal fixation, when performed. <em>The code descriptor does not identify this procedure as a bilateral procedure (or unilateral or bilateral), so when performed bilaterally at the same operative session physicians must report the procedure with modifier “-50” as a single line item using one UOS. Do not use modifiers RT and LT when modifier -50 applies.</em></td>
</tr>
<tr>
<td>2</td>
<td>1</td>
<td></td>
<td>52290 Cystourethroscopy; with ureteral meatotomy, <strong>unilateral or bilateral.</strong> <em>The code descriptor identifies this procedure as a unilateral or bilateral procedure, so when performed bilaterally at the same operative session report one UOS as a single line item and do not report the procedure with modifier “-50”.</em></td>
</tr>
<tr>
<td>2</td>
<td>1</td>
<td></td>
<td>64488 Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) <strong>bilateral;</strong> by injections (includes imaging guidance, when performed). <em>The code descriptor identifies this procedure as a bilateral procedure, so when performed bilaterally at the same operative session report one UOS as a single line item and do not report the procedure with modifier “-50”.</em></td>
</tr>
</tbody>
</table>

### Examples of Incorrect Coding for Bilateral Surgical Procedures for PFS

<table>
<thead>
<tr>
<th>Bilateral Indicator</th>
<th>Expected Units of Service if performed bilaterally</th>
<th>Modifier based on Laterality</th>
<th>HCPCS code descriptor and Explanation of Incorrect Coding</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
<td>RT and LT</td>
<td>23515 Open treatment of clavicular fracture, includes internal fixation, when performed. <em>The code descriptor does not identify this procedure as a bilateral procedure (or unilateral or bilateral), so when performed bilaterally at the same operative session physicians must report the procedure with modifier “-50” as a single line item using one UOS. Do not use modifiers RT and LT when modifier -50 applies.</em></td>
</tr>
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Continued >>
2 1 LT 52290 Cystourethroscopy; with ureteral meatotomy, **unilateral or bilateral**. The code descriptor identifies this procedure as a unilateral or bilateral procedure, so when performed bilaterally at the same operative session report one UOS as a single line item and do not report the procedure with modifier “-50”. Do not report the procedure using two line items using RT and LT modifiers.

2 1 RT 52290 Cystourethroscopy; with ureteral meatotomy, **unilateral or bilateral**. The code descriptor identifies this procedure as a unilateral or bilateral procedure, so when performed bilaterally at the same operative session report one UOS as a single line item and do not report the procedure with modifier “-50”. Do not report the procedure using two line items using RT and LT modifiers.

2 2 64488 Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) **bilateral**; by injections (includes imaging guidance, when performed). The code descriptor identifies this procedure as a bilateral procedure, so when performed bilaterally at the same operative session report one UOS as a single line item. Do not report two UOS.

2 1 50 64488 Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) **bilateral**; by injections (includes imaging guidance, when performed). The code descriptor identifies this procedure as a bilateral procedure, so when performed bilaterally at the same operative session report one UOS as a single line item. Do not report the procedure with modifier “-50”.

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**Request for Reopening of a Claim**

For all MUE edit denials, including both MAI of 2 and 3, if the provider identifies a clerical error and the correct value is equal to or less than the MUE, the provider may request a reopening (i.e., a Clerical Error Reopening (CER)) to correct its billing of the claim as an alternative to filing a formal appeal. Providers can request a CER through their Medical Administrative Contractor. Providers are reminded this approach is allowable to redress underpayments resulting from unintentional errors, but it nonetheless delays full payment. For example, if the provider identifies a denial of a bilateral surgical service because it was billed with two UOS instead of being billed with one UOS and a -50 modifier, the provider may request a reopening to correct the coding/billing error, although providers should be aware that reopening requests do not extend the window for filing appeals. More importantly, though, the provider should bring his billing into compliance with CMS instructions, using one UOS and the -50 modifier to avoid future denials and delays in payment.

Continued >>
**Additional Information**

If you have any questions, please contact your MAC at their toll-free number. That number is available at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html) under - How Does It Work.

You may also want to review the following publications:

- For information on Clerical Error Reopenings (CERs) consult the Claims Processing Manual Pub. 100-04 Chapter 34 and work with your Medicare Administrative Contractor.
- For information on Reporting Hospital Outpatient Services Using Healthcare Common Procedure Coding System (HCPCS) consult the Claims Processing Manual Pub. 100-04 Chapter 4 Section 20.6 - Use of Modifiers.

**Document History**

<table>
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<tr>
<th>Date of Change</th>
<th>Description</th>
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<tr>
<td>January 17, 2018</td>
<td>This article was revised with more details and examples and was re-issued.</td>
</tr>
<tr>
<td>June 30, 2014</td>
<td>Initial article released.</td>
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Next Generation Accountable Care Organization (NGACO) 
Year Three Benefit Enhancements

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

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

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

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

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

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

Asynchronous Telehealth 
CMS is expanding the current telehealth waiver to include asynchronous (also known as “store-and-forward”) telehealth in the specialties of teledermatology and teleophthalmology. Asynchronous telehealth includes the transmission of recorded health history (for example, retinal scanning and digital images) through a secure electronic communications system to a practitioner, usually a specialist, who uses the information to evaluate the case or render a service outside of a real-time interaction. Asynchronous telecommunications system in

Continued >>
single media format does not include telephone calls, images transmitted via facsimile machines, and text messages without visualization of the patient (electronic mail). Photographs must be specific to the patients’ condition and adequate for rendering or confirming a diagnosis or treatment plan.

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

Asynchronous Telehealth Based on Intra-Service + 5 Minutes Post-Service Time
- Code 1: G9868– Receipt and analysis of remote, asynchronous images for dermatologic and/or ophthalmologic evaluation, for use under the Next Generation ACO model, less than 10 minutes.
- Code 2: G9869– Receipt and analysis of remote, asynchronous images for dermatologic and/or ophthalmologic evaluation, for use under the Next Generation ACO model, 10-20 minutes.
- Code 3: G9870 – Receipt and analysis of remote, asynchronous images for dermatologic and/or ophthalmologic evaluation, for use under the Next Generation ACO model, 20 or more minutes.

ADDITIONAL INFORMATION

DOCUMENT HISTORY

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<th>Date of Change</th>
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<td>August 4, 2017</td>
<td>Initial article issued.</td>
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<tr>
<td>January 23, 2018</td>
<td>The article was revised to reflect the revised CR10044 issued on November 22, 2017. In the article, the CR release date, transmittal number, and the Web address of the CR are revised. All other information is the same.</td>
</tr>
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</table>
April 2018 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

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

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

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

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

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

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

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

ADDITIONAL INFORMATION

DOCUMENT HISTORY

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

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Calendar Year (CY) 2018 Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule

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

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

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

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

Section 1834(a)(1)(F)(ii) of the Act mandates adjustments to the fee schedule amounts for certain items furnished on or after January 1, 2016, in areas that are not competitive bid areas, based on information from Competitive Bidding Programs (CBPs) for DME. Section 1842(s)(3)(B) of the Act provides authority for making adjustments to the fee schedule amounts for enteral nutrients, equipment, and supplies (enteral nutrition) based on information from CBPs. Regulations at 42 CFR Section 414.210(g) established the methodologies for adjusting DMEPOS fee schedule amounts using information from CBPs. Recent program instructions on these changes are available in Transmittal 3551, CR9642, dated June 23, 2016 (MM9642 is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM9642.pdf), and Transmittal 3416, CR9431, dated November 23, 2015 (MM9431 is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM9431.pdf).

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

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

The ZIP code associated with the address used for pricing a DMEPOS claim determines the rural fee schedule payment applicability for codes with rural and non-rural adjusted fee schedule amounts. ZIP codes for non-continental Metropolitan Statistical Areas (MSAs) are not included in the DMEPOS Rural ZIP code file. The DMEPOS Rural ZIP code file is updated on a quarterly basis, as necessary. Regulations at 42 CFR 414.202 define a rural area to be a geographical area represented by a postal ZIP code where at least 50 percent of the total geographical area of the ZIP code is estimated to be outside any MSA. A rural area also included any ZIP code within an MSA that is excluded from a competitive bidding area established for that MSA.

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

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

**New Codes Added**

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

- E0953 and E0954 in the Inexpensive/Routinely Purchased (IN) payment category
- L3761, L7700, L8625, L8694, and Q0477, which are all in the Prosthetics and Orthotics (PO) payment category.

For gap-filling pricing purposes, deflation factors are applied before updating to the current year. The deflation factors for 2017 by the payment category are:

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

**Codes Deleted**

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

**Specific Coding and Pricing Issues**

Effective January 1, 2018, new Off-The-Shelf orthotic (OTS) code L3761 - Elbow Orthosis (EO), with adjustable position locking joint(s) prefabricated off-the-shelf - is included in the fee schedule file. Code L3760 was split into two codes: The existing code revised, effective January 1, 2018, to only describe devices customized to fit a specific patient by an individual with expertise, and a new code describing OTS items (L3761).
The fee schedule amount for existing code L3760 will be applied to new code L3761 effective January 1, 2018. The cross-walking of fee schedule amounts for a single code that is split into two codes for distinct complete items is in accordance with the instructions stated in Chapter 3, Section 60.3.1 of the “Medicare Claims Processing Manual.” An update will be made to the list of orthotic codes that are designated as OTS at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/OTS_Orthotics.html to reflect added code L3761.

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

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

Effective January 1, 2018, the existing fee schedules for L8691 are revised to remove payment for the separate transducer/actuator component. Suppliers billing for replacement sound processors that do not separate the sound processor and the actuator should use both L8691 and L8694 to describe the replaced items. Suppliers billing for replacement sound processors that separate the sound processor and the actuator components should use either or both L8691 and L8694 as appropriate to describe the sound processor component(s).

The replacement Ventricular Assist Device (VAD) power module code Q0479 is split in order to separately identify the patient cable. Effective January 1, 2018, HCPCS code Q0477 identifies a replacement patient cable. Thus, the fees for Q0479 are revised to reflect the establishment of the new patient cable code.

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

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

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

HCPCS code Q0477 (Power Module Patient Cable for Use with Electric or Electric/Pneumatic Ventricular Assist Device, Replacement Only) is being added to the HCPCS file, effective January 1, 2018, to describe a replacement accessory for Ventricular Assist Devices (VADs). Similar to the other VAD supplies and accessories

Continued >>
coded at Q0478 thru Q0495, Q0497-Q0502, and Q0504 thru Q0509, CMS has determined the reasonable useful lifetime for code Q0477 to be one year. Therefore, CMS will deny claims for Q0477 before the lifetime of these items has expired. Suppliers and providers will need to add modifier RA to claims for code Q0477 in cases where the battery is being replaced because it was lost, stolen, or irreparably damaged.

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

**Diabetic Testing Supplies**
The fee schedule amounts for non-mail order Diabetic Testing Supplies (DTS) (without KL modifier) for codes A4233, A4234, A4235, A4236, A4253, A4256, A4258, and A4259 are not updated by the annual covered item update. In accordance with Section 636(a) of the American Taxpayer Relief Act of 2012, the fee schedule amounts for these codes were adjusted in CY 2013 so that they are equal to the Single Payment Amounts (SPAs) for mail order DTS established in implementing the national mail order CBP under Section 1847 of the Act. The National Mail-Order Recompete DTS SPAs are available at https://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home.

The non-mail order DTS amounts on the fee schedule file will be updated each time the SPAs are updated. This can happen no less often than every time the mail order CBP contracts are recompeted. The CBP for mail order diabetic supplies is effective July 1, 2016, to December 31, 2018. The program instructions reviewing these changes are included in Transmittal 2709, Change Request (CR) 8325, dated May 17, 2013, and Transmittal 2661, CR8204, dated February 22, 2013. You can review related article MM8325 at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8325.pdf and MM8204 at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8204.pdf.

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

**2018 Update to the Labor Payment Rates**
The CY 2018 allowed payment amounts for HCPCS labor payment codes K0739, L4205, and L7520 are in the table below. Since the percentage increase in the CPI- U for the 12-month period ending with June 30, 2017, is 1.6 percent, this change is applied to the 2017 labor payment amounts to update the rates for CY 2018.
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**2018 National Monthly Fee Schedule Amounts for Stationary Oxygen Equipment**

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

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

Continued >>
When updating the stationary oxygen equipment amounts, corresponding updates are made to the fee schedule amounts for HCPCS codes E1405 and E1406 for oxygen and water vapor enriching systems. Since 1989, the payment amounts for codes E1405 and E1406 have been established based on a combination of the Medicare payment amounts for stationary oxygen equipment and nebulizer codes E0585 and E0570, respectively.

2018 Maintenance and Servicing Payment Amount for Certain Oxygen Equipment

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

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

ADDITIONAL INFORMATION


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<td>January 5, 2018</td>
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2018 Durable Medical Equipment Prosthetics, Orthotics, and Supplies Healthcare Common Procedure Coding System (HCPCS) Code Jurisdiction List

MLN Matters Number: MM10416
Related Change Request (CR) Number: 10416
Related CR Release Date: January 12, 2018
Effective Date: January 1, 2018
Related CR Transmittal Number: R3950CP
Implementation February 13, 2018

PROVIDER TYPES AFFECTED
This MLN Matters Article is intended for providers and suppliers submitting claims to Medicare Administrative Contractors (MACs), including Durable Medical Equipment (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) 10416 updates the list of Healthcare Common Procedure Coding System (HCPCS) codes for the MACs and DME MACs. Please make sure your billing staffs are aware of these updates.

WHAT YOU NEED TO KNOW
The Centers for Medicare & Medicaid Services (CMS) annually updates a spreadsheet that contains a list of the HCPCS codes for DME MACs and Part B MACs jurisdictions to reflect codes that have been added or discontinued (deleted) each year. The jurisdiction list is an Excel file and is available at http://www.cms.gov/Center/Provider-Type/Durable-Medical-Equipment-DME-Center.html. The file is also available as an attachment to CR10416.

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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:

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<th>Date/Time</th>
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<td>JM Part B Ask the Contractor Teleconference, Topic: Compliance Matters</td>
<td>2/15/2018, 10am, ET</td>
<td>Teleconference Number: 866-745-0425 Confirmation Code: 5457077</td>
</tr>
<tr>
<td>Get to Know KEPRO Your BFCC-QIO Webcast</td>
<td>3/14/2018, 10am, ET</td>
<td><a href="https://event.on24.com/wcc/r/1561142/89967C5899087751D76413DB570ABE78">https://event.on24.com/wcc/r/1561142/89967C5899087751D76413DB570ABE78</a></td>
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<tr>
<td>Part B: Quarterly Updates Webcast</td>
<td>3/14/2018, 10am, ET</td>
<td><a href="https://event.on24.com/wcc/r/1578168/5C1DCB1B25A559AA8FE29F475D64680AE">https://event.on24.com/wcc/r/1578168/5C1DCB1B25A559AA8FE29F475D64680AE</a></td>
</tr>
</tbody>
</table>

Continued >>
Check out these resources

| Quarterly Ask the Contractor Teleconferences (ACTs) | 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. 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](http://tinyurl.com/hjq84dg)). Once the form is completed, please fax it to (803) 935-0140, Attention: Ask-the-Contractor Teleconference |
| http://tinyurl.com/jkb4458 | |
| Quarterly Updates Webcasts | The Quarterly Update Webcasts are intended to provide ongoing, scheduled opportunities for providers to stay up to date on Medicare requirements. 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. |
| http://tinyurl.com/gsrb8gt | |
| Event Registration Portal | Visit our Event Registration Portal to find information on upcoming educational events and seminars. 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. |
| http://tinyurl.com/gsrb8gt | |

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

MLN Matters Number: MM10318 Revised
Related Change Request (CR) Number: 10318
Related CR Release Date: January 18, 2018
Effective Date: April 1, 2018 - Unless otherwise noted in CR10318
Related CR Transmittal Number: R2005OTN
Implementation Date: January 29, 2018 for local MAC edits; April 2, 2018 - for shared system edits (except FISS for NCDs (see below) 1, 8, 12, 19, 21); July 2, 2018 - FISS only for NCDs 1, 8, 12, 19, 21

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

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

PROVIDER ACTION NEEDED
Change Request (CR) 10318 constitutes a maintenance update of the International Code of Diseases, Tenth Revision (ICD-10) conversions and other coding updates specific to National Coverage Determinations (NCDs). These NCD coding changes are the result of newly available codes, coding revisions to NCDs released separately, or coding feedback received. Please follow the link below for the NCD spreadsheets included with this CR: https://www.cms.gov/Medicare/Coverage/DeterminationProcess/downloads/CR10318.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 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.

Continued >>
CR10318 makes coding and clarifying adjustments to the following NCDs:
1. NCD20.9 Artificial Hearts
2. NCD20.9.1 Ventricular Assist Devices (VADs)
3. NCD20.16 Cardiac Output Monitoring by Thoracic Electrical Bioimpedance (TEB)
4. NCD20.29 Hyperbaric Oxygen (HBO) Therapy
5. NCD20.30 Microvolt T-Wave Alternans (MTWA)
6. NCD20.33 Transcatheter Mitral Valve Repair (TMVR)
7. NCD40.1 Diabetes Self-Management Training (DSMT)
8. NCD80.2, 80.2.1, 80.3, 80.3.1 Photodynamic Therapy, OPT, Photosensitive Drugs, Verteporfin
9. NCD110.18 Aprepitant
10. NCD110.21 Erythropoiesis Stimulating Agents (ESAs) in Cancer
11. NCD110.23 Stem Cell Transplants
12. NCD160.27 Transcutaneous Electrical Nerve Stimulation (TENS) for Chronic Low Back Pain (CLBP)
13. NCD190.3 Cytogenetic Studies
14. NCD190.11 Home Prothrombin Time/International Normalized Ratio (PT/INR) for Anticoagulation Management
15. NCD220.4 Mammograms
16. NCD220.6.17 Positron Emission Tomography (FDG) for Solid Tumors
17. NCD260.1 Adult Liver Transplantation
18. NCD220.13 Percutaneous Image-Guided Breast Biopsy
19. NCD270.1 Electrical Stimulation/Electromagnetic Therapy (ES/ET) for Wounds
20. NCD270.3 Blood-Derived Products for Chronic Non-Healing Wounds
21. NCD80.11 Vitrectomy

When denying claims associated with the above NCDs, except where otherwise indicated, MACs will use Remittance Advice Remark Codes (RARC) N386 with Claim Adjustment Reason Code (CARC) 50, 96, and/or 119.

- Group Code PR (Patient Responsibility) assigning financial responsibility to the beneficiary (if a claim is received with occurrence code 32, or with occurrence code 32 and a GA modifier, indicating a signed Advance Beneficiary Notice (ABN) is on file).
- Group Code CO (Contractual Obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).
- For modifier GZ, use CARC 50

**ADDITIONAL INFORMATION**

**DOCUMENT HISTORY**

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

MLN Matters Number: MM10441
Related CR Release Date: December 22, 2017
Related CR Transmittal Number: R3939CP
Related Change Request (CR) Number: 10441
Effective Date: January 1, 2018
Implementation Date: January 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) 10441 informs MACs about updates to the ASC payment system for January 2018. Be sure your billing staffs are aware of these changes.

BACKGROUND
CR10441 includes changes to and billing instructions for various payment policies implemented in the January 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), and the CY 2018 ASC Payment Rates for Covered Surgical and Ancillary Services (ASCFS file). No ASC Code Pair file is being issued with this notice.

ASC payment rates under the ASC payment system are generally established using payment rate information in the hospital Outpatient Prospective Payment System (OPPS) or the Medicare Physician Fee Schedule (MPFS). The payment files associated with CR10441 reflect the most recent changes to CY 2018 OPPS and CY 2018 MPFS payments.

The changes in CR10441 are as follows:

1. a. New Device Pass-Through Policies
Section 1833(t)(6)(B) of the Social Security Act (the Act) requires that, under the OPPS, categories of devices be eligible for transitional pass-through payments for at least two (2), but not more than three (3) years. Section 1833(t)(6)(B)(ii)(IV) of the Act requires that the Centers for Medicare & Medicaid Services (CMS) creates additional categories for transitional pass-through payment of new medical devices not described by existing or previously existing categories of devices. This policy was implemented in the 2008 revised ASC payment system. Therefore, additional payments may be made to the ASC for covered ancillary services, including certain implantable devices with pass-through status under the Outpatient Prospective Payment System (OPPS).

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

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

1. b. Device Offset from Payment for Device Category
Section 1833(t)(6)(D)(ii) of the Act requires that CMS deduct from pass-through payments for devices an amount that reflects the portion of the Ambulatory Payment Classifications (APC) payment amount. With respect to device code C2623, CMS has previously determined that the costs associated with C2623 are not reflected in the APC payment amount. Therefore, CMS is not applying a device offset to the retroactive pass-through payments for C2623. Retroactive pass-through payments for services furnished on August 25, 2017, through December 31, 2017, without deduction, will only apply when HCPCS code C2623 is billed with CPT codes 36902 or 36903.

2. New Separately Payable Procedure Code, Effective January 1, 2018
Effective January 1, 2018, new HCPCS code C9748 has been created as described in Table 1.

Table 1 - New Separately Payable Procedure Code, Effective January 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>C9748</td>
<td>Prostatic rf water vapor tx</td>
<td>Transurethral destruction of prostate tissue; by radiofrequency water vapor (steam) thermal therapy</td>
<td>G2</td>
</tr>
</tbody>
</table>

3. Drugs, Biologicals, and Radiopharmaceuticals
a. New CY 2018 HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Radiopharmaceuticals
For CY 2018, several new HCPCS codes have been created for reporting drugs and biologicals in the ASC payment system, where there have not previously been specific codes available. These new codes are listed in Table 2.
Table 2 - New CY 2018 HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Radiopharmaceuticals

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>ASC PI</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9014</td>
<td>Injection, cerliponase alfa</td>
<td>Injection, cerliponase alfa, 1 mg</td>
<td>K2</td>
</tr>
<tr>
<td>C9015</td>
<td>C-1 esterase, haegarda</td>
<td>Injection, c-1 esterase inhibitor (human), Haegarda, 10 units</td>
<td>K2</td>
</tr>
<tr>
<td>C9016</td>
<td>Inj, triptorelin ext rel</td>
<td>Injection, triptorelin extended release, 3.75 mg</td>
<td>K2</td>
</tr>
<tr>
<td>C9024</td>
<td>Inj, daunorubicin-cytarabine</td>
<td>Injection, liposomal, 1 mg daunorubicin and 2.27 mg cytarabine</td>
<td>K2</td>
</tr>
<tr>
<td>C9028</td>
<td>Inj. inotuzumab ozogamicin</td>
<td>Injection, inotuzumab ozogamicin, 0.1 mg</td>
<td>K2</td>
</tr>
<tr>
<td>C9029</td>
<td>Injection, guselkumab</td>
<td>Injection, guselkumab, 1 mg</td>
<td>K2</td>
</tr>
<tr>
<td>J0606</td>
<td>Inj, etelcalcetide, 0.1 mg</td>
<td>Injection, etelcalcetide, 0.1 mg</td>
<td>K2</td>
</tr>
<tr>
<td>J1555</td>
<td>Inj cuvitru, 100 mg</td>
<td>Injection, immune globulin (cuvitru), 100 mg</td>
<td>K2</td>
</tr>
<tr>
<td>J7211</td>
<td>Inj, kovaltry, 1 i.u.</td>
<td>Injection, factor viii, (antihemophilic factor, recombinant), (kovaltry), 1 i.u.</td>
<td>K2</td>
</tr>
<tr>
<td>J7345</td>
<td>Aminolevulinic acid, 10% gel</td>
<td>Aminolevulinic acid hcl for topical administration, 10% gel, 10 mg</td>
<td>K2</td>
</tr>
<tr>
<td>J9203</td>
<td>Gemtuzumab ozogamicin 0.1 mg</td>
<td>Injection, gemtuzumab ozogamicin, 0.1 mg</td>
<td>K2</td>
</tr>
<tr>
<td>Q2040</td>
<td>Tisagenlecleucel carpos t</td>
<td>Tisagenlecleucel, up to 250 million car-positive viable t cells, including leukapheresis and dose preparation procedures, per infusion</td>
<td>K2</td>
</tr>
</tbody>
</table>

b. Other Changes to CY 2018 HCPCS and CPT Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals

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

Table 3 notes those drugs, biologicals, and radiopharmaceuticals that have undergone changes in their HCPCS/CPT code, their long descriptor, or both. Each product’s CY 2017 HCPCS/CPT code and long description is included.

Continued >>
### Table 3 - Other CY 2018 HCPCS and CPT Code Changes for Certain Drugs, Biologicals, and Radiopharmaceuticals

<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>C9490</td>
<td>Injection, bezlotoxumab, 10 mg</td>
<td>J0565</td>
<td>Injection, bezlotoxumab, 10 mg</td>
</tr>
<tr>
<td>C9484</td>
<td>Injection, eteplirsen, 10 mg</td>
<td>J1428</td>
<td>Injection, eteplirsen, 10 mg</td>
</tr>
<tr>
<td>C9486</td>
<td>Injection, granisetron extended release, 0.1 mg</td>
<td>J1627</td>
<td>Injection, granisetron, extended-release, 0.1 mg</td>
</tr>
<tr>
<td>Q9986</td>
<td>Injection, hydroxyprogesterone caproate (Makena), 10 mg</td>
<td>J1726</td>
<td>Injection, hydroxyprogesterone caproate (Makena), 10 mg</td>
</tr>
<tr>
<td>C9489</td>
<td>Injection, nusinersen, 0.1 mg</td>
<td>J2326</td>
<td>Injection, nusinersen, 0.1 mg</td>
</tr>
<tr>
<td>C9494</td>
<td>Injection, ocrelizumab, 1 mg</td>
<td>J2350</td>
<td>Injection, ocrelizumab, 1 mg</td>
</tr>
<tr>
<td>Q9989</td>
<td>Ustekinumab, for Intravenous Injection, 1 mg</td>
<td>J3358</td>
<td>Ustekinumab, for intravenous injection, 1 mg</td>
</tr>
<tr>
<td>C9140</td>
<td>Injection, Factor VIII (antihemophilic factor, recombinant) (Afstyla), 1 I.U.</td>
<td>J7210</td>
<td>Injection, factor viii, (antihemophilic factor, recombinant), (Afstyla), 1 i.u.</td>
</tr>
<tr>
<td>C9483</td>
<td>Injection, atezolizumab, 10 mg</td>
<td>J9022</td>
<td>Injection, atezolizumab, 10 mg</td>
</tr>
<tr>
<td>C9491</td>
<td>Injection, avelumab, 10 mg</td>
<td>J9023</td>
<td>Injection, avelumab, 10 mg</td>
</tr>
<tr>
<td>C9485</td>
<td>Injection, olaratumab, 10 mg</td>
<td>J9285</td>
<td>Injection, olaratumab, 10 mg</td>
</tr>
</tbody>
</table>

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

For CY 2018, payment for non-pass-through drugs, biologicals and therapeutic radiopharmaceuticals 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 is made to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items. Payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available.

Effective January 1, 2018, payment rates for many drugs and biologicals have changed from the values published in the CY 2018 OPPS/ASC final rule with comment period as a result of the new ASP calculations based on sales price submissions from the third quarter of CY 2017. In cases where adjustments to payment rates are necessary, CMS is not publishing the updated payment rates in CR10441.

However, all ASC payable drugs and biologicals, effective January 1, 2018, including those that were updated as a result of the new ASP calculations are in the January 2018 ASC Addendum BB at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html.
d. Drugs and Biologicals Based on ASP Methodology with Restated Payment Rates
Some drugs and biologicals based on ASP methodology may have payment rates that are corrected retroactively. These retroactive corrections typically occur on a quarterly basis. The list of drugs and biologicals with corrected payments rates will be accessible 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 contractor adjustment of the previously processed claims.

e. Biosimilar Biological Product Payment Policy
Effective January 1, 2018, the payment rate for biosimilars approved for payment in the ASC payment system will be the same as the payment rate in the OPPS and physician office setting, calculated as the ASP of the biosimilar(s) described by the HCPCS code + 6 percent of the ASP of the reference product. Payment will be made at the single ASP + 6 percent rate.

As a reminder, ASC claims for separately paid biosimilar biological products are required to include the modifier that identifies the manufacturer of the specific product. The modifier does not affect payment determination, but is used to distinguish between biosimilar products that appear in the same HCPCS code, but are made by different manufacturers. Any changes to the billing requirements for biosimilar biological products will be issued to ASCs in a future transmittal.

f. Skin-Substitute Assignments to High-Cost and Low-Cost Groups for CY 2018
The payment for skin-substitute products that do not qualify for hospital OPPS pass-through status are packaged into the OPPS payment for the associated skin-substitute application procedure. This policy is also implemented in the ASC payment system.

The skin substitute products are divided into two groups:
1) High-cost skin substitute products, and
2) Low-cost skin substitute products for packaging purposes.

Table 4 lists the skin-substitute products and their assignment as either a high-cost or a low-cost skin substitute product, when applicable. ASCs should not separately bill for packaged skin substitutes (ASC PI=N1). Note that:
• High-cost skin-substitute products should only be used in combination with the performance of one of the skin application procedures described by CPT codes 15271-15278.
• Low-cost skin-substitute products should only be used in combination with the performance of one of the skin application procedures described by HCPCS code C5271-C5278.
• All OPPS pass-through skin-substitute products (ASC PI=K2) should be billed in combination with one of the skin application procedures described by CPT code 15271-15278.

Note: All of the skin substitute products listed in this table are packaged and should not be separately billed by ASCs.
<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>2018 Short Descriptor</th>
<th>ASC PI</th>
<th>CY 2018 High/Low Assignment</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9363</td>
<td>Integra meshed bil wound mat</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4100</td>
<td>Skin substitute, nos</td>
<td>N1</td>
<td>Low</td>
</tr>
<tr>
<td>Q4101</td>
<td>Apligraf</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4102</td>
<td>Oasis wound matrix</td>
<td>N1</td>
<td>Low</td>
</tr>
<tr>
<td>Q4103</td>
<td>Oasis burn matrix</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4104</td>
<td>Integra bmwd</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4105</td>
<td>Integra drt or omnigraft</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4106</td>
<td>Dermagraft</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4107</td>
<td>Graftjacket</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4108</td>
<td>Integra matrix</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4109</td>
<td>Primatrix</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4110</td>
<td>Gammagraft</td>
<td>N1</td>
<td>Low</td>
</tr>
<tr>
<td>Q4115</td>
<td>Alloskin</td>
<td>N1</td>
<td>Low</td>
</tr>
<tr>
<td>Q4116</td>
<td>Alloderm</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4117</td>
<td>Hyalomatrix</td>
<td>N1</td>
<td>Low</td>
</tr>
<tr>
<td>Q4121</td>
<td>Theraskin</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4122</td>
<td>Dermacell</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4123</td>
<td>Alloskin</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4124</td>
<td>Oasis tri-layer wound matrix</td>
<td>N1</td>
<td>Low</td>
</tr>
<tr>
<td>Q4126</td>
<td>Memoderm/derma/tranz/integup</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4127</td>
<td>Talymed</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4128</td>
<td>Flexhd/allopatchhd/matrixhd</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4131</td>
<td>Epifix or epicord</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4132</td>
<td>Grafix core, grafixpl core</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4133</td>
<td>Grafix prime grafix pl prime</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4134</td>
<td>Hmatrix</td>
<td>N1</td>
<td>Low</td>
</tr>
<tr>
<td>Q4135</td>
<td>Mediskin</td>
<td>N1</td>
<td>Low</td>
</tr>
<tr>
<td>Q4136</td>
<td>Ezderm</td>
<td>N1</td>
<td>Low</td>
</tr>
<tr>
<td>Q4137</td>
<td>Amnioexcel or biodexcel, 1cm</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4138</td>
<td>Biodfence dryflex, 1cm</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4140</td>
<td>Biodfence 1cm</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4141</td>
<td>Alloskin ac, 1cm</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4143</td>
<td>Repriza, 1cm</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4146</td>
<td>Tensix, 1 cm</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4147</td>
<td>Architect ecm px fx 1 sq cm</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4148</td>
<td>Neox rt or clarix cord</td>
<td>N1</td>
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<table>
<thead>
<tr>
<th>HCPCS code</th>
<th>Description</th>
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<tr>
<td>Q4150</td>
<td>Allowrap ds or dry 1 sq cm</td>
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<td>Q4151</td>
<td>Amnioband, guardian 1 sq cm</td>
<td>N1</td>
<td>High</td>
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<tr>
<td>Q4152</td>
<td>Dermapure 1 square cm</td>
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<td>High</td>
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<td>Q4153</td>
<td>Dermavest, plurivest sq cm</td>
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<td>Q4154</td>
<td>Biovance 1 square cm</td>
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<td>High</td>
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<tr>
<td>Q4156</td>
<td>Neox 100 or clarix 100</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4157</td>
<td>Revitalon 1 square cm</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4158</td>
<td>Neox 100 or clarix 100</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4159</td>
<td>Neox 100 or clarix 100</td>
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<td>Q4160</td>
<td>Neox 100 or clarix 100</td>
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<tr>
<td>Q4161</td>
<td>Bio-Connekt per square cm</td>
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<td>Q4163</td>
<td>Woundex, bioskin, per sq cm</td>
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<td>Q4164</td>
<td>Helicoll, per square cm</td>
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<td>Q4165</td>
<td>Keramatrix, per square cm</td>
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<td>Q4166</td>
<td>Cytal, per square cm</td>
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<td>Truskin, per square cm</td>
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<td>Q4169</td>
<td>Artacent wound, per square cm</td>
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<tr>
<td>Q4170</td>
<td>Cygnus, per square cm</td>
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<tr>
<td>Q4172*</td>
<td>Puraply or puraply am</td>
<td>N1</td>
<td>High</td>
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<tr>
<td>Q4173</td>
<td>Palingen or palingen xplus</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4175</td>
<td>Miroderm</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4176*</td>
<td>Neopatch, per sq centimeter</td>
<td>N1</td>
<td>Low</td>
</tr>
<tr>
<td>Q4178*</td>
<td>Floweramniopatch, per sq cm</td>
<td>N1</td>
<td>Low</td>
</tr>
<tr>
<td>Q4179*</td>
<td>Flowerderm, per sq cm</td>
<td>N1</td>
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<tr>
<td>Q4180*</td>
<td>Revita, per sq cm</td>
<td>N1</td>
<td>Low</td>
</tr>
<tr>
<td>Q4181*</td>
<td>Amnio wound, per square cm</td>
<td>N1</td>
<td>Low</td>
</tr>
<tr>
<td>Q4182*</td>
<td>Transcyte, per sq centimeter</td>
<td>N1</td>
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</table>

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

### 4. Section 4011 of the 21st Century Cures Act

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

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

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

5. July ASCFS Technical Record Correction CMS is including a revised July ASCFS record to provide a technical correction to the record for 0474T, position 38, on the ASCFS record layout. The original indicator was incompatible with this code. No additional instructions are being provided to MACs at this time.

6. 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

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<td>January 2, 2017</td>
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Changes to the Laboratory National Coverage Determination (NCD) Edit Software for April 2018

MLN Matters Number: MM10424
Related CR Release Date: December 22, 2017
Related CR Transmittal Number: R3937CP
Related Change Request (CR) Number: CR10424
Effective Date: October 1, 2017
Implementation Date: April 2, 2018

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

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

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

In accordance with the Medicare Claims Processing Manual, Chapter 16, Section 120.2, the laboratory edit module is updated quarterly as necessary to reflect ministerial coding updates and substantive changes to the NCDs developed through the NCD process. The changes are a result of coding analysis decisions developed under the procedures for maintenance of codes in the negotiated NCDs and biannual updates of the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes. CR10424 communicates requirements to MACs notifying them of changes to the laboratory edit module for laboratory NCD code lists for April 2018. Please access the following link for the NCD spreadsheets included with CR10424: https://www.cms.gov/Medicare/Coverage/DeterminationProcess/downloads/April2018.zip

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

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

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

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

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

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

The per mile travel allowance (P9603) is to be used in situations where the average trip to the patients’ homes is longer than 20 miles round trip, and is to be prorated in situations where specimens are drawn from non-Medicare patients in the same trip.

The allowance per mile was computed using the Federal mileage rate of $0.545 per mile plus an additional $0.45 per mile to cover the technician’s time and travel costs. MACs have the option of establishing a higher per mile rate in excess of the minimum $1.00 per mile if local conditions warrant it. The minimum mileage rate will be reviewed and updated throughout the year, as well as in conjunction with the CLFS, as needed.
At no time will the laboratory be allowed to bill for more miles than are reasonable, or for miles that are not actually traveled by the laboratory technician.

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

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**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.

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New Waived Tests

MLN Matters Number: MM10418
Related CR Release Date: January 5, 2018
Related CR Transmittal Number: R3945CP
Related Change Request (CR) Number: 10418
Effective Date: April 1, 2018
Implementation Date: April 2, 2018

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

PROVIDER ACTION NEEDED
Change Request (CR) 10418 informs MACs of new Clinical Laboratory Improvement Amendments of 1988 (CLIA) waived tests approved by the Food and Drug Administration. Since these tests are marketed immediately after approval, the Centers for Medicare & Medicaid Services (CMS) must notify its MACs of the new tests so they can accurately process claims. There are four (4) newly added waived complexity tests. Make sure your billing staffs are aware of these changes.

BACKGROUND
The Clinical Laboratory Improvement Amendments of 1988 (CLIA) regulations require a facility to be appropriately certified for each test performed. To ensure that Medicare & Medicaid only pay for laboratory tests categorized as waived complexity under CLIA in facilities with a CLIA certificate of waiver, laboratory claims are currently edited at the CLIA certificate level.

CR10418 describes the latest tests approved by the Food and Drug Administration (FDA) as waived tests under CLIA. The Current Procedural Terminology (CPT) codes for the following new tests must have the modifier QW to be recognized as a waived test. However, the tests mentioned on the first page of the list attached to CR10418 (that is, CPT codes: 81002, 81025, 82270, 82272, 82962, 83026, 84830, 85013, and 85651) do not require a QW modifier to be recognized as a waived test.

The CPT code, effective date, and description for the latest tests approved by the FDA as waived tests under CLIA are as follows:
• 83516QW, October 2, 2017, Quidel Corporation, InflammaDry
• 87809QW, October 3, 2017, Quidel, AdenoPlus Test {Tear Fluid}
• 82274QW, G0328QW, October 13, 2017, Enterix Inc. InSure One – One Day Fecal Immunochemical Test
• 85025QW, November 6, 2017, Sysmex XW-100

The new waived complexity code 85025QW [Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count] was assigned for the detection of hematocrit, hemoglobin, platelet count, red blood cell count, white blood cell count and white blood cell differential performed using the Sysmex XW-100.

Continued >>
The new code 87634 [Infectious agent detection by nucleic acid (DNA or RNA); respiratory syncytial virus, amplified probe technique] was effective 1/1/2018. HCPCS code 87634QW describes the waived testing previously assigned to the code 87801QW. The HCPCS code for the Alere i System Respiratory Syncytial Virus is now assigned the HCPCS code 87634QW.

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**Global Surgery Calculator Self-Service Tool**

This tool will allow you to calculate both 10 and 90 day global surgery periods. You can also look up your 2017 procedure code global days requirement by using this tool. Just enter the procedure code in the tool and the global surgery indicator information will appear. Access the Global Surgery Calculator tool under Forms/Tools on the home page.
Healthcare Common Procedure Coding System (HCPCS) Codes Subject to and Excluded from Clinical Laboratory Improvement Amendments (CLIA) Edits

MLN Matters Number: MM10446
Related Change Request (CR) Number: 10446
Related CR Release Date: January 12, 2018
Effective Date: January 1, 2018
Related CR Transmittal Number: R3949CP
Implementation Date: April 2, 2018

PROVIDER TYPES AFFECTED
This MLN Matters Article is intended for Clinical Laboratories submitting claims to Medicare Administrative Contractors (MACs) or for laboratory services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED
Change Request (CR) 10446 informs providers and MACs about the new Healthcare Common Procedure Coding System (HCPCS) codes for 2018 that are subject to and excluded from Clinical Laboratory Improvement Amendments (CLIA) edits. Make sure your billing staffs are aware of these updates.

BACKGROUND
The HCPCS codes that are considered a laboratory test under CLIA change each year. MACs are informed about the new HCPCS codes that are both subject to CLIA edits and excluded from CLIA edits.

The following HCPCS codes were discontinued on December 31, 2017:
- 83499 – Hydroxyprogesterone, 20 (synthetic hormone) level
- 84061 -Phosphatase (enzyme) level for forensic examination
- 86185 -Immunologic analysis for detection of antigen
- 86243 -Measurement of Fc receptor
- 86378 -Migration inhibitory factor
- 86729 -Lympho venereum antibody
- 86822 -Lymphocyte culture primed
- 87277 -Legionella micdadei ag if
- 87470 -Bartonella dna dir probe
- 87477 -Lyme dis dna quant
- 87515 -Hepatitis b dna dir probe
- 88154 -Cytopath c/v select

The following HCPCS codes were added February 1, 2017, and are subject to CLIA edits. These codes require a facility to have either a CLIA certificate of registration (certificate type code 9), a CLIA certificate of compliance (certificate type code 1), or a CLIA certificate of accreditation (certificate type code 3). A facility without a valid, current, CLIA certificate, with a current CLIA certificate of waiver (certificate type code 2) or with a current CLIA certificate for provider-performed microscopy procedures (certificate type code 4) cannot be paid for these tests.

Continued >>
• 0001U -Red blood cell antigen typing, DNA, human erythrocyte antigen gene analysis of 35 antigens from 11 blood groups, utilizing whole blood, common RBC alleles reported
• 0002U -Oncology (colorectal), quantitative assessment of three urine metabolites (ascorbic acid, succinic acid and carnitine) by liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring acquisition, algorithm reported as likelihood of adenomatous polyps
• 0003U -Oncology (ovarian) biochemical assays of five proteins (apolipoprotein A-1, CA 125 II, follicle stimulating hormone, human epididymis protein 4, transferrin), utilizing serum, algorithm reported as a likelihood score

The following HCPCS codes were added May 1, 2017, and are subject to CLIA edits. These codes require a facility to have either a CLIA certificate of registration (certificate type code 9), a CLIA certificate of compliance (certificate type code 1), or a CLIA certificate of accreditation (certificate type code 3). A facility without a valid, current, CLIA certificate, with a current CLIA certificate of waiver (certificate type code 2) or with a current CLIA certificate for provider-performed microscopy procedures (certificate type code 4) cannot be paid for these tests.
• 0004U -Infectious disease (bacterial), DNA, 27 resistance genes, PCR amplification and probe hybridization in microarray format (molecular detection and identification of AmpC, carbapenemase and ESBL coding genes), bacterial culture colonies, report of genes detected or not detected, per isolate
• 0005U -Oncology (prostate) gene expression profile by real-time RT-PCR of 3 genes (ERG, PCA3, and SPDEF), urine, algorithm reported as risk score

The following HCPCS codes were added August 1, 2017, and are subject to CLIA edits. These codes require a facility to have either a CLIA certificate of registration (certificate type code 9), a CLIA certificate of compliance (certificate type code 1), or a CLIA certificate of accreditation (certificate type code 3). A facility without a valid, current, CLIA certificate, with a current CLIA certificate of waiver (certificate type code 2) or with a current CLIA certificate for provider-performed microscopy procedures (certificate type code 4) cannot be paid for these tests.
• 0006U -Prescription drug monitoring, 120 or more drugs and substances, definitive tandem mass spectrometry with chromatography, urine, qualitative report of presence (including quantitative levels, when detected) or absence of each drug or substance with description and severity of potential interactions, with identified substances, per date of service
• 0007U -Drug test(s), presumptive, with definitive confirmation of positive results, any number of drug classes, urine, includes specimen verification including DNA authentication in comparison to buccal DNA, per date of service
• 0008U -Helicobacter pylori detection and antibiotic resistance, DNA, 16S and 23S rRNA, gyrA, pbp1, rdxA and rpoB, next generation sequencing, formalin-fixed paraffin embedded or fresh tissue, predictive, reported as positive or negative for resistance to clarithromycin, fluoroquinolones, metronidazole, amoxicillin, tetracycline and rifabutin
• 0009U -Oncology (breast cancer), ERBB2 (HER2) copy number by FISH, tumor cells from formalin fixed paraffin embedded tissue isolated using image-based dielectrophoresis (DEP) sorting, reported as ERBB2 gene amplified or non-amplified
• 0010U -Infectious disease (bacterial), strain typing by whole genome sequencing, phylogenetic-based report of strain relatedness, per submitted isolate
• 0011U -Prescription drug monitoring, evaluation of drugs present by LC-MS/MS, using oral fluid, reported as a comparison to an estimated steady-state range, per date of service including all drug compounds and metabolites

Continued >>
• 0012U - Germline disorders, gene rearrangement detection by whole genome next-generation sequencing, DNA, whole blood, report of specific gene rearrangement(s)

• 0013U - Oncology (solid organ neoplasia), gene rearrangement detection by whole genome next-generation sequencing, DNA, fresh or frozen tissue or cells, report of specific gene rearrangement(s)

• 0014U - Hematology (hematolymphoid neoplasia), gene rearrangement detection by whole genome next-generation sequencing, DNA, whole blood or bone marrow, report of specific gene rearrangement(s);

• 0015U - Drug metabolism (adverse drug reactions), DNA, 22 drug metabolism and transporter genes, real-time PCR, blood or buccal swab, genotype and metabolizer status for therapeutic decision support

• 0016U - Oncology (hematolymphoid neoplasia), RNA, BCR/ABL1 major and minor breakpoint fusion transcripts, quantitative PCR amplification, blood or bone marrow, report of fusion not detected or detected with quantitation

• 0017U - Oncology (hematolymphoid neoplasia), JAK2 mutation, DNA, PCR amplification of exons 12-14 and sequence analysis, blood or bone marrow, report of JAK2 mutation not detected or detected

The following HCPCS codes are new for 2018 and are subject to CLIA edits. These codes require a facility to have either a CLIA certificate of registration (certificate type code 9), a CLIA certificate of compliance (certificate type code 1), or a CLIA certificate of accreditation (certificate type code 3). A facility without a valid, current, CLIA certificate, with a current CLIA certificate of waiver (certificate type code 2) or with a current CLIA certificate for provider-performed microscopy procedures (certificate type code 4) cannot be paid for these tests.

• 81105 - Human Platelet Antigen 1 genotyping (HPA-1), ITGB3 (integrin, beta 3 [platelet glycoprotein IIIa], antigen CD61 [GPIIIa]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura) gene analysis, common variant, HPA-1a/b (L33P)

• 81106 - Human Platelet Antigen 2 genotyping (HPA-2), GP1BA (glycoprotein Ib [platelet], alpha polypeptide [GPIba]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura) gene analysis, common variant, HPA-2a/b (T145M)

• 81107 - Human Platelet Antigen 3 genotyping (HPA-3), ITGA2B (integrin, alpha 2 [platelet glycoprotein IIb of IIb/IIIa complex], antigen CD41 [GPIIb]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura) gene analysis, common variant, HPA-3a/b (I843S)

• 81108 - Human Platelet Antigen 4 genotyping (HPA-4), ITGB3 (integrin, beta 3 [platelet glycoprotein IIIa], antigen CD61 [GPIIIa]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura) gene analysis, common variant, HPA-4a/b (R143Q)

• 81109 - Human Platelet Antigen 5 genotyping (HPA-5), ITGA2 (integrin, alpha 2 [CD49B, alpha 2 subunit of VLA-2 receptor] [GPIa]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura) gene analysis, common variant (eg, HPA-5a/b (K505E))

• 81110 - Human Platelet Antigen 6 genotyping (HPA-6w), ITGB3 (integrin, beta 3 [platelet glycoprotein IIIa, antigen CD61] [GPIIIa]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura) gene analysis, common variant, HPA-6a/b (R489Q)

• 81111 - Human Platelet Antigen 9 genotyping (HPA-9w), ITGA2B (integrin, alpha 2b [platelet glycoprotein IIb of IIb/IIIa complex, antigen CD41] [GPIIb]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura) gene analysis, common variant, HPA-9a/b (V837M)

• 81112 - Human Platelet Antigen 15 genotyping (HPA-15), CD109 (CD109 molecule) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura) gene analysis, common variant, HPA-15a/b (S682Y)

• 81120 - IDH1 (isocitrate dehydrogenase 1 [NADP+], soluble) (eg, glioma), common variants (eg, R132H, R132C)

Continued >>
• 81121 -IDH2 (isocitrate dehydrogenase 2 [NADP+], mitochondrial) (eg, glioma), common variants (eg, R140W, R172M)
• 81175 -ASXL1 (additional sex combs like 1, transcriptional regulator) (eg, myelodysplastic syndrome, myeloproliferative neoplasms, chronic myelomonocytic leukemia) gene analysis; full gene sequence
• 81176 -ASXL1 (additional sex combs like 1, transcriptional regulator) (eg, myelodysplastic syndrome, myeloproliferative neoplasms, chronic myelomonocytic leukemia) gene analysis; targeted sequence analysis (eg, exon 12)
• 81230 -CYP3A4 (cytochrome P450 family 3 subfamily A member 4) (eg, drug metabolism) gene analysis, common variant(s) (eg, *2, *22)
• 81232 -DPYD (dihydropyrimidine dehydrogenase) (eg, 5-fluorouracil/5-FU and capecitabine drug metabolism) gene analysis, common variant(s) (eg, *2, *4, *5, *6)
• 81238 -F9 (coagulation factor IX) (eg, hemophilia B) full gene sequence
• 81247 -G6PD (glucose-6-phosphate dehydrogenase) (eg, hemolytic anemia, jaundice) gene analysis; common variant(s) (eg, A, A-)
• 81248 -G6PD (glucose-6-phosphate dehydrogenase) (eg, hemolytic anemia, jaundice) gene analysis; known familial variant(s)
• 81249 -G6PD (glucose-6-phosphate dehydrogenase) (eg, hemolytic anemia, jaundice) gene analysis; full gene sequence
• 81258 -HBA1/HBA2 (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis; known familial variant
• 81259 -HBA1/HBA2 (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis; full gene sequence
• 81269 -HBA1/HBA2 (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, Hb Bart hydrys fetalis syndrome, HbH disease), gene analysis; duplication/deletion variants
• 81283 -IFNL3 (interferon, lambda 3) (eg, drug response) gene analysis, rs12979860 variant
• 81328 -SLCO1B1 (solute carrier organic anion transporter family, member 1B1) (eg, adverse drug reaction) gene analysis, common variant(s) (eg, *5)
• 81334 -RUNX1 (runt related transcription factor 1) (eg, acute myeloid leukemia, familial platelet disorder with associated myeloid malignancy) gene analysis, targeted sequence analysis (eg, exons 3-8)
• 81335 -TPMT (thiopurine S-methyltransferase) (eg, drug metabolism) gene analysis, common variants (eg, *2, *3)
• 81346 -TYMS (thymidylate synthetase) (eg, 5-fluorouracil/5-FU drug metabolism) gene analysis, common variant(s) (eg, tandem repeat variant)
• 81361 -HBB (hemoglobin, subunit beta) (eg, sickle cell anemia, beta thalassemia, hemoglobinopathy); common variant(s) (eg, HbS, HbC, HbE)
• 81362 -HBB (hemoglobin, subunit beta) (eg, sickle cell anemia, beta thalassemia, hemoglobinopathy); known familial variant(s)
• 81363 -HBB (hemoglobin, subunit beta) (eg, sickle cell anemia, beta thalassemia, hemoglobinopathy); duplication/deletion variant(s)
• 81364 -HBB (hemoglobin, subunit beta) (eg, sickle cell anemia, beta thalassemia, hemoglobinopathy); full gene sequence
• 81448 -Hereditary peripheral neuropathies panel (eg, Charcot-Marie-Tooth, spastic paraplegia), genomic sequence analysis panel, must include sequencing of at least 5 peripheral neuropathy-related genes (eg, BSCL2, GJB1, MFN2, MPZ, REEP1, SPAST, SPG11, and SPTLC1)

Continued >>
81520 - Oncology (breast), mRNA gene expression profiling by hybrid capture of 58 genes (50 content and 8 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a recurrence risk score
81521 - Oncology (breast), mRNA, microarray gene expression profiling of 70 content genes and 465 housekeeping genes, utilizing fresh frozen or formalin-fixed paraffin-embedded tissue, algorithm reported as index related to risk of distant metastasis
81541 - Oncology (prostate), mRNA gene expression profiling by real-time RTPCR of 46 genes (31 content and 15 housekeeping), utilizing formalin-fixed paraffin embedded tissue, algorithm reported as a disease-specific mortality risk score
81551 - Oncology (prostate), promoter methylation profiling by real-time PCR of 3 genes (GSTP1, APC, RASSF1), utilizing formalin-fixed paraffin embedded tissue, algorithm reported as a likelihood of prostate cancer detection on repeat biopsy
86008 - Allergen specific IgE; quantitative or semiquantitative, recombinant or purified component, each
86794 - Zika virus, IgM
87634 - Infectious agent detection by nucleic acid (DNA or RNA); respiratory syncytial virus, amplified probe technique
87662 - Infectious agent detection by nucleic acid (DNA or RNA); Zika virus, amplified probe technique

The following HCPCS codes are mentioned in Change Request 10445 “Quarterly Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment” as new codes and with the effective date of January 1, 2018. These codes are subject to CLIA edits. The HCPCS codes listed below require a facility to have either a CLIA certificate of registration (certificate type code 9), a CLIA certificate of compliance (certificate type code 1), or a CLIA certificate of accreditation (certificate type code 3). A facility without a valid, current, CLIA certificate, with a current CLIA certificate of waiver (certificate type code 2) or with a current CLIA certificate for provider-performed microscopy procedures (certificate type code 4) must not be permitted to be paid for these tests.

- 0024U - Glycosylated acute phase proteins (GlycA), nuclear magnetic resonance spectroscopy, quantitative GLYCA NUC MR SPECTRSC QUAN
- 0025U - Tenofovir, by liquid chromatography with tandem mass spectrometry (LCMS/MS), urine, quantitative TENOFOVIR LIQ CHROM UR QUAN
- 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
- 0027U - JAK2 (Janus kinase 2) (eg, myeloproliferative disorder) gene analysis, targeted sequence analysis exons 12-15 JAK2 GENE TRGT SEQ ALYS
- 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
- 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
- 0030U - Drug metabolism (warfarin drug response), targeted sequence analysis (ie, CYP2C9, CYP4F2, VKORC1, rs12777823) RX METAB WARF TRGT SEQ ALYS
- 0031U - CYP1A2 (cytochrome P450 family 1, subfamily A, member 2)(eg, drug metabolism) gene analysis, common variants (ie, *1F, *1K, *6, *7) CYP1A2 GENE

Continued >>
• 0032U -COMT (catechol-O-methyltransferase)(drug metabolism) gene analysis, c.472G>A (rs4680) variant  
  COMT GENE

• 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.5513008C>G]) HTR2A HTR2C GENES

• 0034U -TPMT (thiopurine S-methyltransferase), NUDT15 (nudix hydroxylase 15)(eg, thiopurine  
  *3, *4, *5) TPMT NUDT15 GENES

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

ADDITIONAL INFORMATION
The official instruction, CR10446, issued to your MAC regarding this change is available at  

DOCUMENT HISTORY

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>January 12, 2018</td>
<td>Initial article released</td>
</tr>
</tbody>
</table>
Prostate Resection after TURP

Palmetto GBA has received several appeals involving CPT code 52601 when that code is being used to bill for the resection of prostate tissue after the beneficiary has previously undergone a complete transurethral resection of the prostate (TURP).

Medicare has established CPT code 52601 (Prostatectomy (TURP)) as a once-in-a-lifetime procedure. Medicare will only pay for CPT code 52601 once during a beneficiary’s lifetime. If that code is used at any time after an initial TURP has been paid, Medicare will deny payment.

If any additional procedures are needed to remove residual or regrowth tissue from the prostate after a TURP has been done (and after the 90-day global period has completed), those procedures should be billed to Medicare using CPT code 52630 (Remove prostate growth).

If your office bills for prostate resection procedures, please make sure that your billing staff are aware of the correct use of CPT codes 52601 and 52630.
Updated Editing of Always Therapy Services - MCS

MLN Matters Number: MM10176 Revised
Related CR Release Date: December 21, 2017
Related CR Transmittal Number: R3936CP
Related Change Request (CR) Number: 10176
Effective Date: January 1, 2018
Implementation Date: January 2, 2018

This article was revised on December 21, 2017, to reflect an updated CR10176. The CR was revised to delete HCPCS code 97532 from the list of therapy codes in the attachment to the CR. That code is also removed from the list of those codes in this article. Also, in the article, the CR release date, transmittal, number and link to the transmittal changed. All other information is unchanged.

PROVIDER TYPE AFFECTED
This MLN Matters Article is intended for therapists, physicians, and certain other practitioners billing Medicare Administrative Contractors (MACs) for therapy services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED
CR 10176 implements revised editing of Part B “Always Therapy” services to require the appropriate therapy modifier in order for the service to be accurately applied to the therapy cap. CR10176 contains no new policy. Instead, the guidelines presented in the CR improve the enforcement of longstanding, existing instructions. Make sure your billing staffs are aware of these revisions.

BACKGROUND
Services furnished under the Outpatient Therapy (OPT) services benefit – including Speech-Language Pathology (SLP), Occupational Therapy (OT), and Physical Therapy (PT) – are subject to the financial limitations, known as therapy caps, originally required under Section 4541 of the Balanced Budget Act (1997).

There are two such caps. One cap is for PT and SLP services combined and another cap is for OT services. In order to accrue incurred expenses to the correct therapy cap; the use of one of the three therapy modifiers (GN, GO, or GP) is required on a certain set of Healthcare Common Procedure Coding System (HCPCS) codes in order to identify when each OPT service is furnished under an SLP, OT, or PT plan of care, respectively.

Medicare recognizes the services furnished under the OPT services benefit as either “always” or “sometimes” therapy and publishes this list as an Annual Update on the Therapy Services Billing page at https://www.cms.gov/Medicare/Billing/TherapyServices/AnnualTherapyUpdate.html.

On professional claims, each code designated as “always therapy”:
• Must always be furnished under an SLP, OT, or PT plan of care, regardless of who furnishes them; and, as such,
• Must always be accompanied by one of the GN, GO, or GP therapy modifiers.

Continued >>
In addition, several “always therapy” codes have been identified as discipline-specific – requiring the GN modifier for six codes, the GO modifier for four codes, and the GP modifier for four codes, as illustrated in Tables 1-3.

### Table 1: Codes Requiring the “GN” Therapy Modifier

<table>
<thead>
<tr>
<th>Code</th>
<th>CPT Short Descriptor</th>
<th>Therapy Modifier Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>92521</td>
<td>Evaluation of speech fluency</td>
<td>GN</td>
</tr>
<tr>
<td>92522</td>
<td>Evaluate speech production</td>
<td>GN</td>
</tr>
<tr>
<td>92523</td>
<td>Speech sound lang comprehend</td>
<td>GN</td>
</tr>
<tr>
<td>92524</td>
<td>Behavral quality analys voice</td>
<td>GN</td>
</tr>
<tr>
<td>92597</td>
<td>Oral speech device eval</td>
<td>GN</td>
</tr>
<tr>
<td>92607</td>
<td>Ex for speech device rx 1hr</td>
<td>GN</td>
</tr>
</tbody>
</table>

### Table 2: Codes Requiring the “GO” Therapy Modifier

<table>
<thead>
<tr>
<th>Code</th>
<th>CPT Short Descriptor</th>
<th>Therapy Modifier Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>97165</td>
<td>Ot eval low complex 30 min</td>
<td>GO</td>
</tr>
<tr>
<td>97166</td>
<td>Ot eval mod complex 45 min</td>
<td>GO</td>
</tr>
<tr>
<td>97167</td>
<td>Ot eval high complex 60 min</td>
<td>GO</td>
</tr>
<tr>
<td>97168</td>
<td>Ot re-eval est plan care</td>
<td>GO</td>
</tr>
</tbody>
</table>

### Table 3: Codes Requiring the “GP” Therapy Modifier

<table>
<thead>
<tr>
<th>Code</th>
<th>CPT Short Descriptor</th>
<th>Therapy Modifier Required</th>
</tr>
</thead>
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<tr>
<td>97161</td>
<td>Pt eval low complex 20 min</td>
<td>GP</td>
</tr>
<tr>
<td>97162</td>
<td>Pt eval mod complex 30 min</td>
<td>GP</td>
</tr>
<tr>
<td>97163</td>
<td>Pt eval high complex 45 min</td>
<td>GP</td>
</tr>
<tr>
<td>97164</td>
<td>Pt re-eval est plan care</td>
<td>GP</td>
</tr>
</tbody>
</table>

The following “Always Therapy” HCPCS codes require a GN, GO, or GP modifier, as appropriate. Descriptors for these codes are included as an attachment to CR 10176.

92507 92508 92526 92608 92609 96125 97012 97016 97018 97022 97024 97026 97028 97032 97033 97034 97035 97036 97039 97110 97112 97113 97116 97124 97139 97140 97150 97530 97533 97535 97537 97542 97750 97755 97760 97761 97762 97799 G0281 G0283 G0329

In addition to Therapists in Private Practice (TPPs) – including physical therapists, occupational therapists, and speech-language pathologists – professional claims for OPT services may be furnished by physicians and certain Non-Physician Practitioners (NPPs) – specifically, physician assistants, nurse practitioners, and certified nurse specialists.

All OPT services furnished by TPPs are always considered therapy services, regardless of whether they are designated as “always therapy” or “sometimes therapy.” As such, the appropriate therapy modifier must be included on the claim. However, it may be clinically appropriate for physicians and NPPs to furnish OPT services for evaluation and re-evaluation that are not “always therapy” codes.
services that have been designated “sometimes therapy” codes outside a therapy plan of care - in these cases, therapy modifiers are not required and claims may be processed without them.

During analyses of Medicare claims data for OPT services, the Centers for Medicare & Medicaid Services (CMS) found that these “always therapy” codes and modifiers are not always used in a correct and consistent manner. CMS found OPT professional claims for “always therapy” codes without the required modifiers. Also, CMS found claims that reported more than one therapy modifier for the same therapy service; for example, both a GP and GO modifier, when only one modifier was allowed.

These claims represent non-compliant billing by TPPs, physicians, and NPPs, and hamper CMS’ ability to properly track the therapy caps and analyze claims data for purposes of Medicare program improvements. The requirements in CR10176 will create new edits for Medicare professional claims processing systems to return claims when “always therapy” codes and the associated therapy modifiers are improperly reported.

Providers should expect the following:
• MACs will return/reject claims which contain an “always therapy” procedure code, but do not also contain the appropriate discipline-specific therapy modifier of GN, GO, or GP.
• MACs will also return/reject claims if any service line on the claim contains more than one occurrence of a GN, GO, or GP therapy modifier.
• MACs who are returning/rejecting such claims will use Group Code CO and Claim Adjustment Reason Code (CARC) 4 on the related remittance advice.

ADDITIONAL INFORMATION

DOCUMENT HISTORY

<table>
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<tr>
<th>Date of Change</th>
<th>Description</th>
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<tr>
<td>December 21, 2017</td>
<td>The article was revised to reflect an updated CR. The CR was revised to remove HCPCS code 97532 from the list of always therapy codes in the attachment to the CR. That code is also removed from the list of those codes in this article. Also, in the article, the CR release date, transmittal, number and link to the transmittal changed. All other information is unchanged.</td>
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<tr>
<td>September 15, 2017</td>
<td>The article was revised to reflect an updated CR. In the article, the CR release date, transmittal, number and link to the transmittal changed. All other information is unchanged.</td>
</tr>
<tr>
<td>July 31, 2017</td>
<td>Initial article released.</td>
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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
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: Part B Medical Affairs, AG-300
      Palmetto GBA
      PO Box 100190
      Columbia, SC 29202-3190

A/B MAC Local Coverage Determinations

<table>
<thead>
<tr>
<th>Article Title</th>
<th>Articles</th>
<th>Effective Date</th>
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<tbody>
<tr>
<td>Herceptin® (trastuzumab): Coverage and Billing Article A53777 Rev #9</td>
<td>Under Article Text corrected the registered symbol throughout the verbiage. Under CPT/HCPCS deleted the Group 1 and Group 2: Paragraphs. Under CPT/HCPCS deleted the Group 2: Codes as this is redundant. Under Covered ICD-10 Codes deleted the Group 2: Codes as the ICD-10 code is included in the Group 1: Codes.</td>
<td>1/18/2018</td>
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<th>Policy Title</th>
<th>LCD Revision</th>
<th>Effective Date</th>
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<tr>
<td>MolDX-CDD: Genomic Health™ Oncotype DX® Prostate Cancer Assay L36153, #11</td>
<td>Palmetto GBA is removing 81541 from CPT/HCPCS Codes: Group 1 and replacing it with 81479. This revision is effective 01/01/2018 for all jurisdiction JM contract numbers.</td>
<td>1/1/2018</td>
</tr>
<tr>
<td>MolDX: Oncotype DX® Genomic Prostate Score for Men with Favorable Intermediate Risk Prostate Cancer L37262, #6</td>
<td>Palmetto GBA is removing 81541 from CPT/HCPCS Codes: Group 1 and replacing it with 81479. This revision is effective 01/01/2018 for all jurisdiction JM contract numbers.</td>
<td>1/1/2018</td>
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<tr>
<td>MolDX: Prolaris™ Prostate Cancer Genomic Assay for Men with Favorable Intermediate Risk Disease L37043, #5</td>
<td>Palmetto GBA is removing 81479 from CPT/HCPCS Codes: Group 1 and replacing it with 81541. This revision is effective 01/01/2018 for all jurisdiction JM contract numbers.</td>
<td>1/1/2018</td>
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<td>MolDX: HLA-DQB1*06:02 Testing for Narcolepsy L36464, #6</td>
<td>Removed the bold text formatting from the LCD title. There were no changes to the LCD coverage.</td>
<td>2/27/2018</td>
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<tr>
<td>MolDX: Chromosome 1p/19q Deletion Analysis L36483, #5</td>
<td>Removed the bold text formatting from the LCD title. There were no changes to the LCD coverage.</td>
<td>2/27/2018</td>
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</table>

**Article Title** | **Article Revision** | **Effective Date**
--- | --- | ---
MolDX: FDA Approved ALK Companion Diagnostic Tests Coding and Billing Guidelines A54656 | Article no longer effective. Billing instructions no longer needed. | 2/27/2018 (Retire) |
MolDX: FDA-Approved KRAS Tests A54472, #8 | Corrected the Diagnostics Exchange Web address and name from McKesson Diagnostics Exchange to DEX™ Diagnostics Exchange. | 12/21/2017 |

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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 December 21, 2017

MLN Connects™ for January 4, 2018

MLN Connects™ for January 11, 2018

MLN Connects™ for January 18, 2018

MLN Connects™ for January 25, 2018
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>
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<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 <a href="https://www.PalmettoGBA.com/JMB/forms">https://www.PalmettoGBA.com/JMB/forms</a>.</td>
</tr>
<tr>
<td>(855) 696-0705 (Toll-Free)</td>
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<tr>
<td><strong>Electronic Data Interchange (EDI)</strong></td>
<td><strong><a href="http://www.PalmettoGBA.com/Medicare">http://www.PalmettoGBA.com/Medicare</a></strong></td>
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<td><strong>Technical Support</strong></td>
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<td>(855) 696-0705</td>
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<td><strong>Medicare Beneficiary Call Center</strong></td>
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<tr>
<td>1-800-MEDICARE (1-800-633-4227)</td>
<td><strong>Important Sources For You</strong></td>
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<td>TTY 1-877-486-2048</td>
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Attention: Billing Manager