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

MLN Connects ..............................................................................................................4
Weekly Articles .......................................................................................................4
Special Edition Articles ..........................................................................................4
Public Comments on New Product Categories for DMEPOS ..........................4
Competitive Bidding ..............................................................................................4
Medicare FFS Response to the 2018 Alaska Earthquake .................................4
MLN Matters Article — New ................................................................................5
Multiple Provider Information..................................................................................5
Ambulance Inflation Factor for Calendar Year 2019 and Productivity Adjustment ..............................................................5
Revision of Definition of the Physician Supervision of Diagnostic Procedures, Clarification of DSMT Telehealth Services, and Establishing a Modifier for Expanding the Use of Telehealth for Individuals with Stroke ........................................6
Annual Update to the Per-Beneficiary Therapy Amounts....................................9
Next Generation Accountable Care Organization (NGACO) Model Post Discharge Home Visit HCPCS .........................................................10
Next Generation Accountable Care Organization (ACO) Model 2019 Benefit Enhancement ………………………………………………………………………12
New Modifier for Expanding the Use of Telehealth for Individuals with Stroke ..16
New Medicare Beneficiary Identifier (MBI) Get It, Use It .................................18
Medicare Beneficiary Identifier (MBI) Look-up Tool .............................................22
Help Us Improve/Enhance Our Website ..............................................................24
Get Your Medicare News Electronically .............................................................26
Medicare Learning Network® (MLN) ......................................................................26
Appeals Information ..............................................................................................28
Notification of the 2019 Dollar Amount in Controversy Required to Sustain Appeal Rights for an Administrative Law Judge (ALJ) Hearing or Federal District Court Review ...............................................................28

The JJ Part A Medicare Advisory contains coverage, billing and other information for Jurisdiction J Part A. 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 JJ Part A 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 http://www.PalmettoGBA.com/Medicare.

CPT only copyright 2017 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association. Applicable FARS/DFARS Restrictions Apply to Government Use. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT®, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

The Code on Dental Procedures and Nomenclature is published in Current Dental Terminology (CDT), Copyright © 2012 American Dental Association (ADA). All rights reserved.
End Stage Renal Disease (ESRD) Information .................................................................28
Implementation of Changes in the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) and Payment for Dialysis Furnished for Acute Kidney Injury (AKI) in ESRD Facilities for Calendar Year (CY) 2019 ..................................................28
Federally Qualified Health Center (FQHC) Information ......................................................32
Update to the Federally Qualified Health Center (FQHC) Prospective Payment System (PPS) for Calendar Year (CY) 2019 - Recurring File Update ..........................32
Fee Schedule Information .................................................................................................33
Summary of Policies in the Calendar Year (CY) 2019 Medicare Physician Fee Schedule (MPFS) Final Rule, Telehealth Originating Site Facility Fee Payment Amount and Telehealth Services List, CT Modifier Reduction List, and Preventive Services List ..................................................................................................................33
Calendar Year (CY) 2019 Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule ..................................................38
Calendar Year (CY) 2019 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment ..............................48
Hospital Information .......................................................................................................62
Updates to the Inpatient Psychiatric Facility Benefit Policy Manual ....................................62
Hurricane Florence and Michael Information ....................................................................64
Hurricane Florence and Medicare Disaster Related North Carolina, South Carolina, and the Commonwealth of Virginia Claims ..............................................64
Hurricane Michael and Medicare Disaster Related Florida and Georgia Claims ........................69
Influenza (Flu) Information ..............................................................................................74
Quarterly Influenza Virus Vaccine Code Update - January 2019 ........................................74
Learning and Education Information ..................................................................................76
Part A Ask the Contractor Teleconference (ACT) Specialty Clinical Topic:
Outpatient Therapies – January 16, 2019 .................................................................76
Part A Skilled Nursing Facility (SNF) Consolidated Billing Webcast – January 23, 2019 .................................................................77
KEPRO - The Beneficiary and Family Centered Care Quality Improvement Organization Webinar: January 29, 2019 .................................................................77
Home Health Referrals and Clinical Documentation Requirements Webinar:
February 26, 2019 ........................................................................................................77
2019 Medical Review (MR) Hot Topic Targeted Probe and Educate (TPE)
Teleconference Schedule .................................................................................................78
National Provider Enrollment Conference – March 2019 ..............................................79
Educational Events Where You Can Ask Questions and Get Answers
from Palmetto GBA .......................................................................................................79
Medical Policy Information ..............................................................................................80
National Coverage Determination (NCD90.2): Next Generation Sequencing
(NGS) ..................................................................................................................................80
International Classification of Diseases, 10th Revision (ICD-10)
and Other Coding Revisions to National Coverage Determinations (NCDs) 82
NCD 20.4 Implantable Cardiac Defibrillators (ICDs) ...................................................84
Part A Local Coverage Determinations (LCDs) Updates .................................................88
Part A/B Medicare Administrative Contractor (MAC) Local Coverage
Determinations (LCDs) Updates ..................................................................................88
MolDX Local Coverage Determinations (LCDs) Updates ..........................................89
MolDX Local Coverage Determinations (LCDs) Article Updates ............................90
Rural Health Clinic (RHC) Information and Federally Qualified
Health Center (FQHC) Information .................................................................................90
Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC)
Medicare Benefit Policy Manual Chapter 13 Update ..................................................90
Skilled Nursing Facility (SNF) Information .....................................................................93
New Medicare Webpage on Patient Driven Payment Model ........................................93
Tools You Can Use.......................................................................................................96
  Utilization of Lifetime Reserve Days Module ....................................................96
  Clinical Trials Coverage & Billing Module .......................................................97
  New Medicare Card Information .......................................................................98
Helpful Information..................................................................................................99
  Contact Information for Palmetto GBA Part A .................................................99

Upcoming Part A Educational Events

Part A Ask the Contractor Teleconference (ACT) Specialty Clinical Topic: Outpatient Therapies –
January 16, 2019
Palmetto GBA will host the Part A Ask the Contractor Teleconference (ACT) on Wednesday, January 16, 2019, at 11 a.m. ET. The ACT Specialty Topic is Outpatient Therapies. Join our Clinical Consultant, Sandra Booker, as she provides information concerning recent medical review findings and how to improve your documentation.

Part A Skilled Nursing Facility (SNF) Consolidated Billing Webcast: January 23, 2019
Please join Palmetto GBA for an informative Part A Skilled Nursing Facility (SNF) Consolidated Billing (CB) webcast on Wednesday, January 23, 2019, at 11 a.m. ET!

KEPRO - The Beneficiary and Family Centered Care Quality Improvement Organization Webinar:
January 29, 2019
Palmetto GBA would like to encourage our provider community to join KEPRO in a webinar on January 29, 2019, at 2:00 p.m. ET

Home Health Referrals and Clinical Documentation Requirements Webinar: February 26, 2019
In collaboration with the Medicare A/B and Home Health and Hospice Medicare Administration Contractors (MACs), the Provider Outreach and Education teams are hosting a home health webinar for providers who order home health services for Medicare beneficiaries. This webinar is designed to provide clarity to the physician offices on Medicare coverage criteria and documentation requirements for their Medicare patients who receive home health services.

2019 Medical Review (MR) Hot Topic Targeted Probe and Educate (TPE) Teleconference
Palmetto GBA will host a series of Medical Review Hot Topic Targeted Probe and Educate (TPE) Teleconferences in 2019. These calls are open to all providers.

National Provider Enrollment Conference: March 2019
The National Provider Enrollment Conference will be held on Tuesday, March 12, 2019 from 8:00 a.m. to 5:00 p.m. CT and Wednesday, March 13, 2019 from 8:30 a.m. to 5:00 p.m. CT in Nashville, TN.

For more information and registration instructions to attend these education sessions, please go to Page 76 of this issue.
MLN CONNECTS

MLN Connects will contain Medicare-related messages from the Centers of Medicare & Medicaid Services (CMS). These messages ensure planned, coordinated messages are delivered timely about Medicare-related topics. Please share with appropriate staff. To view the most recent issues, please copy and paste the following links into your Web browser:

**Weekly Articles**

**December 20, 2018**  

**December 13, 2018**  

**December 6, 2018**  

**November 29, 2018**  

**Special Edition Articles**

**November 27, 2018**

**Public Comments on New Product Categories for DMEPOS Competitive Bidding**

CMS is extending the public comment period on new product categories to be phased-in for the next round of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. Comments will now be accepted through December 17, 2018. See the Public Comments on New Product Categories (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid/Comment-Period.html) webpage for more information.
December 6, 2018

**Medicare FFS Response to the 2018 Alaska Earthquake MLN Matters Article — New**

The President declared a state of emergency for the state of Alaska, and the HHS Secretary declared a Public Health Emergency, which allows for a CMS programmatic waivers based on Section 1135 of the Social Security Act. An MLN Matters Special Edition Article on *Medicare Fee-for-Service (FFS) Response to the 2018 Alaska Earthquake* ([https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE18027.pdf](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE18027.pdf)) is available. Learn about blanket waivers CMS issued for the impacted geographical areas. These waivers will prevent gaps in access to care for beneficiaries impacted by the emergency.

**MULTIPLE PROVIDER INFORMATION**

**Ambulance Inflation Factor for Calendar Year 2019 and Productivity Adjustment**

MLN Matters Number: MM11031  
Related CR Release Date: November 30, 2018  
Related CR Transmittal Number: R4172CP  
Related Change Request (CR) Number: 11031  
Effective Date: January 1, 2019  
Implementation Date: January 7, 2019

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

**Provider Action Needed**  
CR 11031 furnishes the Calendar Year (CY) 2019 Ambulance Inflation Factor (AIF) for determining the payment limit for ambulance services. The AIF for CY 2019 is 2.3 percent. Make sure that your billing staffs are aware of this change.

**Background**  
Section 1834(l)(3)(B) of the Social Security Act provides the basis for an update to the payment limits for ambulance services that is equal to the percentage increase in the Consumer Price Index for all Urban Consumers (CPI-U) for the 12-month period ending with June of the previous year. On March 23, 2010, the Affordable Care Act (Pub. L. 111-148) was enacted. Following the enactment of Pub. L. 111-148, the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152 (enacted on March 30, 2010), amended certain provisions of Pub. L. 111-148. These public laws are collectively known as the Affordable Care Act (ACA). Section 3401 of the ACA amended Section 1834(l)(3) of the Act to apply a productivity adjustment to this update equal to the 10-year moving average of changes in economy-wide private nonfarm business multi-factor productivity (MPF) beginning January 1, 2011. The resulting update percentage is referred to as the AIF.
Section 3401 of the ACA requires that specific Prospective Payment System (PPS) and Fee Schedule (FS) update factors be adjusted by changes in economy-wide productivity. The statute defines the productivity adjustment to be equal to the 10-year moving average of changes in annual economy-wide private nonfarm business MFP (as projected by the Secretary of Health and Human Services (the Secretary) for the 10-year period ending with the applicable fiscal year, cost reporting period, or other annual period).

The MFP for CY 2019 is 0.6 percent and the CPI-U for 2019 is 2.9 percent. According to the ACA, the CPI-U is reduced by the MFP, even if this reduction results in a negative AIF update. Therefore, the AIF for CY 2019 is 2.3 percent.

The Part B coinsurance and deductible requirements apply to payments under the ambulance fee schedule.

**Additional Information**


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

**Document History**

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>November 30, 2018</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>

**Revision of Definition of the Physician Supervision of Diagnostic Procedures, Clarification of DSMT Telehealth Services, and Establishing a Modifier for Expanding the Use of Telehealth for Individuals with Stroke**

MLN Matters Number: MM11043
Related CR Release Date: November 30, 2018
Related CR Transmittal Number: R251BP and R4173CP
Related Change Request (CR) Number: 11043
Effective Date: January 1, 2019
Implementation Date: January 2, 2019

**Provider Types Affected**

This MLN Matters Article is intended for physicians, providers and suppliers billing Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.
What You Need To Know
This article is based on CR 11043, which:

- Revises the definition of “Personal Supervision” of the Physician Supervision of Diagnostic Procedures indicator to specify that procedures performed by a Registered Radiologist Assistant (RRA) or a Radiology Practitioner Assistant (RPA) may be performed under direct supervision
- Adds instructions to use modifier G0 (G zero) to identify Telehealth services furnished for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke
- Clarifies requirements for when Diabetes Self-Management Training (DSMT) services may be paid as a telehealth service

Please be sure your staffs are aware of these changes.

Background
The Physician Supervision of Diagnostic Procedures indicator specifies a level of physician supervision required for certain diagnostic tests. The levels of supervision are “general,” “direct,” and “personal” supervision, and each of these levels of supervision have a corresponding indicator value assigned to each diagnostic procedure.

The Centers for Medicare & Medicaid Services (CMS) is revising its policy to specify that beginning with dates of services on or after January 1, 2019, diagnostic procedures that are furnished by a Radiologist Assistant, who CMS defines as either RRAs, who are certified by The American Registry of Radiologic Technologists, and RPAs, who are certified by the Certification Board for Radiology Practitioner Assistants, require only a direct level of physician supervision, when permitted by state law and state scope of practice regulations. CMS notes that for diagnostic imaging tests requiring a general level of physician supervision, this policy revision does not change the level of physician supervision to direct supervision. Otherwise, the diagnostic imaging tests must be performed as specified elsewhere under 42 Code of Federal Regulations (CFR), section 410.32(b).

Be aware that beginning with dates of services on or after January 1, 2019, the description for Physician Supervision of Diagnostic Procedures indicator “03” on the Medicare Physician Fee Schedule is revised to say the following:

“03 = Procedure must be performed under the personal supervision of a physician. (Diagnostic imaging procedures performed by a Registered Radiologist Assistant (RRA) who is certified and registered by The American Registry of Radiologic Technologists (ARRT) or a Radiology Practitioner Assistant (RPA) who is certified by the Certification Board for Radiology Practitioner Assistants (CBRPA) and is authorized to furnish the procedure under state law, may be performed under direct supervision).”

Special rules for telehealth services for acute stroke telehealth services
Section 50325 of the Bipartisan Budget Act of 2018 amended section 1834(m) of the Social Security Act (the Act) by adding a new paragraph (6) that provides special rules for telehealth services furnished on or after January 1, 2019, for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke (acute stroke telehealth services), as determined by the Secretary.
Specifically, section 1834(m)(6)(A) of the Act removes the restrictions on the geographic locations and the types of originating sites where acute stroke telehealth services can be furnished. Section 1834(m)(6)(B) of the Act specifies that acute stroke telehealth services can be furnished in any hospital, critical access hospital, mobile stroke units (as defined by the Secretary), or any other site determined appropriate by the Secretary, in addition to the current eligible telehealth originating sites. Section 1834(m)(6)(C) of the Act limits payment of an originating site facility fee to acute stroke telehealth services furnished in sites that meet the usual telehealth restrictions under section 1834(m)(4)(C) of the Act. This CR instructs MACs on billing procedures for these services.

CR 11043 clarifies CMS policy to accept new informational HCPCS modifier G0 (G zero) to be used to identify Telehealth services furnished for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke. Modifier G0 is valid for all:

- Telehealth distant site codes billed with Place of Service (POS) code 02 or Critical Access Hospitals, CAH method II (revenue codes 096X, 097X, or 098X) or

- Telehealth originating site facility fee, billed with HCPCS code Q3014.

**Diabetes Self-Management Training (DSMT) Services**

CMS is clarifying DSMT policy to specify that all 10 hours of the initial DSMT training and the two (2) hours of annual follow-up DSMT training may be furnished via telehealth in cases when injection training is not applicable.

**Additional Information**


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

**Document History**

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 10, 2018</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>
Annual Update to the Per-Beneficiary Therapy Amounts

MLN Matters Number: MM11055
Related CR Release Date: November 30, 2018
Related CR Transmittal Number: R4178CP
Related Change Request (CR) Number: CR 11055
Effective Date: January 1, 2019
Implementation Date: January 7, 2019

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

Provider Action Needed
CR 11055 describes the annual per-beneficiary incurred expense amounts now known as the KX modifier thresholds, and related policy updates for CY 2019. These amounts were previously associated with the financial limitation amounts that were more commonly referred to as “therapy caps” before the application of the therapy limits/caps was repealed when the Bipartisan Budget Act of 2018 (BBA of 2018) was signed into law. Another provision of the BBA of 2018 lowers the threshold of the targeted medical review process as explained in the Background section below.

For CY 2019, the KX modifier threshold amount for physical therapy (PT) and speech-language pathology (SLP) services combined is $2,040. For occupational therapy (OT) services, the CY 2019 threshold amount is $2,040. Make sure that your billing staffs are aware of these updates.

Background
Effective for January 1, 2018, section 50202 of the Bipartisan Budget Act of 2018, P.L. 115-123 (BBA of 2018) amended section 1833(g) of the Social Security Act (the Act) to repeal the application of the therapy caps and the therapy caps exceptions process while also retaining and adding limitations to ensure appropriate therapy. The therapy caps or financial limitations originally applied through section 4541(c) of the Balanced Budget Act of 1997, P.L. 105-33 (1997 BBA) are no longer applicable to beneficiaries.

A separate provision of section 50202 of the BBA of 2018 adds section 1833(g)(7)(A) of the Act to preserve the former therapy cap amounts as thresholds above which claims must include the KX modifier to confirm that services are medically necessary as justified by appropriate documentation in the medical record. Claims from suppliers or providers for therapy services above these amounts without the KX modifier are denied. These amounts are now known as the KX modifier thresholds.

Just as with the incurred expenses for the therapy cap amounts, there is one KX modifier threshold amount for physical therapy (PT) and speech-language pathology (SLP) services combined and a separate amount for occupational therapy (OT) services. These per-beneficiary amounts under section 1833(g) of the Act (as amended by 1997 BBA) are updated each year by the Medicare Economic Index (MEI).
For CY 2019, the KX modifier threshold amounts are: (a) $2,040 for PT and SLP services combined, and (b) $2,040 for OT services.

Another provision of section 50202 of the BBA of 2018 adds section 1833(g)(7)(B) of the Act which maintains the targeted medical review process (first established through section 202 of the Medicare Access and CHIP Reauthorization Act of 2015), but at a lower threshold than the $3,700 amount established as part of the therapy caps exceptions process via section 3005 of the Middle Class Tax Relief and Jobs Creation Act of 2012. For CY 2018 (and each successive calendar year until 2028, at which time it is indexed annually by the MEI), this now-termed Medical Review (MR) threshold amount is $3,000 for PT and SLP services combined and $3,000 for OT services.

For more information, please see the pages for Therapy Services of CMS-1693-F on the CMS web page at the following link for PFS Federal Regulation Notices: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html.

Additional Information

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

Document History

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 4, 2018</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>

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

MLN Matters Number: MM10907 Revised
Related Change Request (CR) Number: 10907
Related CR Release Date: November 28, 2018
Effective Date: January 1, 2019
Related CR Transmittal Number: R215DEMO
Implementation Date: April 1, 2019

Note: This article was revised on November 29, 2018, to reflect a revised CR10907 issued on November 28. The CR was revised to show the correct HCPCS codes of G2001 - G2009 and G2013 - G2015 for NGACO Model Post Discharge Home Visits. The article was revised accordingly. Also, the CR release date, transmittal number, and the Web address of the CR are revised in the article. 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
CR10907 makes modifications to the operations of a current benefit enhancement offered by the NGACO Model. Claims for Post Discharge Home Visit Waiver shall be processed for reimbursement and paid when they meet the appropriate payment requirements as outlined in CR1907. Make sure your billing staffs are aware of these changes.

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

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

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

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

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

Note: RTI International is the specialty contractor creating the Next Generation ACO provider alignment files.
For dates of service of April 1, 2019, and later, MACs will allow NGACO, including the Vermont (VT) ACO, post discharge home visit claims for licensed clinicians under the general supervision of an NGACO or VT ACO provider when this benefit enhancement is elected by the provider for the Date of Service (DOS) on the claims and only when the claim contains the following HCPCS codes: G2001; G2002; G2003; G2004; G2005; G2006; G2007; G2008; G2009; G2013; G2014; and G2015. This applies to Type of Bill (TOB) 85X, Rev Codes 96X; 97X; and 98X.

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

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

Additional Information

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

Document History

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>November 29, 2018</td>
<td>The article was revised to reflect a revised CR10907 issued on November 28. The CR was revised to show the correct HCPCS codes of G2001 - G2009 and G2013 - G2015 for NGACO Model Post Discharge Home Visits. The article was revised accordingly. Also, the CR release date, transmittal number, and the Web address of the CR are revised in the article. All other information remains the same.</td>
</tr>
<tr>
<td>October 29, 2018</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>

Next Generation Accountable Care Organization (ACO) Model 2019 Benefit Enhancement

MLN Matters Number: MM10824 Revised
Related CR Release Date: October 5, 2018
Related CR Transmittal Number: R210DEMO
Related Change Request (CR) Number: 10824
Effective Date: January 1, 2019
Implementation Date: January 7, 2019
Provider Type Affected
This MLN Matters® Article is intended for providers who are participating in Next Generation Accountable Care Organizations (NGACOs) and submitting claims to Medicare Administrative Contractors (MACs) for certain care management home visit services to Medicare beneficiaries that would not otherwise be covered by Original Fee-For-Service (FFS) Medicare.

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

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

New Benefit Enhancement for 2019 - Care Management Home Visits
Building upon the NGACOs’ experience in offering the Post-Discharge Home Visits Benefit Enhancement, the Model will offer a new Care Management Home Visits Benefit Enhancement to equip the NGACOs with a new tool to provide home visits proactively and in advance of a potential hospitalization. Next Generation Participants and Preferred Providers who have initiated a care treatment plan for aligned beneficiaries will be eligible to receive up to two Care Management Home Visits within 90 days of seeing that Next Generation Participant or Preferred Provider.

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

With the exception that CMS will waive the direct supervision requirement such that the services and supplies may be furnished by auxiliary personnel under the billing physician’s or other billing practitioner’s general supervision, this new Care Management Home Visits Benefit Enhancement will provide NGACO Participants and Preferred Providers greater flexibility to furnish these services within a beneficiary’s home or place of residence.
The items and services provided as part of these care management home visits are intended to supplement, rather than substitute for, visits to a primary care provider or specialist in a traditional health care setting. As such, these home visits are not intended to be performed on an ongoing basis, nor to serve as a substitute for the Medicare home health benefit, nor as the primary mechanism to meet beneficiaries’ care needs. Also, note that this is not a home health benefit, and beneficiaries eligible to receive home health services will not be eligible for this Benefit Enhancement.

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

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

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

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

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

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

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

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

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

- **G0084**: Comprehensive (60 minutes) care management home visit for an existing patient. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary’s home, domiciliary, rest home, assisted living and/or nursing facility.)
• G0085: Extensive (75 minutes) care management home visit for an existing patient. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary’s home, domiciliary, rest home, assisted living and/or nursing facility.)

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

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

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

Additional Information

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


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

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

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 14, 2018</td>
<td>The article was revised to reflect a revised CR10824 issued on October 5. In the article, the CR release date, transmittal number, and the Web address of the CR are also revised. All other information remains the same.</td>
</tr>
<tr>
<td>August 29, 2018</td>
<td>The article was revised on August 29, 2018, to reflect a revised CR10824 issued on August 28. The CR was revised to show this is year four of the NGACO model. The article was revised accordingly. In the article, the CR release date, transmittal number, and the Web address of the CR are also revised. All other information remains the same.</td>
</tr>
<tr>
<td>August 22, 2018</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>

New Modifier for Expanding the Use of Telehealth for Individuals with Stroke

MLN Matters Number: MM10883
Related CR Release Date: September 28, 2018
Related CR Transmittal Number: R2142OTN
Related Change Request (CR) Number: 10883
Effective Date: January 1, 2019
Implementation Date: January 7, 2019

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

Provider Action Needed
Change request (CR) 10883 establishes use of a new Healthcare Common Procedure Coding System (HCPCS) modifier, G0 (G Zero), to be appended on claims for telehealth services that are furnished on or after January 1, 2019, for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke. Make certain your billing staff is aware of this new code.

Background
Section 50325 of the Bipartisan Budget Act of 2018 amended section 1834(m) of the Act by adding a new paragraph (6) that provides special rules for telehealth services furnished on or after January 1, 2019, for purposes of diagnosis, evaluation or treatment of symptoms of an acute stroke (acute stroke telehealth services), as determined by the Secretary. Specifically, section 1834(m)(6)(A) of the Act removes the restrictions on the geographic locations and the types of originating sites where acute stroke telehealth services can be furnished.

Section 1834(m)(6)(B) of the Act specifies that acute stroke telehealth services can be furnished in any hospital, critical access hospital, mobile stroke units (as defined by the Secretary), or any other site determined appropriate by the Secretary, in addition to the current eligible telehealth originating sites.
Section 1834(m)(6)(C) of the Act limits payment of an originating site facility fee to acute stroke telehealth services furnished in sites that meet the usual telehealth restrictions under section 1834(m)(4)(C) of the Act.

In order to implement the requirements described in Section 50325 of the Bipartisan Budget Act of 2018, Centers for Medicare & Medicaid Services (CMS) is proposing to create a new modifier that would be used to identify acute stroke telehealth services. The distant site practitioner and, as appropriate, the originating site, would append this modifier when clinically appropriate to the HCPCS code when billing for an acute stroke telehealth service or an originating site facility fee, respectively. Section 50325 of the Bipartisan Budget Act of 2018 did not amend section 1834(m)(4)(F) of the Act, which limits the scope of telehealth services to those on the Medicare telehealth list. Practitioners are responsible for assessing whether it would be clinically appropriate to use this modifier with codes from the Medicare telehealth list. By billing with this modifier, practitioners are indicating that the codes billed were used to furnish telehealth services for diagnosis, evaluation, or treatment of symptoms of an acute stroke.

**Key Points**

This new modifier will be part of the annual January 2019 HCPCS update

- Effective for claims with dates of service on and after January 1, 2019, MACs will accept new informational HCPCS modifier G0 to be used to identify Telehealth services furnished for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke.

- Modifier G0 is valid for all:
  - Telehealth distant site codes billed with Place of Service (POS) code 02 or Critical Access Hospitals, CAH method II (revenue codes 096X, 097X, or 098X); or
  - Telehealth originating site facility fee, billed with HCPCS code Q3014.

**Additional Information**


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

**Document History**

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>November 27, 2018</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>

CPT codes, descriptors and other data only are copyright 2017 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.
New Medicare Beneficiary Identifier (MBI) Get It, Use It

MLN Matters Number: SE18006 Revised
Article Release Date: December 10, 2018
Related CR Transmittal Number: N/A
Related Change Request (CR) Number: N/A
Effective Date: N/A
Implementation Date: N/A

Note: This article was revised on December 10, 2018, to update the language regarding when MACs can return an MBI through the MBI look up tool (page 1). All other information remains the same.

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

Provider Action Needed
The Centers for Medicare & Medicaid Services (CMS) is mailing the new Medicare cards with the MBI in phases by geographic location (https://www.cms.gov/Medicare/New-Medicare-Card/NMC-Mailing-Strategy.pdf). There are 3 ways you and your office staff can get MBIs:

1. Ask your Medicare patients

Ask your Medicare patients for their new Medicare card when they come for care. If they haven’t received a new card at the completion of their geographic mailing wave, give them the “Still Waiting for Your New Card?” handout (in English (https://www.cms.gov/Medicare/New-Medicare-Card/Outreach-and-Education/Tear-Off-for-After-Card-Mailing-Ends.pdf) or Spanish (https://www.cms.gov/Medicare/New-Medicare-Card/Outreach-and-Education/Tear-Off-for-After-Card-Mailing-Ends-Spanish.pdf)) or refer them to 1-800-Medicare (1-800-633-4227).

2. Use the MAC’s secure MBI look-up tool

You can look up MBIs for your Medicare patients when they don’t or can’t give them. Sign up (https://www.cms.gov/Medicare/New-Medicare-Card/Providers/MACs-Provider-Portals-by-State.pdf) for the Portal to use the tool. You can use this tool even after the end of the transition period – it doesn’t end on December 31, 2019.

3. Check the remittance advice

Starting in October 2018 through the end of the transition period, we’ll also return the MBI on every remittance advice when you submit claims with valid and active Health Insurance Claim Numbers (HICNs).

You can start using the MBIs even if the other health care providers and hospitals who also treat your patients haven’t. When the transition period ends on December 31, 2019, you must use the MBI for most transactions.

CPT codes, descriptors and other data only are copyright 2017 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.
Background
The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS to remove Social Security Numbers from all Medicare cards by April 2019. A new, randomly generated Medicare Beneficiary Identifier, or MBI, is replacing the SSN-based HICN. The new MBI is noticeably different than the HICN. Just like with the HICN, the MBI hyphens on the card are for illustration purposes: don’t include the hyphens or spaces on transactions. The MBI uses numbers 0-9 and all uppercase letters except for S, L, O, I, B, and Z. We exclude these letters to avoid confusion when differentiating some letters and numbers (e.g., between “0” and “O”).

The Railroad Retirement Board (RRB) is also mailing new Medicare cards with the MBI. The RRB logo will be in the upper left corner and “Railroad Retirement Board” at the bottom, but you can’t tell from looking at the MBI if your patients are eligible for Medicare because they’re railroad retirees. You’ll be able to identify them by the RRB logo on their card, and we’ll return a “Railroad Retirement Medicare Beneficiary” message on the Fee-For-Service (FFS) MBI eligibility transaction response.

Use the MBI the same way you use the HICN today. Put the MBI in the same field where you’ve always put the HICN. This also applies to reporting informational only and no-pay claims. Don’t use hyphens or spaces with the MBI to avoid rejection of your claim. The MBI will replace the HICN on Medicare transactions including Billing, Eligibility Status, and Claim Status. The effective date of the MBI, like the old HICN, is the date each beneficiary was or is eligible for Medicare. Until December 31, 2019, you
can use either the HICN or the MBI in the same field where you’ve always put the HICN. After that the remittance advice will tell you if we rejected claims because the MBI wasn’t used. It will include Claim Adjustment Reason Code (CARC) 16, “Claim/service lacks information or has submission/billing error(s),” along with Remittance Advice Remark Code (RARC) N382 “Missing/incomplete/invalid patient identifier”.

The beneficiary or their authorized representative can request an MBI change. CMS can also initiate a change to an MBI. An example is if the MBI is compromised. There are different scenarios for using the old or new MBIs:

**FFS claims submissions with:**
- Dates of service before the MBI change date – use the old or new MBI.
- Span-date claims with a “From Date” before the MBI change date – use the old or new MBI.
- Dates of service that are entirely on or after the effective date of the MBI change – use the new MBI.
- FFS eligibility transactions when the:
  - Inquiry uses new MBI – we’ll return all eligibility data.
  - Inquiry uses the old MBI and request date or date range overlap the active period for the old MBI –we’ll return all eligibility data. We’ll also return the old MBI termination date.
  - Inquiry uses the old MBI and request date or date range are entirely on or after the effective date of the new MBI – we’ll return an error code (AAA 72) of “invalid member ID.”

When the MBI changes, we ask the beneficiary to share the new MBI with you. You can also get the MBI from your MACs secure MBI lookup tool.

**Protect the MBI as Personally Identifiable Information (PII); it is confidential like the HICN.**
Submit all HICN-based claims by the end of the transition period, December 31, 2019. On January 1, 2020, even for dates of services before this date, you must use MBIs for all transactions; there are a few exceptions when you can use either the HICN or MBI:
- Appeals – You can use either the HICN or MBI for claim appeals and related forms.
- Claim status query – You can use HICNs or MBIs to check the status of a claim (276 transactions) if the earliest date of service on the claim is before January 1, 2020. If you are checking the status of a claim with a date of service on or after January 1, 2020, you must use the MBI.
• Span-date claims – You can use the HICN or the MBI for 11X-Inpatient Hospital, 32X- Home Health (home health claims and Request for Anticipated Payments [RAPS]) and 41X-Religious Non-Medical Health Care Institution claims if the “From Date” is before the end of the transition period (December 31, 2019). If a patient starts getting services in an inpatient hospital, home health, or religious non-medical health care institution before December 31, 2019, but stops getting those services after December 31, 2019, you may submit a claim using either the HICN or the MBI, even if you submit it after December 31, 2019. Since you submit home health claims for a 60-day payment episode, you can send in the episode’s RAP with either the HICN or the MBI, but after the transition period ends on December 31, 2019, you have to use the MBI when you send in the final claim that goes with it.

The MBI does not change Medicare benefits. Medicare beneficiaries may start using their new Medicare cards and MBIs as soon as they get them. Use MBIs as soon as your patients share them. The new cards are effective the date beneficiaries are eligible for Medicare.

Medicare Advantage and Prescription Drug plans continue to assign and use their own identifiers on their health insurance cards. For patients in these plans, continue to ask for and use the plans’ health insurance cards.

Additional Information

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

The MBI format specifications, which provide more details on the construct of the MBI, are available at https://www.cms.gov/Medicare/New-Medicare-Card/Understanding-the-MBI.pdf.


Document History

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 10, 2018</td>
<td>The article was revised to update the language regarding when MACs can return an MBI through the MBI look up tool (page 1). All other information remains the same.</td>
</tr>
<tr>
<td>July 11, 2018</td>
<td>This article was revised to provide additional information regarding the format of the MBI not using letters S, L, O, I, B, and Z (page 2).</td>
</tr>
<tr>
<td>June 25, 2018</td>
<td>This article was revised to provide additional information regarding the ways your staff can get MBIs (page 1).</td>
</tr>
<tr>
<td>June 21, 2018</td>
<td>The article was revised to emphasize the need to submit the MBI without hyphens or spaces to avoid rejection of your claim.</td>
</tr>
<tr>
<td>May 25, 2018</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>
Medicare Beneficiary Identifier (MBI) Look-up Tool

Palmetto GBA is excited to announce that the Medicare Beneficiary Identifier (MBI) Look-up tool is now available in eServices! This tool allows providers to use our secure online portal to obtain the new MBI number when patients do not present their Medicare card. The MBI Look-up tool will only return an MBI if the new Medicare card has been mailed to avoid potential confusion if the MBI is used before the beneficiary receives their new Medicare card.

As background, the New Medicare Card Project, was established in the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 which mandates the removal of the Social Security Number (SSN)-based Health Insurance Claim Number (HICN) from Medicare cards by April 2019. CMS began mailing new Medicare cards with the MBI on April 2, 2018.

From April 1, 2018 to December 31, 2019, CMS will offer a transition period during which the system will accept both HICNs and MBIs on Medicare transactions (including eligibility requests and claims) for beneficiaries in the Medicare program prior to April 1, 2018 (i.e., those who received a HICN on their Medicare card). Note: Providers should not submit both numbers on the same transaction.

Beginning in January 2020, physicians may only use MBIs, with limited exceptions. When the new Medicare card is mailed to people with Medicare, you will be able to use the eServices MBI Look-Up Tool to obtain a patient’s MBI. To submit an inquiry you must do the following:

- Once logged into eServices, click on the **MBI LOOKUP** tab located in the header of the portal
- Complete the **required** fields: ◦Beneficiary’s Last Name
- First Name
- Date of birth and
- Social security number. NOTE: The social security number must be in the XXX-XX-XXXX format
- To meet our CAPTCHA requirements, you must select the **I’M NOT A ROBOT** checkbox
- Click **SUBMIT INQUIRY**
Figure 1: MBI Lookup Tab

**Figure 1: MBI Lookup Tab**

**Medicare Administrative Contractor (MAC) Provider Medicare Beneficiary Identifier (MBI) Lookup Tool**

Starting in April 2018, to make it easier for health care providers and those working on their behalf to get Medicare patients' MBIs when they don’t or can’t give them, providers can use a MAC’s secure portal to look up MBIs. To find MBIs through the portal, providers must key the Medicare patient’s first name, last name, date of birth, and SSN.

**Beneficiary Information**

Beneficiary Last Name:"  
Beneficiary First Name:"  
Beneficiary Name Suffix:  
Beneficiary Date Of Birth:"  
Beneficiary Social Security Number:"  

I'm not a robot

Submit Inquiry  Clear

Look-Up Tool Status Results

If the inquiry successfully returns an MBI, the screen will refresh with the data at the bottom.

**Figure 2: MBI Lookup Successful Response Screenshot**

**Look-up Status: MBI: 0X00XX0XX00**

In the event that your MBI lookup request does not result in a successful response, eServices will display error messages to assist you. If any required fields are left blank or are not in a proper format, a message will appear advising you which fields to correct.

CPT codes, descriptors and other data only are copyright 2017 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply. 23 01/2019
Figure 3: MBI Lookup Unsuccessful Response Screenshot

*Lookup Status: MBI not found


Help Us Improve/Enhance Our Website

We need your help to enhance the Palmetto GBA website. As a valued website visitor, only you know what information and tools are needed to assist you with your work.

Your input is important! Please complete our short survey that’s sponsored by CMS and conducted by ForeSee Results. It represents your voice and provides us with detailed information on the types of services you like, want, or are dissatisfied with on the website. Please be specific in your evaluation of the website. Your detailed answers help us ‘get it right’!

Palmetto GBA strives to ensure your experience with our website provides accurate, detailed, and current information. With the content changing daily, it’s best to access the website regularly to ensure you have the most current information. We have found that some visitors print old forms and articles that may have become obsolete So it’s important to visit often.

If you have taken the survey in the past, Thank You! We have used those results to add many new features to help you diagnose and fix claim denials, stay in compliance with Medicare regulations, and ultimately, better serve your patients.

We encourage you to complete this survey and appreciate your feedback. Each new idea, self-service tool, and article depends on you, and your participation in our Foresee survey.
Please complete the survey today!

https://survey.foreseeresults.com/survey/display?cid=wtsU0tp0khBZxlUgcpcMxA==&sid=link-palmetto-jj
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
- Fee Schedule changes
- New legislation concerning Medicare
- And so much more!

How to register to receive the Palmetto GBA Medicare Listserv:

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

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

Medicare Learning Network® (MLN)

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:


- 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.

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

Notification of the 2019 Dollar Amount in Controversy Required to Sustain Appeal Rights for an Administrative Law Judge (ALJ) Hearing or Federal District Court Review

Section 1869(b)(1)(E) of the Social Security Act (the Act), as amended by Section 940 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), requires an annual reevaluation of the dollar amount in controversy required for an Administrative Law Judge (ALJ) hearing or Federal District Court review.

The amount in controversy is adjusted by the percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) for July 2003 to the July preceding the year involved. Any amount that is not a multiple of $10 will be rounded to the nearest multiple of $10.

- ALJ Hearing Requests- The amount that must remain in controversy for ALJ hearing requests filed on or before December 31, 2018 is $160. This amount will remain at $160 for ALJ hearing requests filed on or after January 1, 2019.

- Federal District Court - The amount that must remain in controversy for reviews in Federal District Court requested on or before December 31, 2018 is $1,600. This amount will increase to $1,630 for appeals to Federal District Court filed on or after January 1, 2019.

END STAGE RENAL DISEASE (ESRD) INFORMATION

Implementation of Changes in the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) and Payment for Dialysis Furnished for Acute Kidney Injury (AKI) in ESRD Facilities for Calendar Year (CY) 2019

MLN Matters Number: MM11021 Revised
Related CR Release Date: December 13, 2018
Related CR Transmittal Number: R254BP
Related Change Request (CR) Number: 11021
Effective Date: January 1, 2019
Implementation Date: January 7, 2019

Note: This article was revised on December 14, 2018, to reflect a revised CR11021 issued on December 13, 2018. The CR was revised to correct typos. In the article, the CR release date, transmittal number, and the Web address of the CR are revised. Also, the legislative reference in the second paragraph of the Background section is changed to section 808(b) of the Trade Preferences Extension Act of 2015 (TPEA). All other information remains the same.
Provider Type Affected
This MLN Matters® Article is intended for End Stage Renal Disease (ESRD) facilities that submit claims to Medicare Administrative Contractors (MACs) for renal dialysis services provided to Medicare beneficiaries.

Provider Action Needed
CR11021 implements the Calendar Year (CY) 2019 rate updates for the ESRD Prospective Payment System (PPS) and updates the payment for renal dialysis services furnished to beneficiaries with Acute Kidney Injury (AKI) in ESRD facilities. The CR also includes some changes to Chapter 11, Section 60 of the Medicare Benefit Policy Manual, with the revised manual section attached to CR11021. Please make sure that your billing staffs are aware of these changes.

Background
Effective January 1, 2011, the Centers for Medicare & Medicaid Services (CMS) implemented the ESRD PPS based on the requirements of Section 1881(b)(14) of the Social Security Act (the Act) as added by Section 153(b) of the Medicare Improvements for Patients and Providers Act (MIPPA). Section 1881(b)(14) (F) of the Act, as added by Section 153(b) of MIPPA and amended by Section 3401(h) of the Affordable Care Act established that beginning CY 2012, and each subsequent year, the Secretary shall annually increase payment amounts by an ESRD market basket increase factor, reduced by the productivity adjustment described in Section 1886(b)(3)(B)(ii) of the Act. The ESRD bundled (ESRDB) market basket increase factor minus the productivity adjustment will update the ESRD PPS base rate.


The ESRD PPS includes consolidated billing requirements for limited Part B services included in the ESRD facility’s bundled payment. CMS periodically updates the lists of items and services that are subject to Part B consolidated billing and are therefore no longer separately payable when provided to ESRD beneficiaries by providers other than ESRD facilities.

CY 2019 ESRD PPS Updates are as follows:

**ESRD PPS base rate:**
2. A wage index budget-neutrality adjustment factor of 0.999506. ($235.39 × 0.999506 = $235.27)

**Wage index:**
1. The wage index adjustment will be updated to reflect the latest available wage data.
2. The wage index floor will increase to 0.50.

---

CPT codes, descriptors and other data only are copyright 2017 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.
**Labor-related share:**
The labor-related share should be updated to 52.3 percent.

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

1. For adult patients, the adjusted average outlier service MAP amount per treatment is $38.51.
2. For pediatric patients, the adjusted average outlier service MAP amount per treatment is $35.18.

CMS made the following updates to the Fixed Dollar Loss (FDL) amount that is added to the predicted MAP to determine the outlier threshold:

1. The fixed dollar loss amount is $65.11 for adult patients.
2. The fixed dollar loss amount is $57.14 for pediatric patients.

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

1. Renal dialysis drugs that are oral equivalents to injectable drugs are based on the most recent prices retrieved from the Medicare Prescription Drug Plan Finder, are updated to reflect the most recent mean unit cost. In addition, CMS will add or remove any renal dialysis items and services that are eligible for outlier payment. See Attachment A of CR11021 for a list of these drugs.
2. The mean dispensing fee of the National Drug Codes (NDCs) qualifying for outlier consideration is revised to $0.75 per NDC per month for claims with dates of service on or after January 1, 2019.

**Consolidated Billing Requirements:**
For CY 2019, there are no changes to the ESRD PPS consolidated billing requirements. The current version of the consolidated billing requirements are available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/Consolidated_Billing.html.

**New non-ESRD Healthcare Common Procedure Coding System (HCPCS) code**
There is a new HCPCS Q5106 for Injection, epoetin alfa, biosimilar, (Retacrit) (for non-esrd use), 1000 units. This code will not be permitted on the Type of Bill 072x for an ESRD PPS claim. It is permitted for AKI claims as discussed in CR10839. (See the related MLN Matters article at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10839.pdf.

**CY 2019 AKI Dialysis Payment Rate for Renal Dialysis Services:**
1. Beginning January 1, 2019, CMS will pay ESRD facilities $235.27 per treatment.
2. The labor-related share is 52.3 percent.
3. The AKI dialysis payment rate will be adjusted for wages using the same wage index that is used under the ESRD PPS.
4. The AKI dialysis payment rate is not reduced for the ESRD Quality Incentive Program (QIP).

5. The Transitional Drug Add-on Adjustment (TDAPA) does not apply to AKI claims.

The key changes made to the Medicare Benefit Policy Manual, Chapter 11, Section 60 are as follows:

- To qualify for the comorbidity adjustment there must be adherence to diagnosis coding requirements. Diagnosis codes are updated annually and are posted at [http://www.cms.gov/Medicare/Coding/ICD10/index.html](http://www.cms.gov/Medicare/Coding/ICD10/index.html) and are effective each October 1st.

- Beginning January 1, 2019, if there is a Change of Ownership (CHOW) that results in a dialysis facility to independent dialysis facility) and the new owner accepts the Medicare agreement, the ESRD facility can qualify for the Low Volume Payment Adjustment (LVPA) if they otherwise meet the LVPA eligibility criteria. This policy does not extend to CHOWs where a new PTAN is issued for any other reason.

- Effective January 1, 2019, ESRD facilities that change their fiscal year end for cost reporting purposes, outside of a CHOW, qualify for the LVPA if they otherwise meet the LVPA eligibility criteria. When this occurs, the MACs will combine the two nonstandard cost reporting periods of less than 12 months to equal a full 12- consecutive month period or combine the two non-standard cost reporting periods, that in combination may exceed 12-consecutive months, and prorate the data to equal a full 12-consecutive month period. This does not impact or change requirements for reporting, as established by the MACs, or those set forth in regulations at Section 413.24(f)(3).

- November 1st of each year is the mandatory deadline for the submission of attestations for ESRD facilities that believe they are eligible to receive the low-volume payment adjustment. Beginning January 1, 2019, ESRD facilities may request an extraordinary circumstance exception to the November 1 deadline. In order to request an extraordinary circumstance exception, the facility is required to submit a narrative explaining the rationale for the exception to their MAC. The MAC will evaluate the narrative to determine if an exception is justified. The determination will be final, with no appeal.

**Additional Information**


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

Update to the Federally Qualified Health Center (FQHC) Prospective Payment System (PPS) for Calendar Year (CY) 2019 - Recurring File Update

MLN Matters Number: MM10990
Related CR Release Date: October 25, 2018
Related CR Transmittal Number: R4155CP
Related Change Request (CR) Number: 10990
Effective Date: January 1, 2019
Implementation Date: January 7, 2019

Provider Types Affected
This MLN Matters Article is intended for Federally Qualified Health Centers (FQHCs) billing Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed
CR10990 informs MACs about the updates to the Prospective Payment System (PPS) base payment rate and the Geographic Adjustment Factors (GAFs) for the Federally Qualified Health Centers (FQHCs). Make sure that your billing staffs are aware of these changes.

Background
Section 10501(i)(3)(A) of the Affordable Care Act added Section 1834(o) to the Social Security Act (the Act) to establish a payment system for the costs of FQHC services under Medicare Part B based on prospectively set rates. In the PPS for FQHC Final Rule published in the May 2, 2014, Federal Register (79 FR 25436), the Centers for Medicare & Medicaid Services (CMS) implemented a methodology and payment rates for FQHCs under the PPS beginning on October 1, 2014.

Under the FQHC PPS, Medicare pays FQHCs based on the lesser of their actual charges or the PPS rate for all FQHC services furnished to a beneficiary on the same day when the FQHC furnishes a medically necessary face-to-face FQHC visit to a Medicare beneficiary. Section 1834(o)(2)(B)(ii) of the Act requires that the payment for the first year after the implementation year be increased by the percentage increase in

CPT codes, descriptors and other data only are copyright 2017 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.
the Medicare Economic Index (MEI). In subsequent years, the FQHC PPS base payment rate is increased by the percentage increase in a market basket of FQHC goods and services, or if such an index is not available, by the percentage increase in the MEI.

Beginning in 2017, the FQHC PPS rate is updated annually by the FQHC market basket. Based on historical data through second quarter 2018, the FQHC market basket for Calendar Year (CY) 2019 is 1.9 percent. From January 1, 2019 through December 31, 2019, the FQHC PPS base payment rate is $169.77. The 2019 base payment rate reflects a 1.9 percent increase above the 2018 base payment rate of $166.60.

In accordance with Section 1834(o)(1)(A) of the Act, the FQHC PPS base rate is adjusted for each FQHC by the FQHC Geographic Adjustment Factor (GAF), based on the Geographic Practice Cost Indices (GPCIs) used to adjust payment under the Physician Fee Schedule (PFS). The FQHC GAF is adapted from the work and practice expense GPCIs, and are updated when the work and practice expense GPCIs are updated for the PFS. For CY 2019, the FQHC PPS GAFs have been updated in order to be consistent with the statutory requirements.

Additional Information

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

Document History

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>November 21, 2018</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>

**FEE SCHEDULE INFORMATION**

**Summary of Policies in the Calendar Year (CY) 2019 Medicare Physician Fee Schedule (MPFS) Final Rule, Telehealth Originating Site Facility Fee Payment Amount and Telehealth Services List, CT Modifier Reduction List, and Preventive Services List**

MLN Matters Number: MM11063
Related CR Release Date: November 30, 2018
Related CR Transmittal Number: R4176CP
Related Change Request (CR) Number: 11063
Effective Date: January 1, 2019
Implementation Date: January 7, 2019
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
CR 11063 provides a summary of policies in the Calendar Year (CY) 2019 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 2019. 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 to establish by regulation a fee schedule of payment amounts for physicians’ services for the subsequent year. The Centers for Medicare & Medicaid Services (CMS) final rule (Regulation number CMS-1693-F) that updates payment policies and Medicare payment rates for services furnished by physicians and Nonphysician Practitioners (NPPs) that are paid under the MPFS in CY 2019 went on display on November 1, 2018. The final rule also addresses public comments on Medicare payment policies proposed earlier this year. The following summarizes the key provisions of this final rule.

Streamlining Evaluation and Management (E/M) Payment and Reducing Clinician Burden
For CY 2019 and CY 2020, CMS will continue the current coding and payment structure for E/M office/outpatient visits and practitioners should continue to use either the 1995 or 1997 E/M documentation guidelines to document E/M office/outpatient visits billed to Medicare. For CY 2019 and beyond, CMS is finalizing the following policies:

- Elimination of the requirement to document the medical necessity of a home visit in lieu of an office visit

- For established patient office/outpatient visits, when relevant information is already contained in the medical record, practitioners may choose to focus their documentation on what has changed since the last visit, or on pertinent items that have not changed, and need not re-record the defined list of required elements if there is evidence that the practitioner reviewed the previous information and updated it as needed. Practitioners should still review prior data, update as necessary, and indicate in the medical record that they have done so.

- CMS is clarifying that for E/M office/outpatient visits, for new and established patients for visits, practitioners need not re-enter in the medical record information on the patient’s chief complaint and history that has already been entered by ancillary staff or the beneficiary. The practitioner may simply indicate in the medical record that he or she reviewed and verified this information.

- Removal of potentially duplicative requirements for notations in medical records that may have previously been included in the medical records by residents or other members of the medical team for E/M visits furnished by teaching physicians.
Beginning in CY 2021, CMS will further reduce burden with the implementation of payment, coding, and other documentation changes. Payment for E/M office/outpatient visits will be simplified and payment would vary primarily based on attributes that do not require separate, complex documentation.

Specifically for CY 2021, CMS is finalizing the following policies:

- Reduction in the payment variation for E/M office/outpatient visit levels by paying a single rate for E/M office/outpatient visit levels 2 through 4 for established and new patients while maintaining the payment rate for E/M office/outpatient visit level 5 in order to better account for the care and needs of complex patients.

- Permitting practitioners to choose to document E/M office/outpatient level 2 through 5 visits using Medical Decision Making (MDM) or time instead of applying the current 1995 or 1997 E/M documentation guidelines, or alternatively practitioners could continue using the current framework.

- Beginning in CY 2021, for E/M office/outpatient levels 2 through 5 visits, CMS will allow for flexibility in how visit levels are documented— specifically a choice to use the current framework, MDM, or time. For E/M office/outpatient level 2 through 4 visits, when using MDM or current framework to document the visit, CMS will also apply a minimum supporting documentation standard associated with level 2 visits. For these cases, Medicare would require information to support a level 2 E/M office/outpatient visit code for history, exam and/or MDM.

- When time is used to document, practitioners will document the medical necessity of the visit and that the billing practitioner personally spent the required amount of time face-to-face with the beneficiary.

- Implementation of add-on codes that describe the additional resources inherent in visits for primary care and particular kinds of non-procedural specialized medical care, though they would not be restricted by physician specialty. These codes would only be reportable with E/M office/outpatient level 2 through 4 visits, and their use generally would not impose new per-visit documentation requirements.

- Adoption of a new “extended visit” add-on code for use only with E/M office/outpatient level 2 through 4 visits to account for the additional resources required when practitioners need to spend extended time with the patient.

CMS believes these policies will allow practitioners greater flexibility to exercise clinical judgment in documentation, so they can focus on what is clinically relevant and medically necessary for the beneficiary. CMS intends to engage in further discussions with the public to potentially further refine the policies for CY 2021.

After consideration of concerns raised by commenters in response to the proposed rule, CMS is not finalizing aspects of the proposal that would have:

1. Reduced payment when E/M office/outpatient visits are furnished on the same day as procedures
2. Established separate coding and payment for podiatric E/M visits
3. Standardized the allocation of practice expense Relative Value Unit (RVUs) for the codes that describe these services
Modernizing Medicare Physician Payment by Recognizing Communication Technology-Based Services

CMS is finalizing its proposals to pay separately for two newly defined physicians’ services furnished using communication technology:

- Brief communication technology-based service, for example, virtual check-in (Healthcare Common Procedure Coding System (HCPCS) code G2012)
- Remote evaluation of recorded video and/or images submitted by an established patient (HCPCS code G2010)

CMS is also finalizing policies to pay separately for new coding describing chronic care remote physiologic monitoring (Current Procedural Terminology (CPT) codes 99453, 99454, and 99457) and interprofessional internet consultation (CPT codes 99451, 99452, 99446, 99447, 99448, and 99449).

Expanding the Use of Telehealth Services for the Treatment of Opioid Use Disorder and Other Substance Use Disorders

Through an interim final rule with comment period, CMS is implementing a provision from the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act that removes the originating site geographic requirements and adds the home of an individual as a permissible originating site for telehealth services furnished for purposes of treatment of a substance use disorder or a co-occurring mental health disorder for services furnished on or after July 1, 2019.

Providing Practice Flexibility for Radiologist Assistants

CMS is revising the physician supervision requirements so that diagnostic tests performed by a Radiologist Assistant (RA) that meets certain requirements, that would otherwise require a personal level of physician supervision as specified in its regulations, may be furnished under a direct level of physician supervision to the extent permitted by state law and state scope of practice regulations.

Discontinue Functional Status Reporting Requirements for Outpatient Therapy

CMS is finalizing its proposal to discontinue the functional status reporting requirements for services furnished on or after January 1, 2019.

Outpatient Physical Therapy and Occupational Therapy Services Furnished by Therapy Assistants

The Bipartisan Budget Act of 2018 requires payment for services furnished in whole or in part by a therapy assistant at 85 percent of the applicable Part B payment amount for the service effective January 1, 2022. In order to implement this payment reduction, the law requires CMS to establish a new modifier by January 1, 2019, and CMS to detail its plans to accomplish this in the final rule.

CMS is finalizing its proposal to establish two new modifiers – one for Physical Therapy Assistants (PTA) and another for Occupational Therapy Assistants (OTA) – when services are furnished in whole or in part by a PTA or OTA. However, CMS is finalizing the new modifiers as “payment” rather than as “therapy” modifiers, based on comments from stakeholders. These will be used alongside of the current PT and OT modifiers, instead of replacing them, which retains the use of the three existing therapy modifiers to
report all PT, OT, and Speech Language Pathology (SLP) services, that have been used since 1998 to track outpatient therapy services that were subject to the therapy caps.

CMS is also finalizing a de minimis standard under which a service is furnished in whole or in part by a PTA or OTA when more than 10 percent of the service is furnished by the PTA or OTA, instead of the proposed definition that applied when a PTA or OTA furnished any minute of a therapeutic service. The new therapy modifiers for services furnished by PTAs and OTAs are not required on claims until January 1, 2020.

**Practice Expense (PE): Market-Based Supply and Equipment Pricing Update**

CMS is finalizing the proposal to adopt updated direct PE input prices for supplies and equipment. While CMS is adopting most of the prices for supplies and equipment as recommended by the contractor and included in the proposed rule, in the case of particular items, CMS is finalizing refinements to the proposed prices based on feedback from commenters. CMS is also finalizing its proposal to phase-in use of these new prices over a 4-year period beginning in CY 2019 to ensure a smooth transition.

**Payment Rates for Non-excepted Off-campus Provider-Based Hospital Departments Paid Under the PFS**

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 Hospital Outpatient Prospective Payment System (OPPS) and are instead paid under the applicable payment system. In CY 2017, CMS finalized the PFS as the applicable payment system for most of these items and services.

Since CY 2017, payment for these items and services furnished in non-excepted off-campus provider-based departments has been made under the PFS using a PFS Relativity Adjuster based on a percentage of the OPPS payment rate. The PFS Relativity Adjuster in CY 2018 is 40 percent, meaning that non-excepted items and services are paid 40 percent of the amount that would have been paid for those services under the OPPS. CMS is finalizing that the PFS Relativity Adjuster remain at 40 percent for CY 2019. CMS believes that this PFS Relativity Adjuster encourages fairer competition between hospitals and physician practices by promoting greater payment alignment between outpatient care settings.

**Medicare Telehealth Services**

For CY 2019, CMS is finalizing its proposals to add HCPCS codes G0513 and G0514 (Prolonged preventive service(s)) to the list of telehealth services.

CMS is also finalizing policies to implement the requirements of the Bipartisan Budget Act of 2018 for telehealth services related to beneficiaries with End-Stage Renal Disease (ESRD) receiving home dialysis and beneficiaries with acute stroke effective January 1, 2019. CMS is finalizing the addition of renal dialysis facilities and the homes of ESRD beneficiaries receiving home dialysis as originating sites, and to not apply originating site geographic requirements for hospital-based or critical access hospital-based renal dialysis centers, renal dialysis facilities, and beneficiary homes, for purposes of furnishing the home dialysis monthly ESRD-related clinical assessments.

CMS is also finalizing policies to add mobile stroke units as originating sites and not to apply originating site type or geographic requirements for telehealth services furnished for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke.
Telehealth origination 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 2019 is 1.5 percent. Therefore, for CY 2019, the payment amount for HCPCS code Q3014 (Telehealth originating site facility fee) is 80 percent of the lesser of the actual charge, or $26.15. (The beneficiary is responsible for any unmet deductible amount and Medicare coinsurance.)

Additional Information


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

Document History

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 3, 2018</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>

Calendar Year (CY) 2019 Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule

MLN Matters Number: MM11064
Related CR Release Date: December 14, 2018
Related CR Transmittal Number: R4181CP
Related Change Request (CR) Number: 11064
Effective Date: January 1, 2019
Implementation Date: January 7, 2019

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 or services paid under the DMEPOS fee schedule provided to Medicare beneficiaries.

Provider Action Needed

CR 11064 provides the Calendar Year (CY) 2019 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
The Centers for Medicare & Medicaid Services (CMS) updates the DMEPOS fee schedule on an annual basis in accordance with statute and regulations. Payment on a fee schedule basis is required for certain Durable Medical Equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by Section 1834 (a), (h), and (i) of the Social Security Act (the Act). Additionally, payment on a fee schedule basis is a regulatory requirement at 42 Code of Federal Regulation (CFR) Section 414.102 for Parenteral and Enteral Nutrition (PEN), splints, casts and Intraocular Lenses (IOLs) inserted in a physician’s office. The DMEPOS and PEN fee schedule files contain Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the adjusted fee schedule amounts under Section 1834(a)(1)(F) as well as codes that are not subject to the fee schedule Competitive Bidding Program (CBP) adjustments.

The key updates for CY 2019 are as follows:

Fee Schedule Adjustment Methodologies
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 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.

The methodologies for adjusting DMEPOS fee schedule amounts using information from CBPs are established in regulations at 42 CFR Section 414.210(g). The DMEPOS and 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. Initial program instructions on these fee schedule adjustments 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).

For CY 2019, the following Fee Schedule Adjustment Methodologies apply and fee schedule amounts are based on the area in which the items and services are furnished. Additional discussion of these methodologies is in the CY 2019 End-Stage Renal Disease (ESRD)/DMEPOS final rule, CMS-1691-F, which is available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/End-Stage-Renal-Disease-ESRD-Payment-Regulations-and-Notices.html.

1. Fee Schedule Amounts for Areas within the Contiguous United States
Beginning January 1, 2109, through December 31, 2020, the adjusted fee schedule amounts for items furnished in non-competitively bid rural areas are based on a blend of 50 percent of the adjusted fee schedule amount and 50 percent of the unadjusted fee schedule amounts updated by the covered item updates specified in Sections 1834(a) (14) and 1842(s)(B) of the Act. For non-competitively bid areas other than rural or non-contiguous areas, the fee schedules for DME and PEN codes with adjusted fee schedule amounts will continue to be based on 100 percent of the adjusted fee schedule amounts from January 1, 2019, through December 31, 2020.
To determine the adjusted fee schedule amounts, the average of Single Payment Amounts (SPAs) from CBPs located in eight different regions of the contiguous United States are used to adjust the fee schedule amounts for the states located in each of the eight regions. These Regional SPAs or RSPAs are also subject to a national ceiling (110 percent of the average of the RSPAs for all contiguous states plus the District of Columbia) and a national floor (90% of the average of the RSPAs for all contiguous states plus the District of Columbia). This methodology applies to enteral nutrition and most competitively bid DME items furnished in the contiguous United States, that is, those included in more than 10 Competitive Bidding Areas (CBAs). Fees schedule amounts for competitively bid DME items included in 10 or fewer CBAs receive adjusted fee schedule amounts so that they are equal to 110 percent of the average of the SPAs for the 10 or fewer CBAs.

Additionally, in determining the adjusted fees, the fee schedule amounts for areas within the contiguous United States that are designated as rural areas are adjusted to equal the national ceiling amounts described above. Regulations at section 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 Metropolitan Statistical Area (MSA). A rural area also includes any ZIP Code within an MSA that is excluded from a CBA established for that MSA.

For the January 1, 2020 fee schedule update, the adjusted fee schedule amounts in non-bid areas will receive a Consumer Price Index for all Urban Consumers (CPI-U) update per Section 414.210(g) due to the adjustments being based on SPAs from CBPs that are no longer in effect.

2. Fee Schedule Amounts for Areas outside the Contiguous United States

Fee schedule amounts for items furnished in areas outside the contiguous United States (the noncontiguous areas, such as Alaska, Guam, Hawaii) are based on a blend of 50 percent of the adjusted fee schedule amount and 50 percent of the unadjusted fee schedule amounts updated by the covered item updates specified in Sections 1834(a)(14) and 1842(s)(B) of the Act. Areas outside the contiguous United States receive adjusted fee schedule amounts so that they are equal to the higher of the average of SPAs for CBAs in areas outside the contiguous United States (currently only applicable to Honolulu, Hawaii) or the national ceiling amounts described above and calculated based on SPAs for areas within the contiguous United States. For the January 1, 2020 fee schedule update, the adjusted fee schedule amounts in non-bid areas will receive a CPI-U update per Section 414.210(g) due to the adjustments being based on SPAs from CBPs that are no longer in effect.

KE Modifier

Because the rural and non-contiguous fee schedule amounts are based in part on unadjusted fee schedule amounts, the fees for certain items included in the 2008 Original Round One CBP, denoted with the KE modifier, appear on the fee schedule file only for items furnished in rural and non-contiguous areas. Instructions and a list of the applicable KE HCPCS codes are available in Transmittal 1630, CR6270, dated November 7, 2008. From June 1, 2018, through December 31, 2020, the rural and non-contiguous KE fee schedule amounts will be based on a blend of 50 percent of the adjusted fee schedule amount and 50 percent of the unadjusted KE fee schedule amount updated by the covered item updates specified in Sections 1834(a)(14) and 1842(s)(B) of the Act. The non-rural fees for these KE codes will be populated with zeros on the fee schedule file since KE is not a valid option for areas without blended fees.
For certain accessories used with base equipment included in the CBP in 2008 (for example, power wheelchairs, walkers, and negative pressure wound therapy pumps), the unadjusted fee schedule amounts include a 9.5 percent reduction in accordance with Federal law if these accessories were also included in the 2008 CBP. The 9.5 percent fee reduction only applies to these accessories when they are furnished for use with the base equipment included in the 2008 CBP. Beginning June 1, 2018, in cases where accessories included in the 2008 CBP are furnished for use with base equipment that was not included in the 2008 CBP (for example, manual wheelchairs, canes and aspirators), for beneficiaries residing in rural or non-contiguous, non-competitive bid areas, suppliers should append the KE modifier to the HCPCS code for the accessory. Suppliers should not use the KE modifier with accessories that were included in the 2008 CBP and furnished for use with base equipment that was not included in the 2008 CBP when these accessories are furnished to beneficiaries residing in non-rural, non-competitive bid areas. The KE modifier is not billable for items furnished in former competitive bid areas effective January 1, 2019 (see payment methodology below).

3. Fee Schedule Amounts for former CBAs
The Round 2 Recompete, National Mail-Order Recompete, and Round One 2017 contract periods of performance expire on December 31, 2018. Due to a delay, contracts will not be in effect beginning January 1, 2019, resulting in a gap in the CBP. Beginning January 1, 2019, fee schedule amounts for items furnished in former CBAs are based on the lower of the supplier’s charge for the item or fee schedule amounts adjusted in accordance with Sections 1834(a)(1)(F) and 1842(s)(3)(B) of the Act. A new fee schedule methodology will apply to items and services furnished within former CBAs in accordance with Sections 1834(a)(1)(F) and 1834(a)(1)(G) of the Act. Pursuant to 42 CFR Section 414.210(g), the fee schedules for items and services furnished in former CBAs are based on the SPAs, in effect in the CBA on the last day before the CBP contract periods of performance ended, increased by the projected percentage change in the CPI-U for the 12-month period on the date after the contract periods ended. If the gap in the CBP lasts for more than 12 months, the fee schedule amounts are increased once every 12 months on the anniversary date of the first day after the contract period ended with the CPI-U. Thus, for dates of service from January 1, 2019, through December 31, 2019, the adjusted fee schedule amounts for former CBAs will be derived based on the SPAs in effect in the CBA as of December 31, 2018, increased by the projected CPI-U change of 2.5 percent.

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. The DMEPOS Rural ZIP code file contains the ZIP codes designated as rural areas. ZIP codes for non-continental MSA are not included in the DMEPOS Rural ZIP code file. The DMEPOS Rural ZIP code file is updated on a quarterly basis as necessary.

The ZIP code associated with the permanent address of the beneficiary determines applicability of the adjusted fee schedule amounts in former CBAs. During a gap in the CBP, a former CBA ZIP code file will contain the ZIP codes and will be updated on a quarterly basis as necessary.
The following CY 2019 DMEPOS fee schedule and ZIP code Public Use Files (PUFs) will be available for State Medicaid Agencies, managed care organizations, and other interested parties at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html.

1. DMEPOS Fee schedule PUF
2. PEN Fee schedule PUF
3. Rural DMEPOS ZIP code PUF
4. Former CBA Fee schedule PUF
5. Former CBA National mail order diabetic testing supply fee schedule PUF
6. Former CBA ZIP code file PUF

**New Codes Added**

New DMEPOS codes added to the HCPCS file, effective January 1, 2019, where applicable, are A4563, A5514, A6460, A6461, B4105, E0447, E0467, L8608, L8698, L8701, L8702, V5171, V5172, V5181, V5211, V5212, V5213, V5214, V5215, and V5221. The new codes are not to be used for billing purposes until they are effective on January 1, 2019. As part of this update, fee schedules for the following new codes will be added to the DMEPOS fee schedule file effective January 1, 2019: A4563, A5514, E0447 and E0467.

Beginning January 1, 2019, the DMEPOS fee schedule file also includes fees for the following three home infusion G-codes: G0068, G0069, and G0070.

For other new CY 2019 codes, fee schedule amounts will be established as part of the July 2019 DMEPOS fee schedule update when applicable. The DME MAC shall establish local fee schedule amounts to pay claims for new codes listed from January 1, 2019, through June 30, 2019.

For gap-filling pricing purposes, deflation factors are applied before updating to the current year. The deflation factors for 2018 by payment category are:

- 0.435 for Oxygen
- 0.437 for Capped Rental
- 0.439 for Prosthetics and Orthotics
- 0.556 for Surgical Dressings
- 0.605 for Parental and Enteral Nutrition
- 0.927 for Splints and Casts
- 0.911 for Intraocular Lenses
**Codes Deleted**

One HCPCS code (K0903) will be deleted from the DMEPOS fee schedule files effective January 1, 2019.

**Multi-Function Ventilators**

Effective January 1, 2019, fees are added for new HCPCS code E0467 (Home ventilator, multi-function respiratory device, also performs any or all of the additional functions of oxygen concentration, drug nebulization, aspiration, and cough stimulation, includes all accessories, components and supplies for all functions).

Pursuant to 42 CFR 414.222(f), the fee schedule amounts for code E0467 are established using the Medicare fee schedule amounts for ventilators and the average cost of the additional functions performed by multi-function ventilators. The multi-function ventilator is classified under the frequent and substantial servicing payment category at Section 1834(a)(3) of the Act and payment will be made on a continuous monthly rental basis for beneficiaries who meet the Medicare medical necessity coverage criteria for a ventilator and at least one of the four additional functions of the device. Additional information on this change is in the CY 2019 End-Stage Renal Disease (ESRD)/DMEPOS final rule, CMS-1691-F which is available at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/End-Stage-Renal-Disease-ESRD-Payment-Regulations-and-Notices.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/End-Stage-Renal-Disease-ESRD-Payment-Regulations-and-Notices.html).

**Therapeutic Shoe Modification Codes**

CMS is also adjusting the fee schedule amounts for shoe modification codes A5503 through A5507 as part of this update 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 CY 2004. For 2019, 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 CY 2017. The fee schedule amounts for shoe modification codes A5503 through A5507 are revised to reflect this change, effective January 1, 2019.

**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 1834(a)(1)(H) of the Act, the fee schedule amounts for these codes were adjusted in CY 2013 so that they are equal to the SPAs for mail order DTS established in implementing the national mail order CBP under Section 1847 of the Act. Initial program instructions on these fees are available in Transmittal 2709, CR8325, dated May 17, 2013 (MM8325 is available at [https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8325.pdf](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8325.pdf)) and Transmittal 2661, CR8204 (MM8204 is available at [https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8204.pdf](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8204.pdf)) dated February 22, 2013. The National Mail-Order Recompete DTS SPAs are available at [https://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home](https://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home).
The non-mail order DTS amounts on the fee schedule will be updated each time the single payment amounts 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. As of January 1, 2019, payment for non-mail order diabetic supplies at the National Mail Order Recompete SPAs will continue in accordance with Section 1834(a)(1)(H) of the Act and these rates will remain in effect until new SPA rates are established under the national mail order program.

Effective January 1, 2019, the fee schedule amounts for mail order DTS (with KL modifier) are adjusted using the methodology for areas that were formerly CBAs during periods when there is a temporary lapse in the CBP. The National Mail-Order Recompete DTS SPAs of December 31, 2018, are increased by the projected percentage change in the CPI-U for the 12-month period on the date after the contract periods ended. For dates of service between January 1, 2019, and December 31, 2019, the National Mail-Order Recompete SPAs are updated by the projected change of 2.5%. The national mail order adjusted fee schedule amounts will be used in paying mail order diabetic testing supply claims in all parts of the United States, including the 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam and the American Samoa.

2019 Fee Schedule Update Factor of 2.3 Percent
For CY 2019, an update factor of 2.3 percent is applied to certain DMEPOS fee schedule amounts. Fee schedule amounts that are adjusted using information from CBPs are not be subject to the annual DMEPOS covered item update, but will be updated pursuant to the applicable adjustment methodologies outlined in 42 CFR Section 414.210(g).

In accordance with the statutory Sections 1834(a)(14) of the Act, certain DMEPOS fee schedule amounts are updated for 2019 by the percentage increase in the CPI-U for the 12-month period ending June 30, 2018, 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 0.6 percent and the CPI-U percentage increase is 2.9 percent. Thus, the 2.9 percentage increase in the CPI-U is reduced by the 0.6 percentage increase in the MFP resulting in a net increase of 2.3 percent for the update factor.

2019 Monthly Fee Schedule Amounts for Oxygen and Oxygen Equipment
As part of this update, CMS is implementing the 2019 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, 2019, through December 31, 2019. As required by statute, the CY 2006 addition of the separate payment classes for Oxygen Generating Portable Equipment (OGPE) and stationary and portable oxygen contents must be annually budget neutral.

For CY 2019, separate payment classes for portable gaseous oxygen equipment only, portable liquid oxygen equipment only, and high flow portable liquid oxygen contents only are established. Higher payments for the two new liquid oxygen classes are established. To implement this change, fees are added for new code E0447 Portable oxygen contents, liquid, 1 month’s supply = 1 unit, prescribed amount at rest or nighttime exceeds 4 Liters Per Minute (LPM). The initial fee for E0447 is set at 150 percent of the fee for portable oxygen contents. This new high flow oxygen content class allows for the continuation of high flow oxygen volume adjustment payments beyond the initial 36 months of continuous use. In addition, the payment
for portable liquid oxygen (code E0434) is set to be equivalent to the rental payment amount for portable concentrators and transfilling equipment (HCPCS codes E1392, K0738 or E0433).

Consistent with the requirements set forth in Section 1834(a) (9)(D)(ii) of the Act, a new methodology is established for ensuring that new payment classes for oxygen and oxygen equipment are budget neutral.

The new methodology for ensuring the budget neutrality of the OGPE payment class and the two new classes related to liquid oxygen is to apply a budget neutrality off-set (percentage reduction) to all oxygen classes beginning January 1, 2019. This would spread the offset across all oxygen and oxygen equipment, thereby lowering the amount taken from the stationary oxygen payment to pay for the separate classes added via Section 1834(a)(9)(D) of the Act. The offset percentage varies by area and ranges from 6 to 9 percent.

Additional discussion of the addition of the new oxygen payment classes and the application of the annual budget neutrality across all classes of oxygen and oxygen equipment is available in the CY 2019 End-Stage Renal Disease (ESRD)/ DMEPOS final rule, CMS-1691-F, https://www.cms.gov/Medicare/Medicare-Fee-For-Service-Payment/ESRDpayment/End-Stage-Renal-Disease-ESRD-Payment-Regulations-and-Notices.html.

2019 Maintenance and Servicing Payment Amount for Certain Oxygen Equipment
The payment amount for maintenance and servicing for certain oxygen equipment is updated also for 2019. Payment for claims for maintenance and servicing of oxygen equipment was included in Transmittal 635, CR6792, dated February 5, 2010, and Transmittal 717, CR6990, dated June 8, 2010. 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 section 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 2018 maintenance and servicing fee is adjusted by the 2.3 percent MFP-adjusted covered item update factor to yield a CY 2019 maintenance and servicing fee of $72.37 for oxygen concentrators and transfilling equipment.

2019 Update to the Labor Payment Rates
Included in the following table are the CY 2019 allowed payment amounts for HCPCS labor payment codes K0739, L4205 and L7520. Since the percentage increase in the CPI- U for the twelve-month period ending with June 30, 2019 is 2.9 percent, this change is applied to the 2019 labor payment amounts to update the rates for CY 2019.
The 2019 labor payment amounts in this table are effective for claims submitted using HCPCS codes K0739, L4205, and L7520 with dates of service from January 1, 2019, through December 31, 2019. 2019 Fees for Codes K0739, L4205, L7520

<table>
<thead>
<tr>
<th>STATE</th>
<th>K0739</th>
<th>L4205</th>
<th>L7520</th>
</tr>
</thead>
<tbody>
<tr>
<td>AK</td>
<td>$29.57</td>
<td>$33.70</td>
<td>$39.65</td>
</tr>
<tr>
<td>AL</td>
<td>$15.70</td>
<td>$23.40</td>
<td>$31.77</td>
</tr>
<tr>
<td>AR</td>
<td>$15.70</td>
<td>$23.40</td>
<td>$31.77</td>
</tr>
<tr>
<td>AZ</td>
<td>$19.42</td>
<td>$23.37</td>
<td>$39.08</td>
</tr>
<tr>
<td>CA</td>
<td>$24.09</td>
<td>$38.41</td>
<td>$44.75</td>
</tr>
<tr>
<td>CO</td>
<td>$15.70</td>
<td>$23.40</td>
<td>$31.77</td>
</tr>
<tr>
<td>CT</td>
<td>$26.22</td>
<td>$23.92</td>
<td>$31.77</td>
</tr>
<tr>
<td>DC</td>
<td>$15.70</td>
<td>$23.37</td>
<td>$31.77</td>
</tr>
<tr>
<td>DE</td>
<td>$28.90</td>
<td>$23.37</td>
<td>$31.77</td>
</tr>
<tr>
<td>FL</td>
<td>$15.70</td>
<td>$23.40</td>
<td>$31.77</td>
</tr>
<tr>
<td>GA</td>
<td>$15.70</td>
<td>$23.40</td>
<td>$31.77</td>
</tr>
<tr>
<td>HI</td>
<td>$19.42</td>
<td>$33.70</td>
<td>$39.65</td>
</tr>
<tr>
<td>IA</td>
<td>$15.70</td>
<td>$23.37</td>
<td>$38.02</td>
</tr>
<tr>
<td>ID</td>
<td>$15.70</td>
<td>$23.37</td>
<td>$31.77</td>
</tr>
<tr>
<td>IL</td>
<td>$15.70</td>
<td>$23.37</td>
<td>$31.77</td>
</tr>
<tr>
<td>IN</td>
<td>$15.70</td>
<td>$23.37</td>
<td>$31.77</td>
</tr>
<tr>
<td>KS</td>
<td>$15.70</td>
<td>$23.37</td>
<td>$39.65</td>
</tr>
<tr>
<td>KY</td>
<td>$15.70</td>
<td>$29.95</td>
<td>$40.61</td>
</tr>
<tr>
<td>LA</td>
<td>$15.70</td>
<td>$23.40</td>
<td>$31.77</td>
</tr>
<tr>
<td>MA</td>
<td>$26.22</td>
<td>$23.37</td>
<td>$31.77</td>
</tr>
<tr>
<td>MD</td>
<td>$15.70</td>
<td>$23.37</td>
<td>$31.77</td>
</tr>
<tr>
<td>ME</td>
<td>$26.22</td>
<td>$23.37</td>
<td>$31.77</td>
</tr>
<tr>
<td>MI</td>
<td>$15.70</td>
<td>$23.37</td>
<td>$31.77</td>
</tr>
<tr>
<td>MN</td>
<td>$15.70</td>
<td>$23.37</td>
<td>$31.77</td>
</tr>
<tr>
<td>MO</td>
<td>$15.70</td>
<td>$23.37</td>
<td>$31.77</td>
</tr>
<tr>
<td>MS</td>
<td>$15.70</td>
<td>$23.40</td>
<td>$31.77</td>
</tr>
<tr>
<td>MT</td>
<td>$15.70</td>
<td>$23.37</td>
<td>$39.65</td>
</tr>
<tr>
<td>NC</td>
<td>$15.70</td>
<td>$23.40</td>
<td>$31.77</td>
</tr>
<tr>
<td>ND</td>
<td>$19.57</td>
<td>$33.62</td>
<td>$39.65</td>
</tr>
<tr>
<td>NE</td>
<td>$15.70</td>
<td>$23.37</td>
<td>$44.29</td>
</tr>
<tr>
<td>NH</td>
<td>$16.87</td>
<td>$23.37</td>
<td>$31.77</td>
</tr>
<tr>
<td>NJ</td>
<td>$21.18</td>
<td>$23.37</td>
<td>$31.77</td>
</tr>
<tr>
<td>NM</td>
<td>$15.70</td>
<td>$23.40</td>
<td>$31.77</td>
</tr>
<tr>
<td>NV</td>
<td>$25.01</td>
<td>$23.37</td>
<td>$43.29</td>
</tr>
<tr>
<td>NY</td>
<td>$28.90</td>
<td>$23.40</td>
<td>$31.77</td>
</tr>
</tbody>
</table>

CPT codes, descriptors and other data only are copyright 2017 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.
<table>
<thead>
<tr>
<th>State</th>
<th>Fee 1</th>
<th>Fee 2</th>
<th>Fee 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>OH</td>
<td>$15.70</td>
<td>$23.37</td>
<td>$31.77</td>
</tr>
<tr>
<td>OK</td>
<td>$15.70</td>
<td>$23.40</td>
<td>$31.77</td>
</tr>
<tr>
<td>OR</td>
<td>$15.70</td>
<td>$23.37</td>
<td>$45.67</td>
</tr>
<tr>
<td>PA</td>
<td>$16.87</td>
<td>$24.07</td>
<td>$31.77</td>
</tr>
<tr>
<td>PR</td>
<td>$15.70</td>
<td>$23.40</td>
<td>$31.77</td>
</tr>
<tr>
<td>RI</td>
<td>$18.72</td>
<td>$24.09</td>
<td>$31.77</td>
</tr>
<tr>
<td>SC</td>
<td>$15.70</td>
<td>$23.40</td>
<td>$31.77</td>
</tr>
<tr>
<td>SD</td>
<td>$17.55</td>
<td>$23.37</td>
<td>$42.47</td>
</tr>
<tr>
<td>TN</td>
<td>$15.70</td>
<td>$23.40</td>
<td>$31.77</td>
</tr>
<tr>
<td>TX</td>
<td>$15.70</td>
<td>$23.40</td>
<td>$31.77</td>
</tr>
<tr>
<td>UT</td>
<td>$15.74</td>
<td>$23.37</td>
<td>$49.46</td>
</tr>
<tr>
<td>VA</td>
<td>$15.70</td>
<td>$23.37</td>
<td>$31.77</td>
</tr>
<tr>
<td>VI</td>
<td>$15.70</td>
<td>$23.40</td>
<td>$31.77</td>
</tr>
<tr>
<td>VT</td>
<td>$16.87</td>
<td>$23.37</td>
<td>$31.77</td>
</tr>
<tr>
<td>WA</td>
<td>$25.01</td>
<td>$34.28</td>
<td>$40.73</td>
</tr>
<tr>
<td>WI</td>
<td>$15.70</td>
<td>$23.37</td>
<td>$31.77</td>
</tr>
<tr>
<td>WV</td>
<td>$15.70</td>
<td>$23.37</td>
<td>$31.77</td>
</tr>
<tr>
<td>WY</td>
<td>$21.90</td>
<td>$31.19</td>
<td>$44.29</td>
</tr>
</tbody>
</table>

Additional Information

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

Document History

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 14, 2018</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>
Calendar Year (CY) 2019 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment

MLN Matters Number: MM11076
Related Change Request (CR) Number: 11076
Related CR Release Date: December 14, 2018
Effective Date: January 1, 2019
Related CR Transmittal Number: R4182CP
Implementation Date: January 7, 2019

Provider Types Affected
This MLN Matters Article is intended for clinical diagnostic laboratories that submit claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed
CR 11076 provides instructions for the Calendar Year (CY) 2019 Clinical Laboratory Fee Schedule (CLFS), mapping for new codes for clinical laboratory tests, and updates for laboratory costs subject to the reasonable charge payment. Make sure your billing staffs are aware of these updates.

Background
The CY 2019 updates are as follows:

Next CLFS Data Collection Period
Section 1834A of the Social Security Act (“the Act”), as established by Section 216(a) of the Protecting Access to Medicare Act of 2014 (PAMA), required significant changes to how Medicare pays for Clinical Diagnostic Laboratory Tests (CDLTs) under the CLFS. The CLFS final rule, “Medicare Clinical Diagnostic Laboratory Tests Payment System Final Rule,” (CMS162-F) was published in the Federal Register on June 23, 2016. The CLFS final rule implemented Section 1834A of the Act.

Under the CLFS final rule, reporting entities must report to the Centers for Medicare & Medicaid Services (CMS) certain private payer rate information (applicable information) for their component applicable laboratories. The next data collection period (the period where applicable information for an applicable laboratory is obtained from claims for which the laboratory received final payment during the period) is from January 1, 2019, through June 30, 2019, and the next 6-month window is July 1, 2019, through December 31, 2019 (the period where laboratories and reporting entities assess whether the applicable laboratory thresholds are met and review and validate applicable information before it is reported to CMS). The next data-reporting period is January 1, 2020, through March 31, 2020, where applicable information is reported to CMS. This data will be used to calculate revised private payer rate-based CLFS rates, effective January 1, 2021. Specific directions on data collection and data reporting are available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/PAMA-regulations.html.

Revisions to the Definition of Applicable Laboratory
The Physician Fee Schedule (PFS) final rule entitled, “Revisions to Payment Policies under the Medicare Physician Fee Schedule, Quality Payment Program and Other Revisions to Part B for CY 2019,” (CMS-1693-F) was displayed in the Federal Register on November 1, 2018, and was published on November 23,
2018. In the CY 2019 PFS final rule, CMS made two revisions to the regulatory definition of Applicable Laboratory: 1. Effective January 1, 2019, Medicare Advantage plan revenues are excluded from total Medicare revenues (the denominator of the majority of Medicare revenues threshold); and 2. Effective January 1, 2019, hospitals that bill for their non-patient laboratory services may use Medicare revenues from the Form CMS-1450 14x Type of Bill (TOB) to determine whether its hospital outreach laboratories meet the majority of Medicare revenues threshold and low-expenditure threshold. Effective January 1, 2019, the regulatory definition of an applicable laboratory is summarized below. An applicable laboratory means an entity that: 1. Is a laboratory as defined under the Clinical Laboratory Improvement Amendments (CLIA) regulatory definition of a laboratory (42 CFR Section 493.2); 2. The laboratory bills Medicare under its own National Provider Identifier (NPI) or a. For hospital outreach laboratories: Bills Medicare Part B on the Form CMS-1450 under TOB 14x 3. The laboratory must meet a “majority of Medicare revenues,” threshold, where it receives more than 50 percent of its total Medicare revenues from one or a combination of the CLFS or the PFS in a data collection period. For purposes of determining whether a laboratory meets the “majority of Medicare revenues” threshold, total Medicare revenues includes: fee-for-service payments under Medicare Parts A and B, prescription drug payments under Medicare Part D, and any associated Medicare beneficiary deductible or coinsurance. Effective January 1, 2019, total Medicare revenues no longer includes Medicare Advantage payments under Medicare Part C. 4. The laboratory must meet a “low expenditure” threshold, where it receives at least $12,500 of its Medicare revenues from the CLFS in a data collection period.

Coding for Health Common Procedure Coding System (HCPCS) Panel Codes
As laboratories are aware, the implementation of PAMA required Medicare to pay the weighted median of private payer rates for each separate HCPCS code. Prior to PAMA implementation, CMS paid for certain chemistry tests using Automated Test Panels (ATPs), which used claims processing logic to apply a bundled rate to sets of these codes, depending on how many of these chemistry tests were ordered. This logic no longer exists under PAMA guidelines. HCPCS codes include those from the AMA Current Procedural Technology (CPT) Manual, that are in the category of Organ or Disease Oriented panels, which are panels that consist of groups of specified tests. Because CMS no longer has payment logic to roll up panel pricing, laboratories shall report the panel test where appropriate and not report separately the tests that make up that panel. This is also consistent with recent changes in CMS’s National Correct Coding Initiative (NCCI) manual. For example, if the individually ordered tests are cholesterol (CPT code 82465), triglycerides (CPT code 84478), and HDL cholesterol (CPT code 83718), the service shall be reported as a lipid panel (CPT code 80061). If the laboratory repeats one of these component tests as a medically reasonable and necessary service on the same date of service, the CPT code corresponding to the repeat laboratory test may be reported with modifier 91 appended. For additional information on coding for these codes, please refer to the NCCI Policy Manual for Medicare Services for CY 2019, available at https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html, specifically Chapter I, Section N (Laboratory Panel), and Chapter X, Section C (Organ or Disease Oriented Panels).

Update to Fees
Based on Section 1833(h)(2)(A)(i) of the Act, available at https://www.ssa.gov/OP_Home/ssact/title18/1833.htm, the annual update to the local clinical laboratory fees for CY 2019 is 2.30 percent. Beginning January 1, 2019, this update applies only to pap smear tests. For a pap smear test, Section 1833(h)(7) of the Act requires payment to be the lesser of the local fee or the National Limitation Amount, but not less than a national minimum payment amount. However, for pap smear tests, payment may also not
exceed the actual charge. The CY 2019 national minimum payment amount is $14.99 (This value reflects the CY 2018 national minimum payment with a 2.3 percent increase or $14.65 times 1.0230). The affected codes for the national minimum payment amount are: 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88164, 88165, 88166, 88167, 88174, 88175, G0123, G0143, G0144, G0145, G0147, G0148, Q0111, Q0115, and P3000.

The annual update to payments made on a reasonable charge basis for all other laboratory services for CY 2019 is 2.3 percent (See 42 CFR 405.509(b)(1)).

The Part B deductible and coinsurance do not apply for services paid under the CLFS.

Access to Data File
Internet access to the CY 2019 CLFS data file will be available after December 1, 2018, at https://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/ClinicalLabFeeSched/index.html. It will be available in multiple formats, including Excel, text, and comma delimited.

Public Comments and Final Payment Determinations
On June 25, 2018, CMS hosted a public meeting to solicit comments on the reconsidered codes from CY 2018 codes and the new CY 2019 CPT codes. CMS published a notice of the meeting in the Federal Register on March 30, 2018. CMS got recommendations from many attendees, including individuals representing laboratories, manufacturers, and medical societies. CMS posted a summary of the meeting and the tentative payment determinations at https://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/ClinicalLabFeeSched/Laboratory_Public_Meetings.html. Additional written comments from the public were accepted until October 22, 2018. CMS also posted a summary of the public comments and the rationale for the final payment determinations at the same webpage shown in the previous sentence.

Pricing Information
The CY 2019 CLFS includes separately payable fees for certain specimen collection methods (codes 36415, P9612, and P9615). The fees have been established in accordance with Section 1833(h)(4)(B) of the Act.

The fees for clinical laboratory travel codes P9603 and P9604 are updated on an annual basis. The clinical laboratory travel codes are billable only for traveling to perform a specimen collection for either a nursing home or homebound patient. If there is a revision to the standard mileage rate for CY 2019, CMS will issue a separate instruction on the clinical laboratory travel fees.

The CY 2019 CLFS also includes codes that have a “QW” modifier to both identify codes and determine payment for tests performed by a laboratory having only a CLIA certificate of waiver.

Mapping Information - Pricing
- Reconsidered code 81326 is priced at the same rate as code 81322.
- Reconsidered code 81334 is priced at the same rate as code 81272.
- New code 0011M is priced at the same rate as code 0005U.
- New code 0012M is priced at the same rate as code 0005U.
• New code 0013M is priced at the same rate as code 0005U.
• New code 0018U is to be gapfilled.
• New code 0019U is to be gapfilled.
• New code 0020U is to be deleted.
• New code 0021U is to be gapfilled.
• New code 0022U is to be gapfilled.
• New code 0023U is to be gapfilled.
• New code 0024U is priced at the same rate as code 83704.
• New code 0025U is priced at the same rate as code G0480. • New code 0026U is priced at the same rate as code 81545.
• New code 0027U is priced at the same rate as 1.33 times code 0017U.
• New code 0028U is to be deleted.
• New code 0029U is to be gapfilled.
• New code 0030U is to be gapfilled.
• New code 0031U is priced at the same rate as code 81227.
• New code 0032U is priced at the same rate as code 81230.
• New code 0033U is priced at the same rate as 2 times code 81230.
• New code 0034U is priced at the same rate as code 81225 plus code 81335.
• New code 0035U is to be gapfilled
• New code 0036U is priced at the same rate as code 81415.
• New code 0038U is priced at the same rate as code 82306.
• New code 0039U is priced at the same rate as code 86225.
• New code 0040U is priced at the same rate as 2.5 times code 81206.
• New code 0041U is to be gapfilled.
• New code 0042U is to be gapfilled.
• New code 0043U is to be gapfilled.
• New code 0044U is to be gapfilled.
• New code 0045U is priced at the same rate as code 81519.
• New code 0046U is priced at the same rate as code 81245.
• New code 0047U is priced at the same rate as code 81519.
• New code 0048U is to be gapfilled.
• New code 0049U is priced at the same rate as code 81310.
• New code 0050U is to be gapfilled.
• New code 0051U is priced at the same rate as code G0483.
• New code 0052U is priced at the same rate as code 83701.
• New code 0053U is to be gapfilled.
• New code 0054U is priced at the same rate as code G0482.
• New code 0055U is to be gapfilled.
• New code 0056U is to be gapfilled.
• New code 0057U is to be gapfilled.
• New code 0058U is priced at the same rate as code 86835.
• New code 0059U is priced at the same rate as code 86835.
• New code 0060U is priced at the same rate as code 81420.
• New code 0061U is priced at the same rate as 5 times code 88738.
• New code 81345 is priced at the same rate as code 81403.
• New code 82642 is priced at the same rate as code 82634.
• New code 81333 is priced at the same rate as code 81401.
• New code 81596 is priced at the same rate as code 0001M.
• New code 81518 is priced at the same rate as code 81519.
• New code 81236 is priced at the same rate as code 81406.
• New code 81237 is priced at the same rate as code 81210.
• New code 81233 is priced at the same rate as code 81210.
• New code 81320 is priced at the same rate as code 81225.
• New code 81305 is priced at the same rate as code 81210.
• New code 81443 is priced at the same rate as code 81412.
• New code 81163 is priced at the same rate as code 81406 plus code 81216.
• New code 81164 is priced at the same rate as code 81405 plus code 81406.
• New code 81165 is priced at the same rate as code 81406.
• New code 81166 is priced at the same rate as code 81405.
• New code 81167 is priced at the same rate as code 81406.
• New code 81306 is priced at the same rate as code 81225.
• New code 81171 is priced at the same rate as code 81401.
• New code 81172 is priced at the same rate as code 81404.
• New code 81204 is priced at the same rate as code 81401.
• New code 81173 is priced at the same rate as code 81405.
• New code 81174 is priced at the same rate as code 81403.
• New code 81177 is priced at the same rate as code 81401.
• New code 81178 is priced at the same rate as code 81401.
• New code 81183 is priced at the same rate as code 81401.
• New code 81179 is priced at the same rate as code 81401.
• New code 81180 is priced at the same rate as code 81401.
• New code 81181 is priced at the same rate as code 81401.
• New code 81182 is priced at the same rate as code 81401.
• New code 81184 is priced at the same rate as code 81401.
• New code 81185 is priced at the same rate as code 81407.
• New code 81186 is priced at the same rate as code 81403.
• New code 81187 is priced at the same rate as code 81401.
• New code 81188 is priced at the same rate as code 81401.
• New code 81189 is priced at the same rate as code 81404.
• New code 81190 is priced at the same rate as code 81403.
• New code 81234 is priced at the same rate as code 81401.
• New code 81239 is priced at the same rate as code 81404.
• New code 81284 is priced at the same rate as code 81401.
• New code 81285 is priced at the same rate as code 81404.
• New code 81286 is priced at the same rate as code 81404.
• New code 81289 is priced at the same rate as code 81403.
• New code 81271 is priced at the same rate as code 81401.
• New code 81274 is priced at the same rate as code 81404.
• New code 81312 is priced at the same rate as code 81401.
• New code 81329 is priced at the same rate as code 81401.
• New code 81336 is priced at the same rate as code 81405.
• New code 81337 is priced at the same rate as code 81403.
• New code 81343 is priced at the same rate as code 81401.
• New code 81344 is priced at the same rate as code 81401.
• New code 87634QW is priced at the same rate as code 87634.
• Existing code 81211 is to be deleted.
• Existing code 81213 is to be deleted.
• Existing code 81214 is to be deleted.
• Existing code 0001M is to be deleted.
Laboratory Costs Subject to Reasonable Charge Payment in CY 2019

Hospital outpatient claims are paid under a reasonable charge basis (see Section 1842(b)(3) of the Act). In accordance with 42 CFR 405.502 through 405.508, the reasonable charge may not exceed the lowest of the actual charge or the customary or prevailing charge for the previous 12-month period ending June 30, updated by the inflation-indexed update. The inflation-indexed update is calculated using the change in the applicable Consumer Price Index (CPI) for the 12-month period ending June 30 of each year, as set forth in 42 CFR 405.509(b)(1). The CPI update for CY 2019 is 2.90 percent.

Manual instructions for determining the reasonable charge payment are available in Chapter 23, Sections 80 through 80.8 of the Medicare Claims Processing Manual at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf. If there is not sufficient charge data for a code, the instructions permit considering charges for other, similar services and price lists.

Services described by HCPCS codes in the following list are performed for independent dialysis facility patents. Chapter 8, Section 60.3 of the Medicare Claims Processing Manual available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c08.pdf, instructs that the reasonable charge basis applies. However, when these services are performed for hospital-based renal dialysis facility patients, payment is made on a reasonable cost basis. Also, when these services are performed for hospital outpatients, payment is made under the Hospital Outpatient Prospective Payment System (OPPS).

Codes – Blood Products

Payment for the following codes should be applied to the blood deductible as instructed in Chapter 3, Sections 20.5 through 20.5.4 of the Medicare General Information, Eligibility, and Entitlement Manual:
- P9010, P9016, P9021, P9022, P9038, P9039, P9040, P9051, P9054, P9056, P9057, and P9058.

Note: Biologic product not paid on a cost or prospective payment basis are paid based on Section 1842(o) of the Act. The payment limits based on Section 1842(o), including the payment limits for code P9041, P9045, P9046, and P9047, should be obtained from the Medicare Part B drug pricing files.

Codes – Transfusion Medicine
86850, 86860, 86870, 86880, 86885, 86886, 86890, 86891, 86900, 86901, 86902, 86904, 86905, 86906, 86920, 86921, 86922, 86923, 86927, 86930, 86931, 86932, 86945, 86950, 86960, 86965, 86970, 86971, 86972, 86975, 86976, 86977, 86978, and 86985

Codes – Reproductive Medicine Procedures
89250, 89251, 89253, 89254, 89255, 89257, 89258, 89259, 89260, 89261, 89264, 89268, 89272, 89280, 89281, 89290, 89291, 89335, 89337, 89342, 89343, 89344, 89346, 89352, 89353, 89354, and 89356
New Codes Effective October 1, 2018

Proprietary Laboratory Analysis (PLAs)
The following new codes have been added to the national HCPCS file with an effective date of October 1, 2018. These new codes are contractor-priced until they are addressed at the annual Clinical Laboratory Public Meeting, which will take place in June or July of 2019, as they were received after the 2018 public meeting. (MACs will only price PLA codes for laboratories within their jurisdiction.)

CPT Code: 0062U
- Short Descriptor: Ai sle igg&igm alys 80 bmrk
  - Long Descriptor: Autoimmune (systemic lupus erythematosus), IgG and IgM analysis of 80 biomarkers, utilizing serum, algorithm reported with a risk score
  - Laboratory: SLE-key® Rule Out, Veracis Inc, Veracis Inc

CPT Code: 0063U
- Short Descriptor: Neuro autism 32 amines alg
  - Long Descriptor: Neurology (autism), 32 amines by LC-MS/MS, using plasma, algorithm reported as metabolic signature associated with autism spectrum disorder
  - Laboratory: NPDX ASD ADM Panel I, Stemina Biomarker Discovery, Inc, Stemina Biomarker Discovery, Inc d/b/a NeuroPointDX

CPT Code: 0064U
- Short Descriptor: Antb tp total&rpr ia qual
  - Long Descriptor: Antibody, Treponema pallidum, total and rapid plasma reagin (RPR), immunoassay, qualitative
  - Laboratory: BioPlex 2200 Syphilis Total & RPR Assay, Bio-Rad Laboratories, Bio-Rad Laboratories

CPT Code: 0065U
- Short Descriptor: Syfls tst nontreponemal antb
  - Long Descriptor: Syphilis test, non-treponemal antibody, immunoassay, qualitative (RPR)
  - Laboratory: BioPlex 2200 RPR Assay, Bio-Rad Laboratories, Bio-Rad Laboratories
• CPT Code: 0066U
  o Short Descriptor: Pamg-1 ia cervico-vag fluid
  o Long Descriptor: Placental alpha-micro globulin-1 (PAMG-1), immunoassay with direct optical observation, cervico-vaginal fluid, each specimen
  o Laboratory: PartoSure™ Test, Parsagen Diagnostics, Inc, Parsagen Diagnostics, Inc, a QIAGEN Company

• CPT Code: 0067U
  o Short Descriptor: Onc brst imhchem prfl 4 bmrk
  o Long Descriptor: Oncology (breast), immunohistochemistry, protein expression profiling of 4 biomarkers (matrix metalloproteinase-1 [MMP-1], carcinoembryonic antigen-related cell adhesion molecule 6 [CEACAM6], hyaluronoglucosaminidase [HYAL1], highly expressed in cancer protein [HEC1]), formalin-fixed paraffin-embedded precancerous breast tissue, algorithm reported as carcinoma risk score
  o Laboratory: BBDRisk Dx™, Silbiotech, Inc

• CPT Code: 0068U
  o Short Descriptor: Candida species pnl amp prb
  o Long Descriptor: Candida species panel (C. albicans, C. glabrata, C. parapsilosis, C. kruseii, C. tropicalis, and C. auris), amplified probe technique with qualitative report of the presence or absence of each species
  o Laboratory: MYCODART Dual Amplification Real Time PCR Panel for 6 Candida species, RealTime Laboratories, Inc

• CPT Code: 0069U
  o Short Descriptor: Onc clrct microrna mir-31-3p
  o Long Descriptor: Oncology (colorectal), microRNA, RT-PCR expression profiling of miR-31-3p, formalin-fixed paraffin-embedded tissue, algorithm reported as an expression score
  o Laboratory: miR-31now™, GoPath Laboratories, GoPath Laboratories
• CPT Code: 0070U
  o Short Descriptor: Cyp2d6 gen com&slct rar vrnt
  o Laboratory: CYP2D6 Common Variants and Copy Number, Mayo Clinic, Laboratory Developed Test

• CPT Code: 0071U
  o Short Descriptor: Cyp2d6 full gene sequence
  o Long Descriptor: CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism) gene analysis, full gene sequence (List separately in addition to code for primary procedure)
  o Laboratory: CYP2D6 Full Gene Sequencing, Mayo Clinic, Laboratory Developed Test

• CPT Code: 0072U
  o Short Descriptor: Cyp2d6 gen cyp2d6-2d7 hybrid
  o Long Descriptor: CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism) gene analysis, targeted sequence analysis (ie, CYP2D6-2D7 hybrid gene) (List separately in addition to code for primary procedure)
  o Laboratory: CYP2D6-2D7 Hybrid Gene Targeted Sequence Analysis, Mayo Clinic, Laboratory Developed Test

• CPT Code: 0073U
  o Short Descriptor: Cyp2d6 gen cyp2d7-2d6 hybrid
  o Long Descriptor: CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism) gene analysis, targeted sequence analysis (ie, CYP2D7-2D6 hybrid gene) (List separately in addition to code for primary procedure)
  o Laboratory: CYP2D7-2D6 Hybrid Gene Targeted Sequence Analysis, Mayo Clinic, Laboratory Developed Test
• CPT Code: 0074U
  o Short Descriptor: Cyp2d6 nonduplicated gene
  o Long Descriptor: CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism) gene analysis, targeted sequence analysis (ie, non-duplicated gene when duplication/multiplication is trans) (List separately in addition to code for primary procedure)
  o Laboratory: CYP2D6 trans-duplication/multiplication non-duplicated gene targeted sequence analysis, Mayo Clinic, Laboratory Developed Test

• CPT Code: 0075U
  o Short Descriptor: Cyp2d6 5’ gene dup/mlt
  o Long Descriptor: CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism) gene analysis, targeted sequence analysis (ie, 5’ gene duplication/multiplication) (List separately in addition to code for primary procedure)
  o Laboratory: CYP2D6 5’ gene duplication/multiplication targeted sequence analysis, Mayo Clinic, Laboratory Developed Test

• CPT Code: 0076U
  o Short Descriptor: Cyp2d6 3’ gene dup/mlt
  o Long Descriptor: CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism) gene analysis, targeted sequence analysis (ie, 3’ gene duplication/multiplication) (List separately in addition to code for primary procedure)
  o Laboratory: CYP2D6 3’ gene duplication/multiplication targeted sequence analysis, Mayo Clinic, Laboratory Developed Test

• CPT Code: 0077U
  o Short Descriptor: Ig paraprotein qual bld/ur
  o Long Descriptor: Immunoglobulin paraprotein (M-protein), qualitative, immunoprecipitation and mass spectrometry, blood or urine, including isotype
  o Laboratory: M-Protein Detection and Isotyping by MALDI-TOF Mass Spectrometry, Mayo Clinic, Laboratory Developed Test

• CPT Code: 0078U
  o Short Descriptor: Pain mgt opi use gnotyp pnl
  o Long Descriptor: Pain management (opioid-use disorder) genotyping panel, 16 common variants (ie, ABCB1, COMT, DAT1, DBH, DOR, DRD1, DRD2, DRD4, GABA, GAL, HTR2A, HTTLPR, MTHFR, MUOR, OPRK1, OPRM1), buccal swab or other germline tissue sample, algorithm reported as positive or negative risk of opioid-use disorder
Revised and New Codes Effective January 1, 2019

Proprietary Laboratory Analysis (PLAs)
The following revised and new codes have been included in the national HCPCS file correction with an effective date of January 1, 2019 and may need to be manually added to the HCPCS file by the MACs. These revised and new codes are also contractor-priced until they are addressed at the annual Clinical Laboratory Public Meeting, which will take place in June or July 2019 as they were received after the 2018 public meeting. MACs shall only price PLA codes for laboratories within their jurisdiction.

Revised Codes

• CPT Code: 0008U
  - Short Descriptor: HPYLORI DETCJ ABX RSTNC DNA
  - Long Descriptor: 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 or fecal sample, predictive, reported as positive or negative for resistance to clarithromycin, fluoroquinolones, metronidazole, amoxicillin, tetracycline, and rifabutin
  - Laboratory: AmHPR® H.pylori Antibiotic Resistance, Panel, American Molecular Laboratories, Inc

New Codes

• CPT Code: 0080U
  - Short Descriptor: ONC LNG 5 CLIN RSK FACTR ALG
  - Long Descriptor: Oncology (lung), mass spectrometric analysis of galectin-3-binding protein and scavenger receptor cysteine-rich type 1 protein M130, with five clinical risk factors (age, smoking status, nodule diameter, nodule-spiculation status and nodule location), utilizing plasma, algorithm reported as a categorical probability of malignancy
  - Laboratory: BDX-XL2, Biodesix®, Inc

• CPT Code: 0081U
  - Short Descriptor: ONC UVEAL MLNMA MRNA 15 GENE
  - Long Descriptor: Oncology (uveal melanoma), mRNA, gene-expression profiling by real-time RT-PCR of 15 genes (12 content and 3 housekeeping genes), utilizing fine needle aspirate or formalin-fixed paraffin-embedded tissue, algorithm reported as risk of metastasis
  - Laboratory: DecisionDx®-UM, Castle Biosciences, Inc
• CPT Code: 0082U
  o Short Descriptor: RX TEST DEF 90+ RX/SBSTS UR
  o Long Descriptor: Drug test(s), definitive, 90 or more drugs or substances, definitive chromatography with mass spectrometry, and presumptive, any number of drug classes, by instrument chemistry analyzer (utilizing immunoassay), urine, report of presence or absence of each drug, drug metabolite or substance with description and severity of significant interactions per date of service
  o Laboratory: NextGen Precision™ Testing, Precision Diagnostics LBN Precision Toxicology, LLC

• CPT Code: 0083U
  o Short Descriptor: ONC RSPSE CHEMO CNTRST TOMOG
  o Long Descriptor: Oncology, response to chemotherapy drugs using motility contrast tomography, fresh or frozen tissue, reported as likelihood of sensitivity or resistance to drugs or drug combinations
  o Laboratory: Onco4D™, Animated Dynamics, Inc

Note: MACs will not search their files to either retract payment or retroactively pay claims; however, they should adjust claims if they are brought to their attention.

Additional Information

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

Document History

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 14, 2018</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>
HOSPITAL INFORMATION

Updates to the Inpatient Psychiatric Facility Benefit Policy Manual

MLN Matters Number: MM11062
Related CR Release Date: December 14, 2018
Related CR Transmittal Number: R253BP
Related Change Request (CR) Number: 11062
Effective Date: January 16, 2019
Implementation Date: January 16, 2019

Provider Type Affected
This MLN Matters® Article is intended for Inpatient Psychiatric Facilities (IPFs) providers who submit claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed
CR 11062 updates the language in the Medicare Benefit Policy Manual, Chapter 2, to add language from existing IPF regulations, to make technical corrections, or to clarify existing manual language. This CR also reflects changes to IPF regulations that were made in the Fiscal Year (FY) 2019 IPF Prospective Payment System (PPS) and Quality Reporting Updates final rule.

The changes made in the FY 2019 IPF PPS and Quality Reporting Updates final rule include changes to regulatory text at 42 Code of Federal Regulations (CFR) 412.27 to update language from International Classification of Diseases, 9th version, Clinical Modification (ICD-9-CM) to ICD-10-CM, and to note that the ICD-10-CM is the source for the principal psychiatric diagnosis.

Background
IPFs include freestanding psychiatric hospitals, and certified psychiatric units in acute care hospitals or critical access hospitals. IPFs provide routine hospital services and psychiatric services for the diagnosis and treatment of mentally ill persons. Section 1812(b)(3) of the Social Security Act (“the Act”) imposes a 190-day lifetime limit for care in freestanding psychiatric hospitals, but this limit does not apply to certified psychiatric units.

Section 124 of the Medicare, Medicaid and State Children’s Health Insurance Program (SCHIP) Balanced Budget Refinement Act of 1999 (BBRA) required implementation of a per diem PPS for IPFs. The IPF PPS was implemented for cost reporting periods beginning on or after January 1, 2005, and is comprised of a Federal per diem base rate that covers nearly all labor and non-labor costs of furnishing covered inpatient psychiatric services, including routine, ancillary and capital costs. The per diem base rate is then adjusted to account for differences in resource use based on patient or facility characteristics. In addition, IPFs receive outlier payments for exceptionally high cost patients and a per treatment payment for Electroconvulsive Therapy (ECT).

IPFs must also meet requirements related to admission, medical records, personnel, psychological services, social services, and therapeutic activities.
CR11062 revises the Medicare Benefit Policy Manual Chapter 2 as follows:

- Adds language from existing IPF benefit policy regulations
- Makes technical corrections
- Clarifies language or provides a reference to the supporting regulation
- Updates language as a result of regulation changes made in the FY 2019 IPF PPS and Quality Reporting
- Updates final rule.

The changes made in FY 2019 IPF PPS rulemaking include updating regulation language at 42 Code of Federal Regulations (CFR) 412.27 to replace references to the International Classification of Diseases, 9th version, Clinical Modification (ICD-9-CM) with references to the International Classification of Diseases, 10th version, Clinical Modification (ICD-10-CM). In addition, the regulation change to 42 CFR 412.27 requires that the psychiatric principal diagnosis for IPF patients be found in the ICD-10-CM.

None of the updates to the IPF Benefit Policy manual constitutes a change from existing policy. All changes to the IPF benefit policy manual are simply updates to the manual language to keep it current and to provide more information to IPFs about existing requirements. The key changes are as follows:

**Section 10.1** - This section is revised to specify the requirements that IPFs must meet as specified in 42 CFR 412.23(a) and 42 CFR 412.27.

**Section 10.4** - This section is added to provide conditions for payment under the IPF PPS, as specified in 42 CFR 412.404, including the general criteria IPFs must meet to be subject to the IPF PPS, limitations on charges to beneficiaries, furnishing of inpatient hospital services directly or under arrangement, and reporting and recordkeeping requirements.

If an IPF fails to comply fully with these conditions, CMS may, as appropriate, withhold (in full or in part) or reduce Medicare payment to the IPF until the facility provides adequate assurances of compliance, or CMS may classify the IPF as an inpatient hospital that is subject to the requirements for hospitals and paid under the hospital Inpatient Prospective Payment System.

**Section 20** - This section is modified to clarify admissions requirements to emphasize that the reasons for admission must be documented clearly as stated by the patient and/or others significantly involved.

**Section 30.2** - This section is revised to provide certification and recertification requirements. Medicare Part A pays for inpatient services in an inpatient psychiatric facility only if a physician certifies and recertifies the need for services. The format of all certifications and recertifications and the method by which they are obtained is determined by the individual facility. No specific procedures or forms are required. The provider may adopt any method that permits verification of all the IPFs requirements to continue treatment. The certification period begins with the order for inpatient admission. The certification is required at the time of admission or as soon after that is reasonable and practicable.
Additional Information
The complete manual revision is attached to the CR.

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

Document History

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 14, 2018</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>

HURRICANE FLORENCE AND MICHAEL INFORMATION

Hurricane Florence and Medicare Disaster Related North Carolina, South Carolina, and the Commonwealth of Virginia Claims

MLN Matters Number: SE18014 Revised
Article Release Date: December 12, 2018
Related CR Transmittal Number: N/A
Related Change Request (CR) Number: N/A
Effective Date: N/A
Implementation Date: N/A

Note: This article was revised on December 12, 2018, to advise providers that the public health emergency (PHE) declaration and Section 1135 waiver authority for North Carolina expired on December 6, 2018. Also, the PHE and Section 1135 waiver authority for South Carolina and the Commonwealth of Virginia expired on December 7, 2018. All other information is unchanged.

Provider Types Affected
This MLN Matters® Special Edition Article is intended for providers and suppliers who submit claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries in the States of North Carolina, South Carolina, and the Commonwealth of Virginia who were affected by Hurricane Florence.

Provider Information Available
On September 10, 2018, pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act, President Trump declared that, as a result of the effects of Hurricane Florence, an emergency exists in North Carolina and South Carolina. On September 11, 2018, President Trump declared an emergency exists in the Commonwealth of Virginia as a result of Hurricane Florence. Also, on September 11, 2018, Secretary Azar of the Department of Health & Human Services declared that a public health emergency exists in North Carolina and South Carolina and authorized waivers and modifications under Section 1135 of the Social Security Act (the Act), retroactive to September 7, 2018, for the State of North Carolina and retroactive
to September 8, 2018, for the State of South Carolina. On September 12, Secretary Azar declared a public health emergency exists in the Commonwealth of Virginia, retroactive to September 8, 2018. The PHE and Section 1135 waiver authority for North Carolina expired on December 6, 2018. The PHE and Section 1135 waiver authority for South Carolina and the Commonwealth of Virginia expired on December 7, 2018.

On September 13, 2018, the Administrator of the Centers for Medicare & Medicaid Services (CMS) authorized waivers under Section 1812(f) of the Social Security Act for the States of North Carolina, South Carolina, and the Commonwealth of Virginia for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of Hurricane Florence in 2018.

Under Section 1135 or 1812(f) of the Social Security Act, the CMS has issued several blanket waivers in the impacted geographical areas of the States of North Carolina, South Carolina, and the Commonwealth of Virginia. These waivers will prevent gaps in access to care for beneficiaries impacted by the emergency.

Providers do not need to apply for an individual waiver if a blanket waiver has been issued. Providers can request an individual Section 1135 waiver, if there is no blanket waiver, by following the instructions available at https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Requesting-an-1135-Waiver-Updated-11-16-2016.pdf.

The most current waiver information is available at https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Past-Emergencies/Hurricanes-and-tropical-storms.html. See the Background section of this article for more details.

Background

Section 1135 and Section 1812(f) Waivers

As a result of the aforementioned declaration, CMS has instructed the MACs as follows:

1. Change Request (CR) 6451 (Transmittal 1784, Publication 100-04) issued on July 31, 2009, applies to items and services furnished to Medicare beneficiaries within the State of North Carolina from September 7, 2018, and the States of South Carolina and the Commonwealth of Virginia from September 8, 2018, for the duration of the emergency. In accordance with CR6451, use of the “DR” condition code and the “CR” modifier are mandatory on claims for items and services for which Medicare payment is conditioned on the presence of a “formal waiver” including, but not necessarily limited to, waivers granted under either Section 1135 or Section 1812(f) of the Act.

2. The most current information is available at https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Past-Emergencies/Hurricanes-and-tropical-storms.html. Medicare FFS Questions & Answers (Q&As) posted on the waivers and flexibilities page at https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Resources/Waivers-and-flexibilities.html, and also referenced below are applicable for items and services furnished to Medicare beneficiaries within the States of North Carolina, South Carolina, and the Commonwealth of Virginia. These Q&As are displayed in two files:
• One file addresses policies and procedures that are applicable without any Section 1135 or other formal waiver. These policies are always applicable in any kind of emergency or disaster, including the current emergency in North Carolina, South Carolina and the Commonwealth of Virginia.

• Another file addresses policies and procedures that are applicable only with approved Section 1135 waivers or, when applicable, approved Section 1812(f) waivers. These Q&As are applicable for approved Section 1135 blanket waivers and approved individual 1135 waivers requested by providers and are effective September 7, 2018, for North Carolina and September 8, 2018, for South Carolina and the Commonwealth of Virginia.

In both cases, the links below will open the most current document. The date included in the document filename will change as new information is added, or existing information is revised.

a) Q&As applicable without any Section 1135 or other formal waiver are available at https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Consolidated_Medicare_FFS_Emergency_QsAs.pdf.

b) Q&As applicable only with a Section 1135 waiver or, when applicable, a Section 1812(f) waiver, are available at https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/MedicareFFS-EmergencyQsAs1135Waiver.pdf.

Blanket Waivers Issued by CMS
Under the authority of Section 1135 (or, as noted below, Section 1812(f)), CMS has issued blanket waivers in the affected area of the States of North Carolina, South Carolina, and the Commonwealth of Virginia. Individual facilities do not need to apply for the following approved blanket waivers:

**Skilled Nursing Facilities**

• Section 1812(f): Waiver of the requirement for a 3-day prior hospitalization for coverage of a Skilled Nursing Facility (SNF) stay provides temporary emergency coverage of SNF services without a qualifying hospital stay, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of Hurricane Florence in the States of North Carolina, South Carolina, and the Commonwealth of Virginia in 2018. In addition, for certain beneficiaries who recently exhausted their SNF benefits, it authorizes renewed SNF coverage without first having to start a new benefit period (Blanket waiver for all impacted facilities).

• 42 CFR 483.20: Waiver provides relief to SNFs on the timeframe requirements for Minimum Data Set assessments and transmission (Blanket waiver for all impacted facilities).

**Home Health Agencies**

• 42 CFR 484.20(c)(1): This waiver provides relief to Home Health Agencies on the timeframes related to OASIS Transmission (Blanket waiver for all impacted agencies).
• To ensure the correct processing of home health disaster related claims, Medicare Administrative Contractors (MACs) are allowed to extend the auto-cancellation date of Requests for Anticipated Payment (RAPs).

**Critical Access Hospitals**
This action waives the requirements that Critical Access Hospitals limit the number of beds to 25, and that the length of stay be limited to 96 hours. (Blanket waiver for all impacted hospitals)

**Housing Acute Care Patients In Excluded Distinct Part Units**
CMS has determined it is appropriate to issue a blanket waiver to IPPS hospitals that, as a result of Hurricane Florence, need to house acute care inpatients in excluded distinct part units, where the distinct part unit’s beds are appropriate for acute care inpatient. The IPPS hospital should bill for the care and annotate the patient’s medical record to indicate the patient is an acute care inpatient being housed in the excluded unit because of capacity issues related to Hurricane Florence. (Blanket waiver for all IPPS hospitals located in the affected areas that need to use distinct part beds for acute care patients as a result of the hurricane.)

**Care for Excluded Inpatient Psychiatric Unit Patients in the Acute Care Unit of a Hospital**
CMS has determined it is appropriate to issue a blanket waiver to IPPS and other acute care hospitals with excluded distinct part inpatient psychiatric units that, as a result of Hurricane Florence, need to relocate inpatients from the excluded distinct part psychiatric unit to an acute care bed and unit. The hospital should continue to bill for inpatient psychiatric services under the inpatient psychiatric facility prospective payment system for such patients and annotate the medical record to indicate the patient is a psychiatric inpatient being cared for in an acute care bed because of capacity or other exigent circumstances related to the hurricane. This waiver may be utilized where the hospital’s acute care beds are appropriate for psychiatric patients and the staff and environment are conducive to safe care. For psychiatric patients, this includes assessment of the acute care bed and unit location to ensure those patients at risk of harm to self and others are safely cared for.

**Care for Excluded Inpatient Rehabilitation Unit Patients in the Acute Care Unit of a Hospital**
CMS has determined it is appropriate to issue a blanket waiver to IPPS and other acute care hospitals with excluded distinct part inpatient Rehabilitation units that, as a result of Hurricane Florence, need to relocate inpatients from the excluded distinct part Rehabilitation unit to an acute care bed and unit. The hospital should continue to bill for inpatient rehabilitation services under the inpatient rehabilitation facility prospective payment system for such patients and annotate the medical record to indicate the patient is a rehabilitation inpatient being cared for in an acute care bed because of capacity or other exigent circumstances related to the hurricane. This waiver may be utilized where the hospital’s acute care beds are appropriate for providing care to rehabilitation patients and such patients continue to receive intensive rehabilitation services.

**Emergency Durable Medical Equipment, Prosthetics, Orthotics, and Supplies for Medicare Beneficiaries Impacted by an Emergency or Disaster**
As a result of Hurricane Florence, CMS has determined it is appropriate to issue a blanket waiver to suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) where DMEPOS is lost, destroyed, irreparably damaged, or otherwise rendered unusable. Under this waiver,
the face-to-face requirement, a new physician’s order, and new medical necessity documentation are not required for replacement. Suppliers must still include a narrative description on the claim explaining the reason why the equipment must be replaced and are reminded to maintain documentation indicating that the DMEPOS was lost, destroyed, irreparably damaged or otherwise rendered unusable as a result of the hurricane.


Medicare Advantage Plan or other Medicare Health Plan Beneficiaries
CMS remind suppliers that Medicare beneficiaries enrolled in a Medicare Advantage or other Medicare Health Plans should contact their plan directly to find out how it replaces DMEPOS damaged or lost in an emergency or disaster. Beneficiaries who do not have their plan’s contact information can contact 1-800-MEDICARE (1-800-633-4227) for assistance.

Performance Year 2019 ACO Participant List and SNF Affiliate List Change Request: Response to Hurricane Florence
The Round 3 deadline is extended for ACOs and ACOs with ACO participants and/or SNF affiliates impacted by Hurricane Florence in North Carolina, South Carolina, and the Commonwealth of Virginia. The deadline for these ACOs to submit change request in ACO-Management System (ACO-MS) to add or modify its ACO Participant List and/or SNF Affiliate List is extended until October 26, 2018, at 12:00 p.m. (noon) Eastern Time (ET), for an effective date of January 1, 2019.

Replacement Prescription Fills
Medicare payment may be permitted for replacement prescription fills (for a quantity up to the amount originally dispensed) of covered Part B drugs in circumstances where dispensed medication has been lost or otherwise rendered unusable by damage due to the emergency.

Requesting an 1135 Waiver
Information for requesting an 1135 waiver, when a blanket waiver hasn’t been approved, can be found at https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Requesting-an-1135-Waiver-Updated-11-16-2016.pdf.

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

The Centers for Disease Control and Prevention released ICD-10-CM coding advice to report healthcare encounters in the hurricane aftermath.

Providers may also want to review the CMS Emergency and Preparedness webpage at https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/EPRO-Home.html.

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 12, 2018</td>
<td>The article was revised to advise providers that the PHE declaration and Section 1135 waiver authority for North Carolina expired on December 6, 2018. Also, the PHE and Section 1135 waiver authority for South Carolina and the Commonwealth of Virginia expired on December 7, 2018. All other information is unchanged.</td>
</tr>
<tr>
<td>October 10, 2018</td>
<td>This article was revised on October 9, 2018, to add the section on ACOs on page 5.</td>
</tr>
<tr>
<td>September 14, 2018</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>

**Hurricane Michael and Medicare Disaster Related Florida and Georgia Claims**

MLN Matters Number: SE18021 Revised  
Article Release Date: December 12, 2018  
Related CR Transmittal Number: N/A  
Related Change Request (CR) Number: N/A  
Effective Date: N/A  
Implementation Date: N/A

**Note:** This article was revised on December 12, 2018, to advise providers that the public health emergency (PHE) declaration and Section 1135 waiver authority for Florida expires on January 5, 2019. Also, the PHE and Section 1135 waiver authority for Georgia expires on January 7, 2019. All other information is unchanged.

**Provider Types Affected**

This MLN Matters® Special Edition Article is intended for providers and suppliers who submit claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries in the states of Florida and Georgia who were affected by Hurricane Michael.

**Provider Information Available**

On October 9, 2018, pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act, President Trump declared that, as a result of the effects of Hurricane Michael, an emergency exists in the State of Florida. On October 10, 2018, President Trump declared a similar emergency for the State of Georgia as a result of Hurricane Michael. Also, on October 9, 2018, Secretary Azar of the Department of Health & Human Services declared that a public health emergency exists in Florida and authorized waivers and modifications under Section 1135 of the Social Security Act (the Act), retroactive to October 7, 2018, for Florida. Also, on October 11, 2018, Secretary Azar declared that a public health emergency exists in the State of Georgia, retroactive to October 9, 2018, and authorized the same waivers and modifications for Georgia. The PHE and Section 1135 waiver authority for Florida expires on January 5, 2019. The PHE and Section 1135 waiver authority for Georgia expires on January 7, 2019.
On October 9, 2018, the Administrator of the Centers for Medicare & Medicaid Services (CMS) authorized waivers under Section 1812(f) of the Social Security Act for the state of Florida for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of Hurricane Michael in 2018, retroactive to October 7, 2018. On October 11, 2018, the CMS Administrator authorized the same waivers for the state of Georgia, retroactive to October 9, 2018.

Under Section 1135 or 1812(f) of the Social Security Act, the CMS has issued several blanket waivers in the impacted geographical areas of the States of North Carolina, South Carolina, and the Commonwealth of Virginia. These waivers will prevent gaps in access to care for beneficiaries impacted by the emergency. Providers do not need to apply for an individual waiver if a blanket waiver has been issued. Providers can request an individual Section 1135 waiver, if there is no blanket waiver, by following the instructions available at [https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Requesting-an-1135-Waiver-Updated-11-16-2016.pdf](https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Requesting-an-1135-Waiver-Updated-11-16-2016.pdf).

The most current waiver information is available at [https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Past-Emergencies/Hurricanes-and-tropical-storms.html](https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Past-Emergencies/Hurricanes-and-tropical-storms.html). See the Background section of this article for more details.

**Background**

**Section 1135 and Section 1812(f) Waivers**

As a result of the aforementioned declaration, CMS has instructed the MACs as follows:

1. Change Request (CR) 6451 (Transmittal 1784, Publication 100-04) issued on July 31, 2009, applies to items and services furnished to Medicare beneficiaries within the State of North Carolina from September 7, 2018, and the States of South Carolina and the Commonwealth of Virginia from September 8, 2018, for the duration of the emergency. In accordance with CR6451, use of the “DR” condition code and the “CR” modifier are mandatory on claims for items and services for which Medicare payment is conditioned on the presence of a “formal waiver” including, but not necessarily limited to, waivers granted under either Section 1135 or Section 1812(f) of the Act.

2. The most current information is available at [https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Past-Emergencies/Hurricanes-and-tropical-storms.html](https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Past-Emergencies/Hurricanes-and-tropical-storms.html). Medicare FFS Questions & Answers (Q&As) posted on the waivers and flexibilities page at [https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Resources/Waivers-and-flexibilities.html](https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Resources/Waivers-and-flexibilities.html), and also referenced below are applicable for items and services furnished to Medicare beneficiaries within the States of North Carolina, South Carolina, and the Commonwealth of Virginia. These Q&As are displayed in two files:

- One file addresses policies and procedures that are applicable without any Section 1135 or other formal waiver. These policies are always applicable in any kind of emergency or disaster, including the current emergency in North Carolina, South Carolina and the Commonwealth of Virginia.
• Another file addresses policies and procedures that are applicable only with approved Section 1135 waivers or, when applicable, approved Section 1812(f) waivers. These Q&As are applicable for approved Section 1135 blanket waivers and approved individual 1135 waivers requested by providers and are effective September 7, 2018, for North Carolina and September 8, 2018, for South Carolina and the Commonwealth of Virginia.

In both cases, the links below will open the most current document. The date included in the document filename will change as new information is added, or existing information is revised.

a) Q&As applicable **without any Section 1135** or other formal waiver are available at [https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Consolidated_Medicare_FFS_Emergency_QsAs.pdf](https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Consolidated_Medicare_FFS_Emergency_QsAs.pdf).

b) Q&As applicable **only with a Section 1135** waiver or, when applicable, a Section 1812(f) waiver, are available at [https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/MedicareFFS-EmergencyQsAs1135Waiver.pdf](https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/MedicareFFS-EmergencyQsAs1135Waiver.pdf).

**Blanket Waivers Issued by CMS**

Under the authority of Section 1135 (or, as noted below, Section 1812(f)), CMS has issued blanket waivers in the affected area of **the States of North Carolina, South Carolina, and the Commonwealth of Virginia**. Individual facilities do not need to apply for the following approved blanket waivers:

**Skilled Nursing Facilities**

- **Section 1812(f):** Waiver of the requirement for a 3-day prior hospitalization for coverage of a Skilled Nursing Facility (SNF) stay provides temporary emergency coverage of SNF services without a qualifying hospital stay, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of Hurricane Florence in the States of North Carolina, South Carolina, and the Commonwealth of Virginia in 2018. In addition, for certain beneficiaries who recently exhausted their SNF benefits, it authorizes renewed SNF coverage without first having to start a new benefit period (Blanket waiver for all impacted facilities).

- **42 CFR 483.20:** Waiver provides relief to SNFs on the timeframe requirements for Minimum Data Set assessments and transmission (Blanket waiver for all impacted facilities).

**Home Health Agencies**

- **42 CFR 484.20(c)(1):** This waiver provides relief to Home Health Agencies on the timeframes related to OASIS Transmission (Blanket waiver for all impacted agencies).

- To ensure the correct processing of home health disaster related claims, Medicare Administrative Contractors (MACs) are allowed to extend the auto-cancellation date of Requests for Anticipated Payment (RAPs).
Critical Access Hospitals
This action waives the requirements that Critical Access Hospitals limit the number of beds to 25, and that the length of stay be limited to 96 hours. (Blanket waiver for all impacted hospitals)

Housing Acute Care Patients In Excluded Distinct Part Units
CMS has determined it is appropriate to issue a blanket waiver to IPPS hospitals that, as a result of Hurricane Florence, need to house acute care inpatients in excluded distinct part units, where the distinct part unit’s beds are appropriate for acute care inpatient. The IPPS hospital should bill for the care and annotate the patient’s medical record to indicate the patient is an acute care inpatient being housed in the excluded unit because of capacity issues related to Hurricane Florence. (Blanket waiver for all IPPS hospitals located in the affected areas that need to use distinct part beds for acute care patients as a result of the hurricane.)

Care for Excluded Inpatient Psychiatric Unit Patients in the Acute Care Unit of a Hospital
CMS has determined it is appropriate to issue a blanket waiver to IPPS and other acute care hospitals with excluded distinct part inpatient psychiatric units that, as a result of Hurricane Florence, need to relocate inpatients from the excluded distinct part psychiatric unit to an acute care bed and unit. The hospital should continue to bill for inpatient psychiatric services under the inpatient psychiatric facility prospective payment system for such patients and annotate the medical record to indicate the patient is a psychiatric inpatient being cared for in an acute care bed because of capacity or other exigent circumstances related to the hurricane. This waiver may be utilized where the hospital’s acute care beds are appropriate for psychiatric patients and the staff and environment are conducive to safe care. For psychiatric patients, this includes assessment of the acute care bed and unit location to ensure those patients at risk of harm to self and others are safely cared for.

Care for Excluded Inpatient Rehabilitation Unit Patients in the Acute Care Unit of a Hospital
CMS has determined it is appropriate to issue a blanket waiver to IPPS and other acute care hospitals with excluded distinct part inpatient Rehabilitation units that, as a result of Hurricane Florence, need to relocate inpatients from the excluded distinct part Rehabilitation unit to an acute care bed and unit. The hospital should continue to bill for inpatient rehabilitation services under the inpatient rehabilitation facility prospective payment system for such patients and annotate the medical record to indicate the patient is a rehabilitation inpatient being cared for in an acute care bed because of capacity or other exigent circumstances related to the hurricane. This waiver may be utilized where the hospital’s acute care beds are appropriate for providing care to rehabilitation patients and such patients continue to receive intensive rehabilitation services.

Emergency Durable Medical Equipment, Prosthetics, Orthotics, and Supplies for Medicare Beneficiaries Impacted by an Emergency or Disaster
As a result of Hurricane Florence, CMS has determined it is appropriate to issue a blanket waiver to suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) where DMEPOS is lost, destroyed, irreparably damaged, or otherwise rendered unusable. Under this waiver, the face-to-face requirement, a new physician’s order, and new medical necessity documentation are not required for replacement. Suppliers must still include a narrative description on the claim explaining the reason why the equipment must be replaced and are reminded to maintain documentation indicating that the DMEPOS was lost, destroyed, irreparably damaged or otherwise rendered unusable as a result of the hurricane.

CPT codes, descriptors and other data only are copyright 2017 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

**Medicare Advantage Plan or other Medicare Health Plan Beneficiaries**

CMS remind suppliers that Medicare beneficiaries enrolled in a Medicare Advantage or other Medicare Health Plans should contact their plan directly to find out how it replaces DMEPOS damaged or lost in an emergency or disaster. Beneficiaries who do not have their plan’s contact information can contact 1-800-MEDICARE (1-800-633-4227) for assistance.

**Performance Year 2019 ACO Participant List and SNF Affiliate List Change Request: Response to Hurricane Florence**

The Round 3 deadline is extended for ACOs and ACOs with ACO participants and/or SNF affiliates impacted by Hurricane Florence in North Carolina, South Carolina, and the Commonwealth of Virginia. The deadline for these ACOs to submit change request in ACO-Management System (ACO-MS) to add or modify its ACO Participant List and/or SNF Affiliate List is extended until October 26, 2018, at 12:00 p.m. (noon) Eastern Time (ET), for an effective date of January 1, 2019.

**Replacement Prescription Fills**

Medicare payment may be permitted for replacement prescription fills (for a quantity up to the amount originally dispensed) of covered Part B drugs in circumstances where dispensed medication has been lost or otherwise rendered unusable by damage due to the emergency.

**Requesting an 1135 Waiver**

Information for requesting an 1135 waiver, when a blanket waiver hasn’t been approved, can be found at https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Requesting-an-1135-Waiver-Updated-11-16-2016.pdf.

**Additional Information**

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


Providers may also want to review the CMS Emergency and Preparedness webpage at https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/EPRO-Home.html.

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 12, 2018</td>
<td>The article was revised to advise providers that the PHE declaration and Section 1135 waiver authority for North Carolina expired on December 6, 2018. Also, the PHE and Section 1135 waiver authority for South Carolina and the Commonwealth of Virginia expired on December 7, 2018. All other information is unchanged.</td>
</tr>
<tr>
<td>October 10, 2018</td>
<td>This article was revised on October 9, 2018, to add the section on ACOs on page 5.</td>
</tr>
<tr>
<td>September 14, 2018</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>

**INFLUENZA (FLU) VACCINE INFORMATION**

**Quarterly Influenza Virus Vaccine Code Update - January 2019**

MLN Matters Number: MM10871 Revised
Related CR Release Date: September 27, 2018
Related CR Transmittal Number: R4141CP
Related Change Request (CR) Number: 10871
Effective Date: January 1, 2019
Implementation Date: January 7, 2019

**Note:** This article was revised on December 14, 2018 to reflect the revised CR10871 issued on September 27. In the article, the CR release date, transmittal number, and the Web address for accessing CR10871 are revised. All other information remains the same.

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

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

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

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

**Payment Basis for Institutional Claims**
MACs will pay for influenza virus vaccine code 90689 with a Type of Service (TOS) of V based on reasonable cost to

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

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

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

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

**Additional Information**

CPT codes, descriptors and other data only are copyright 2017 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.
If you have questions, your MACs may have more information. Find their website at [http://go.cms.gov/MAC-website-list](http://go.cms.gov/MAC-website-list).

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 14, 2018</td>
<td>The article was revised to reflect the revised CR10871 issued on September 27. In the article, the CR release date, transmittal number, and the Web address for accessing CR10871 are revised. All other information remains the same.</td>
</tr>
<tr>
<td>September 6, 2018</td>
<td>The article was revised to reflect the revised CR10871 issued on September 5. In the article, the CR release date, transmittal number, and the Web address for accessing CR10871 are revised. All other information remains the same.</td>
</tr>
<tr>
<td>August 6, 2018</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>

**LEARNING AND EDUCATION INFORMATION**

**Part A Ask the Contractor Teleconference (ACT) Specialty Clinical Topic: Outpatient Therapies – January 16, 2019**

Palmetto GBA will host the Part A Ask the Contractor Teleconference (ACT) on Wednesday, January 16, 2019, at 11 a.m. ET. The ACT call is designed to open the communication channels between Palmetto GBA and our Part A provider community.

The ACT Specialty Topic is Outpatient Therapies. Join our Clinical Consultant, Sandra Booker, as she provides information concerning recent medical review findings and how to improve your documentation.

All provider questions will be responded to during the call regardless of whether they concern this topic or not.

**Conference Call Information**

- **Date:** January 16, 2019
- **Time:** 11 a.m. – 12 p.m. ET; 10– 11 a.m. CT
- **Teleconference Number:** 877-789-3907
- **Confirmation Code:** 6799803

**Submit Your Questions**

We encourage you to submit questions prior to the call. Just fill out the Ask the Contractor Teleconference (ACT): [Submit A Question form](#) (PDF, 333 KB). Once the form is completed, please fax it to (803) 462-2678, Attention: Part A Ask-the-Contractor Teleconference, at least five days before the scheduled teleconference.

---

_CPT codes, descriptors and other data only are copyright 2017 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply._
Part A Skilled Nursing Facility (SNF) Consolidated Billing Webcast – January 23, 2019

Please join Palmetto GBA for an informative Part A Skilled Nursing Facility (SNF) Consolidated Billing (CB) webcast on Wednesday, January 23, 2019, at 11 a.m. ET! This webcast is designed to provide an overview of SNF Coverage, SNF CB, MDS Resource Utilization Groups (RUGs), claim submission, and documentation.

Register Now (https://tinyurl.com/yblf7whk)

Note: An NPI and PTAN are required to register; you may use ‘N/A’ if you do not have an NPI or PTAN.

KEPRO - The Beneficiary and Family Centered Care Quality Improvement Organization Webinar: January 29, 2019

Palmetto GBA would like to encourage our provider community to join KEPRO in a webinar on January 29, 2019, at 2:00 p.m. ET

To register for this webinar select: https://tinyurl.com/ycg8rawo

Home Health Referrals and Clinical Documentation Requirements Webinar: February 26, 2019

In collaboration with the Medicare A/B and Home Health and Hospice Medicare Administration Contractors (MACs), the Provider Outreach and Education teams are hosting a home health webinar for providers who order home health services for Medicare beneficiaries. This webinar is designed to provide clarity to the physician offices on Medicare coverage criteria and documentation requirements for their Medicare patients who receive home health services. If you order home health services, this webinar is a great way to assure you are aware of physician roles and Medicare’s coverage criteria!

The presentation will be conducted through web-based training. This session will include:

- The Role of the Physician
- Medicare Home Health Benefit
- Eligibility Requirements
- Certification and Recertification
- Documentation Collaboration
- Common Documentation Errors
• Billing Requirements

• Resources

In order to accommodate busy offices and time zones, we are offering two sessions. This is the same information presented at both webinars. Please register for the time that fits your schedule.

To register for a webinar session, please select one of the links below:

• Tuesday, February 26, 2019, 10:00 a.m. to 11:30 a.m. CT [https://register.gotowebinar.com/register/5824543396799166723]
• Tuesday, February 26, 2019, 2:00 p.m. to 3:30 p.m. CT [https://register.gotowebinar.com/register/908164014617430787]

** While home health agencies may attend, this webinar is geared towards the provider offices who order home health services. **

2019 Medical Review (MR) Hot Topic Targeted Probe and Educate (TPE) Teleconference Schedule

Palmetto GBA will host a series of Medical Review Hot Topic Targeted Probe and Educate (TPE) Teleconferences in 2019. These calls are open to all providers. Please mark your calendars to join our Medical Review Subject Matter Experts as they discuss and answer your questions concerning current TPE process.

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Participation Number</th>
<th>Confirmation ID Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 4, 2019</td>
<td>2:00 p.m. – 3:00 p.m. ET</td>
<td>(877) 789-3907</td>
<td>8778149</td>
</tr>
<tr>
<td>June 3, 2019</td>
<td>2:00 p.m. - 3:00 p.m. ET</td>
<td>(877) 789-3907</td>
<td>1291838</td>
</tr>
<tr>
<td>September 3, 2019</td>
<td>2:00 p.m. - 3:00 p.m. ET</td>
<td>(877) 789-3907</td>
<td>5369828</td>
</tr>
<tr>
<td>December 2, 2019</td>
<td>2:00 p.m. - 3:00 p.m. ET</td>
<td>(877) 789-3907</td>
<td>6879568</td>
</tr>
</tbody>
</table>

This schedule is also available on the Palmetto GBA Event Registration Portal at [https://www.palmettogba.com/event/pgbaevent.nsf/SeriesDetails.xsp?EventID=B74TM73304](https://www.palmettogba.com/event/pgbaevent.nsf/SeriesDetails.xsp?EventID=B74TM73304)
National Provider Enrollment Conference – March 2019

Tuesday, March 12, 2019 from 8:00 a.m. to 5:00 p.m. CT and Wednesday, March 13, 2019 from 8:30 a.m. to 5:00 p.m. CT, Nashville, TN.

Register at https://www.palmgba.com/events/NPEC2019/ for the CMS National Provider Enrollment Conference at the Nashville Music City Center. Take advantage of this opportunity to interact directly with CMS and Medicare Administrative Contractor provider enrollment experts.

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.

To access the following information, go to https://www.palmettogba.com/palmetto/providers.nsf/DocsR/JJ-Part-A~AW8UM97436

| 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.
Preceding 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. Once the form is completed, please fax it to (803) 935-0140, Attention: Ask-the-Contractor Teleconference |
| 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. |
| 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. |
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 1-877-567-7271.

**MEDICAL POLICY INFORMATION**

**National Coverage Determination (NCD90.2): Next Generation Sequencing (NGS)**

MLN Matters Number: MM10878  
Related CR Release Date: November 30, 2018  
Related CR Transmittal Number: R210NCD  
Related Change Request (CR) Number: 10878  
Effective Date: March 16, 2018  
Implementation Date: March 8, 2019 - A/B MACs

**Provider Type Affected**

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

**Provider Action Needed**

Change Request (CR) 10878 informs, effective March 16, 2018, the Centers for Medicare & Medicaid Services (CMS) covers diagnostic laboratory tests using next generation sequencing when performed in a Clinical Laboratory Improvement Amendments- certified laboratory when ordered by a treating physician and when specific requirements are met. Make sure your billing staffs are aware of this change.

This revision to the “Medicare National Coverage Determinations Manual” is a national coverage determination (NCD). NCDs are binding on MACs with the Federal government that review and/or adjudicate claims, determinations, and/or decisions, quality improvement organizations, qualified independent contractors, the Medicare appeals council, and administrative law judges (ALJs) (see 42 CFR Section 405.1060(a)(4) (2005)). An NCD that expands coverage is also binding on a Medicare advantage organization. In addition, an ALJ may not review an NCD. (See section 1869(f)(1)(A)(i) of the Social Security Act.)

**Background**

Clinical laboratory diagnostic tests can include tests that, for example, predict the risk associated with one or more genetic variations. In vitro companion diagnostic laboratory tests provide a report of test results of genetic variations and are essential for the safe and effective use of a corresponding therapeutic product. NGS is one technique that can measure one or more genetic variation as a laboratory diagnostic test, such as when used as a companion in vitro diagnostic test.

Patients with advanced cancer can have recurrent, relapsed, refractory, metastatic, and/or stages III or IV of cancer. Clinical studies show that genetic variations in a patient’s cancer can, in concert with clinical factors, predict how each individual responds to specific treatments.
In application, a report of results of a diagnostic laboratory test using NGS (that is, information on the cancer’s genetic variations) can contribute to predicting a patient’s response to a given drug: good, bad, or none at all. Applications of NGS to predict a patient’s response to treatment occurs ideally prior to initiation of the drug.

CMS reviewed the evidence for laboratory diagnostic tests using NGS in patients with cancer, and determined that such tests with analytical and clinical validity, and clinical utility, could also improve health outcomes for Medicare beneficiaries with advanced cancer. Therefore, CMS shall cover certain diagnostic laboratory tests using NGS when requirements are met.

Effective for claims with dates of service on or after March 16, 2018, CMS has determined that the evidence is sufficient to cover diagnostic laboratory tests that use NGS under specified conditions. CMS will cover such testing under the Medicare program for beneficiaries with recurrent, relapsed, refractory, metastatic cancer, or advanced stages III or IV cancer if the beneficiary has either not been previously tested using the same NGS test for the same primary diagnosis of cancer or repeat testing using the same NGS test only when a new primary cancer diagnosis is made by the treating physician, and decided to seek further cancer treatment (e.g., therapeutic chemotherapy). The test must be ordered by the treating physician, performed in a Clinical Laboratory Improvement Amendments (CLIA)-certified laboratory, and have all of the following requirements met:

- Food & Drug Administration (FDA) approval or clearance as a companion in vitro diagnostic;
- An FDA-approved or -cleared indication for use in that patient’s cancer; and,
- Results provided to the treating physician for management of the patient using a report template to specify treatment options.

Additionally, MACs may determine coverage of other diagnostic laboratory tests using NGS for patients with cancer only when the test is performed in a CLIA-certified laboratory, ordered by the treating physician and the patient has:

- Either recurrent, relapsed, refractory, metastatic, or advanced stages III or IV cancer; and,
- Either not been previously tested using the same NGS test for the same primary diagnosis of cancer or repeat testing using the same NGS test only when a new primary cancer diagnosis is made by the treating physician; and,
- Decided to seek further cancer treatment (for example, therapeutic chemotherapy).

A diagnostic laboratory test using NGS is non-covered when cancer patients do not have the above-noted indications for cancer under either national or local coverage criteria.
Additional Information
The official instruction, CR10878, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R210NCD.pdf. Attachment 1 of CR10878 contains a list of covered clinical diagnostic laboratory tests using NGS and respective allowed ICD-10 diagnosis codes for the listed effective dates.

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

Document History

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 10, 2018</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>

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

MLN Matters Number: MM11005
Related CR Release Date: November 9, 2018
Related CR Transmittal Number: R2202OTN
Related Change Request (CR) Number: 11005
Effective Date: April 1, 2009, unless otherwise noted in requirements
Implementation Date: April 1, 2019, for Medicare Shared Systems, for local MACs 60 days from release of CR 11005

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

Provider Action Needed
CR 11005 constitutes a maintenance update of ICD-10 conversions and other coding updates specific to National Coverage Determinations (NCDs). These NCD coding changes are the result of newly available codes, coding revisions to NCDs released separately, or coding feedback received. Please make sure your billing staffs are aware of these updates.

Background
Previous NCD coding changes appear in ICD-10 quarterly updates are available on the Centers for Medicare & Medicaid Services (CMS) website 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.
Please follow the link below for the NCD spreadsheets included with CR:

Relevant NCD coding changes in CR 11005 include:

- NCD20.7 – Percutaneous Transluminal Angioplasty (PTA)
- NCD80.11 – Vitrectomy
- NCD110.21 – Erythropoiesis Stimulating Agents (ESAs) in Cancer and Neoplastic Conditions
- NCD210.2 – Screening Pap Smears and Pelvic Examinations for Early Detection of Cervical or Vaginal Cancers
- NCD220.4 – Mammograms
- NCD230.18 – Sacral Nerve Stimulation (SNS) for Urinary Incontinence

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 CMS and are not intended to change the original intent of the NCD. The exception to this is when coding revisions are released as official implementation of new or reconsidered NCD policy following a formal national coverage analysis.

Providers should be aware that 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 Equivalent 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.

MACs shall use default Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) messages where appropriate:

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

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

- Group Code PR (Patient Responsibility) assigning financial responsibility to the beneficiary (if a claim is received with occurrence code 32, or with occurrence code 32 and a GA modifier, indicating a signed Advance Beneficiary Notice (ABN) is one 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 one file). For modifier GZ, use CARC 50 and Medicare Summary Notice (MSN) 8.81 per instructions in CR 7228/TR 2148.

Note: MACs shall adjust any claims processed in error associated with CR 11005 that are brought to their attention.

Additional Information

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

Document History

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>November 27, 2018</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>

NCD 20.4 Implantable Cardiac Defibrillators (ICDs)

MLN Matters Number: MM10865 Revised
Related CR Release Date: December 13, 2018
Related CR Transmittal Number: R211NCD
Related Change Request (CR) Number: 10865
Effective Date: February 15, 2018
Implementation Date: February 26, 2019 - MAC local edit

Note: This article was revised on December 17, 2018, to reflect a revised CR10865 issued on December 13. In the article, two sentences are added at the end of the Provider Action Needed section to emphasize that this coverage policy no longer requires trial-related coding on claims for dates of service on or after February 15, 2018. Also, the CR release date, transmittal number, and the Web address of the CR are revised. All other information is unchanged.

Provider Types Affected
This MLN Matters Article is intended for physicians, providers and suppliers billing Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.
Provider Action Needed
CR 10865 and the Medicare National Coverage Determinations (NCD) Manual Transmittal reflects the Centers for Medicare & Medicaid Services (CMS) final decision dated February 15, 2018, regarding the reconsideration of NCD 20.4, Implantable Defibrillators (ICDs). Make sure your billing staffs are aware of this decision. Effective February 15, 2018, coverage policy is no longer contingent on participation in a trial/study/registry. Therefore, claims with a Date of Service (DOS) on an after February 15, 2018, no longer require any trial-related coding.

Background
An ICD is an electronic device designed to diagnose and treat life-threatening Ventricular Tachyarrhythmias (VTs). The device consists of a pulse generator and electrodes for sensing and defibrillating. This therapy has been shown in trials to improve survival and reduce sudden cardiac death in patients with certain clinical characteristics.

Section 20.4 of the Medicare NCD Manual establishes conditions of coverage for ICDs. In 1986, CMS first issued an NCD providing limited coverage of ICDs and the policy has been expanded over the years. CMS last reconsidered this NCD in 2005. Effective for claims with dates of service on or after February 15, 2018, CMS will cover ICDs for the following patient indications:

1. Patients with a personal history of sustained VT or cardiac arrest due to Ventricular Fibrillation (VF). Patients must have demonstrated:
   - An episode of sustained VT, either spontaneous or induced by an electrophysiology (EP) study, not associated with an acute myocardial infarction (MI) and not due to a transient or reversible cause; or
   - An episode of cardiac arrest due to VF, not due to a transient or reversible cause.

2. Patients with a prior MI and a measured left ventricular ejection fraction (LVEF) ≤ 0.30. Patients must not have:
   - New York Heart Association (NYHA) classification IV heart failure; or,
   - Had a coronary artery bypass graft (CABG), or percutaneous coronary intervention (PCI) with angioplasty and/or stenting, within the past 3 months; or,
   - Had an MI within the past 40 days; or,
   - Clinical symptoms and findings that would make them a candidate for coronary revascularization.

3. Patients who have severe ischemic dilated cardiomyopathy but no personal history of sustained VT or cardiac arrest due to VF, and have New York Heart Association (NYHA) Class II or III heart failure, LVEF < 35%. Additionally, patients must not have:
   - Had a CABG, or PCI with angioplasty and/or stenting, within the past 3 months; or,
   - Had an MI within the past 40 days; or,
   - Clinical symptoms and findings that would make them a candidate for coronary revascularization.
4. Patients who have severe non-ischemic dilated cardiomyopathy but no personal history of cardiac arrest or sustained VT, NYHA Class II or III heart failure, LVEF < 35%, and been on optimal medical therapy for at least 3 months. Additionally, patients must not have:

- Had a CABG or PCI with angioplasty and/or stenting, within the past 3 months; or,
- Had an MI within the past 40 days; or,
- Clinical symptoms and findings that would make them a candidate for coronary revascularization.

5. Patients with documented familial, or genetic disorders with a high risk of life-threatening tachyarrhythmias (sustained VT or VF), to include, but not limited to, long QT syndrome or hypertrophic cardiomyopathy.

6. Patients with an existing ICD may receive an ICD replacement if it is required due to the end of battery life, elective replacement indicator (ERI), or device/lead malfunction.

For these patients identified in items 2 through 5 above, a formal shared decision-making encounter must occur between the patient and a physician (as defined in Section 1861(r)(1) of the Act) or qualified non-physician practitioner (meaning a physician assistant, nurse practitioner, or clinical nurse specialist as defined in Section 1861(aa)(5) of the Act) using an evidence-based decision tool on ICDs prior to initial ICD implantation. The shared decision-making encounter may occur at a separate visit.

For each of the 6 covered indications above, the following additional criteria must also be met:

1. Patients must be clinically stable (for example, not in shock, from any etiology);

2. LVEF must be measured by echocardiography, radionuclide (nuclear medicine) imaging, cardiac magnetic resonance imaging (MRI), or catheter angiography;

3. Patients must not have:

- Significant, irreversible brain damage; or,
- Any disease, other than cardiac disease (for example, cancer, renal failure, liver failure) associated with a likelihood of survival less than 1 year; or,
- Supraventricular tachycardia such as atrial fibrillation with a poorly controlled ventricular rate.

Exceptions to waiting periods for patients that have had a CABG or PCI with angioplasty and/or stenting within the past 3 months, or had an MI within the past 40 days:

- Cardiac Pacemakers: Patients who meet all CMS coverage requirements for cardiac pacemakers, and who meet the criteria in NCD 20.4 for an ICD, may receive the combined devices in one procedure, at the time the pacemaker is clinically indicated;
• Replacement of ICDs: Patients with an existing ICD may receive an ICD replacement if it is required due to the end of battery life, ERI, or device/lead malfunction.

For patients that are candidates for heart transplantation on the United Network for Organ Sharing (UNOS) transplant list awaiting a donor heart, as with cardiac resynchronization therapy, when used as a bridge-to-transplant to prolong survival until a donor becomes available, MACs determine coverage of ICDs.

All other indications for ICDs not currently covered in accordance with this decision may be covered under Category B investigational device exemption (IDE) trials per regulation at 42 CFR 405.201.

Additional Information

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

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 17, 2018</td>
<td>The article was revised to reflect a revised CR10865 issued on December 13. In the article, two sentences are added at the end of the Provider Action Needed section to emphasize that this coverage policy no longer requires trial-related coding on claims for dates of service on or after February 15, 2018. Also, the CR release date, transmittal number, and the Web address of the CR are revised. All other information is unchanged.</td>
</tr>
<tr>
<td>December 3, 2018</td>
<td>This article was revised on December 3, 2018, to correct the implementation date in the banner above. That date should be February 26, 2019.</td>
</tr>
<tr>
<td>November 29, 2018</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>

CPT codes, descriptors and other data only are copyright 2017 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.
Part A Local Coverage Determinations (LCDs) Updates

Revised ICD-10 LCDs
The table below provides a summary of recent Part A/B MAC ICD-10 LCD revisions/updates. To view these revised LCDs, go to www.PalmettoGBA.com/jja/lcd. Under the Medical Policies section, select Active LCD Policies. Scroll down to the LCDs for Contractor Browser section and make sure the Active LCDs category is selected. Then select the Submit button. The LCDs are listed in alphabetical order.

<table>
<thead>
<tr>
<th>Title</th>
<th>LCD Number</th>
<th>Revision Number</th>
<th>Changes/Additions/Deletions</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partial Hospitalization Programs</td>
<td>L37633</td>
<td>4</td>
<td>Under <em>Bibliography</em> changes were made to reflect AMA citation guidelines. Punctuation was corrected and words were capitalized or changed to lower case as appropriate throughout the policy</td>
<td>12/13/2018</td>
</tr>
</tbody>
</table>

Part A/B Medicare Administrative Contractor (MAC) Local Coverage Determinations (LCDs) Updates

Revised ICD-10 LCDs
The table below provides a summary of recent Part A/B MAC ICD-10 LCD revisions/updates. To view these revised LCDs, go to www.PalmettoGBA.com/jja/lcd. Under the Medical Policies section, select Active LCD Policies. Scroll down to the LCDs for Contractor Browser section and make sure the Active LCDs category is selected. Then select the Submit button. The LCDs are listed in alphabetical order.

<table>
<thead>
<tr>
<th>Title</th>
<th>LCD Number</th>
<th>Revision Number</th>
<th>Changes/Additions/Deletions</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Foot Care</td>
<td>L37643</td>
<td>3</td>
<td>Grammar and punctuation were corrected, words were capitalized or changed to lower case and acronyms were inserted where appropriate throughout the policy</td>
<td>12/13/2018</td>
</tr>
</tbody>
</table>
# MolDX Local Coverage Determinations (LCDs) Updates

## Revised ICD-10 LCDs

The table below provides a summary of recent Part A MolDX ICD-10 LCD revisions/updates. To view these revised LCDs, go to [www.palmettogba.com/moldx](http://www.palmettogba.com/moldx). Select MolDX LCDs under the **Topics section**. Go to your state and select **Active**. Scroll down to the **Final LCDs for Contractor Results** section and make sure the **Active LCDs** category is selected. Then select the **Submit** button. The LCDs are listed in alphabetical order.

<table>
<thead>
<tr>
<th>Title</th>
<th>LCD Number</th>
<th>Revision Number</th>
<th>Changes/Additions/Deletions</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>MolDX: BDX-XL2</td>
<td>L37031</td>
<td>4</td>
<td>Changed the title of the LCD to BDX-XL2 and all Xpresys references to BDX-XL2. Removed “The test is ordered by a physician certified in the XL2 Certification and Training Registry (CTR), and • The following information is recorded: all clinical risk factors to calculate the Mayo, VA, and Brock cancer risk predictors; PET result (if used), physician pre-test risk assessment, physician post-test lung nodule management recommendation, any subsequent procedures (non-invasive or invasive), and clinical diagnosis based on those procedures (i.e., benign or malignant)” from the Coverage Summary section. Added additional data collected by Biodesix information to the Analysis of Evidence section. Changed the Level of evidence strength from Limited to Moderate. Added reference #18.</td>
<td>11/08/2018</td>
</tr>
<tr>
<td>MolDX: BDX-XL2</td>
<td>L37031</td>
<td>5</td>
<td>Corrected a typographical error in the Analysis of Evidence sentence, “This contractor recognizes that evidence of clinical utility for the (BDX-XL2) assay for ≥40 year old patients with an 8 to 30mm lung nodules and a pre-test cancer risk (as assessed by the Mayo Clinic Model for Solitary Pulmonary Nodules) of ≤50% is promising at the current time.” Previous versions indicated “≥40 year old patients” and “of ≤50%,” however in the last revision the “≤” and “≥” symbols were inadvertently replaced with “=.” Removed a reference to Xpresys and replaced it with BDX-XL2 in the Clinical Validation section.</td>
<td>11/22/2018</td>
</tr>
<tr>
<td>MolDX: BRCA1 and BRCA2 Genetic Testing</td>
<td>L36082</td>
<td>15</td>
<td>Added “1” in two bullet points under “Personal History of prostate cancer (Gleason score ≥7) at any age with:” where it was erroneously omitted: • ≥1 first, second, or third degree relative of pancreatic cancer at any age, or • ≥1 first, second, or third degree relative with metastatic prostate cancer at any age, or</td>
<td>11/22/2018</td>
</tr>
</tbody>
</table>
MolDX Local Coverage Determinations (LCDs) Article Updates

Revised ICD-10 LCD Article Updates
The table below provides a summary of recent Part A MolDX ICD-10 LCD article revisions/updates. To view these revised LCD articles, go to www.palmettogba.com/moldx. Select MolDX LCDs under the Topics section. Go to your state and select Active. Scroll down to the Final LCDs for Contractor Results section and make sure the Active LCDs category is selected. Scroll down to the Associated Documents section and access the link. Then select the Submit button. The LCDs are listed in alphabetical order.

<table>
<thead>
<tr>
<th>Title</th>
<th>LCD Article ID Number</th>
<th>Revision Number</th>
<th>Changes/Additions/Deletions</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influenza Diagnostic Tests</td>
<td>A54769</td>
<td>4</td>
<td>Removed “Test Selection” section from Article.</td>
<td>11/22/2018</td>
</tr>
</tbody>
</table>

RURAL HEALTH CLINIC (RHC) AND FEDERALLY QUALIFIED HEALTH CENTER (FQHC) INFORMATION

Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Medicare Benefit Policy Manual Chapter 13 Update
MLN Matters Number: MM11019
Related CR Release Date: December 7, 2018
Related CR Transmittal Number: R252BP
Related Change Request (CR) Number: 11019
Effective Date: January 1, 2019
Implementation Date: January 2, 2019

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

Provider Action Needed
CR 11019 informs MACs about the updates to Chapter 13 of the Medicare Benefit Policy Manual to clarify RHC and FQHC payment and other policy information. Make sure that your billing staffs are aware of these changes.

CPT codes, descriptors and other data only are copyright 2017 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.
Background
The 2019 update of the Medicare Benefit Policy Manual, Chapter 13 - Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services provides information on requirements and payment policies for RHCs and FQHCs, as authorized by Section 1861(aa) of the Social Security Act.

Chapter 13 of the Medicare Benefit Policy Manual has been revised to include payment policy for Care Management and Virtual Communication Services in RHCs and FQHCs as finalized in the CY 2019 Physician Fee Schedule (PFS) Final Rule. All other revisions serve to clarify existing policy.

Payment for General Care Management Services
Care management services are RHC and FQHC services and include Transitional Care Management (TCM), Chronic Care Management (CCM), general Behavioral Health Integration (BHI), and psychiatric Collaborative Care Model (CoCM) services. The RHC and FQHC face-to-face requirements are waived for these care management services. Effective January 1, 2017, care management services furnished by auxiliary personnel may be furnished under general supervision. (Note: General supervision does not require the RHC or FQHC practitioner to be in the same building or immediately available, but it does require the services to be furnished under the overall supervision and control of the RHC or FQHC practitioner.)

Except for TCM services, care management services are paid separately from the RHC All Inclusive Rate (AIR) or FQHC Prospective Payment System (PPS) payment methodology. RHCs and FQHCs may not bill for care management services for a beneficiary if another practitioner or facility has already billed for care management services for the same beneficiary during the same time period. RHCs and FQHCs may not bill for care management and TCM services, or another program that provides additional payment for care management services (outside of the RHC AIR or FQHC PPS payment), for the same beneficiary during the same time period.

Medicare pays for CCM services furnished between January 1, 2016, and December 31, 2017, based on the PFS national average non-facility payment rate when CPT code 99490 is billed alone or with other payable services on an RHC or FQHC claim.

Medicare pays for CCM or general BHI services furnished between January 1, 2018, and December 31, 2018, at the average of the national non-facility PFS payment rate for CPT codes 99490 (30 minutes or more of CCM services), 99487 (60 minutes or more of complex CCM services), and 99484 (20 minutes or more of general behavioral health integration services), when general care management HCPCS code G0511 is on an RHC or FQHC claim, either alone or with other payable services.

CCM or general BHI services furnished on or after January 1, 2019, are paid at the average of the national non-facility PFS payment rate for CPT codes 99490, 99487, 99484, and 99491(30 minutes or more of CCM furnished by a physician or other qualified health care professional), when general care management HCPCS code G0511 is on an RHC or FQHC claim, either alone or with other payable services. The payment rate for HCPCS code G0511 is updated annually based on the PFS amounts for these codes.

Coinsurance for care management services is 20 percent of the lesser of submitted charges or the payment rate for G0511. Care management costs are reported in the non-reimbursable section of the cost report and are not used in determining the RHC AIR or the FQHC PPS rate. G0511 can be billed once per month per
beneficiary when at least 20 minutes of CCM services or at least 20 minutes of general BHI services have been furnished and all other requirements have been met.

Only services furnished by an RHC or FQHC practitioner or auxiliary personnel that are within the scope of service elements can be counted toward the minimum 20 minutes that is required to bill for general care management services and does not include administrative activities such as transcription or translation services.

**Virtual Communications Services**

Virtual communication services are RHC and FQHC services and include communications-based technology and remote evaluation services. The RHC and FQHC face-to-face requirements are waived when these services are furnished to an RHC or FQHC patient.

Effective January 1, 2019, RHCs and FQHCs receive an additional payment for the costs of communication technology-based services or remote evaluation services that are not already captured in the RHC AIR or the FQHC PPS payment when the requirements for these services are met. Coinsurance and deductibles apply to RHC claims, and coinsurance applies to FQHC claims for these services.

RHCs and FQHCs must meet the following requirements to bill for virtual communication services:

- The RHC or FQHC must furnish at least 5 minutes of communications-based technology or remote evaluation services by an RHC or FQHC practitioner to a patient that has had a billable visit in the RHC or FQHC within the previous year.

- The medical discussion or remote evaluation is for a condition not related to an RHC or FQHC service provided within the previous 7 days, and does not lead to an RHC or FQHC service within the next 24 hours or at the soonest available appointment.

If the discussion between the patient and the RHC or FQHC practitioner is related to a billable visit furnished by the RHC or FQHC within the previous 7 days or within the next 24 hours or at the soonest available appointment, the cost of the RHC or FQHC practitioner’s time would be included in the RHC AIR or the FQHC PPS payment and is not separately billable.

Virtual communication services furnished by RHCs and FQHCs on or after January 1, 2019, are paid at the average of the national non-facility PFS payment rate for HCPCS code G2012 (communication technology-based services), and HCPCS code G2010 (remote evaluation services), when the virtual communication HCPCS code, G0071, is on an RHC or FQHC claim, either alone or with other payable services. The payment rate for HCPCS code G0071 is updated annually based on the PFS amounts for these codes.

**Additional Information**

SKILLED NURSING FACILITY (SNF) INFORMATION

New Medicare Webpage on Patient Driven Payment Model

MLN Matters Number: SE18026
Article Release Date: November 28, 2018
Related CR Transmittal Number: NA
Related Change Request (CR) Number: N/A
Effective Date: N/A
Implementation Date: N/A

Provider Type Affected
This MLN Matters® Special Edition (SE) article is intended for Skilled Nursing Facility (SNF) providers billing Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries using the Patient Driven Payment Model (PDPM).

Provider Action Needed
In this article, the Centers for Medicare & Medicaid Services (CMS) introduces SNF providers to a new Patient Driven Payment Model (PDPM) webpage that is now available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html.

This new webpage includes a variety of educational and training resources to assist you in preparing for PDPM implementation and this article contains a summary of some of these educational and training resources for your review.

You may refer to the PDPM webpage for more information from its Fact Sheets, Frequently Asked Questions, a PowerPoint training presentation, and other PDPM Resources.

Background
In July 2018, CMS finalized a new case-mix classification model, the PDPM, effective October 1, 2019, which Medicare will use under the SNF Prospective Payment System (PPS) for classifying SNF patients in a covered Part A stay. The PDPM represents a marked improvement over the Resource Utilization Groups, Version IV (RUG-IV) model by:

- Improving payment accuracy and appropriateness through focusing on the patient, rather than the volume of services provided
- Significantly reducing administrative burden on providers

If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.
• Improving SNF payments to currently underserved beneficiaries without increasing total Medicare payments

PDPM consists of five case-mix adjusted components, all based on data-driven, stakeholder-vetted patient characteristics, which are:

• Physical therapy (PT)
• Occupational therapy (OT)
• Speech-language pathology (SLP)
• Non-therapy ancillary (NTA) services
• Nursing

PDPM also includes a “variable per diem (VPD) adjustment” that adjusts the per diem rate over the course of the stay.

The new PDPM webpage at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html has links to new fact sheets with more information on the following topics:

• Administrative Level of Care Presumption under the PDPM
• PDPM Payments for SNF Patients with HIV/AIDS
• Concurrent and Group Therapy Limit
• PDPM Functional and Cognitive Scoring
• Interrupted Stay Policy
• Minimum Data Set (MDS) Changes
• Non-Therapy Ancillary (NTA) Comorbidity Score
• PDPM Patient Classification
• Variable Per Diem Adjustment

A comprehensive set of Frequently Asked Questions (FAQs) with answers is available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/PDPM_FAQ_Final.pdf.

The new PDPM webpage also has links to a PowerPoint presentation that gives a complete overview of the PDPM. The webpage also has links to more information on the following coding and classification topics:

• PDPM Classification Walkthrough
• PDPM GROUPEr Logic (SAS)
• ICD-10 Clinical Category Crosswalk
• ICD-10 NTA Comorbidity Crosswalk

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

Document History

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>November 28, 2018</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>

This advisory should be shared with all health care practitioners and managerial members of the provider/supplier staff. Medicare Advisories are available at no cost from the Palmetto GBA website at www.PalmettoGBA.com/jja.

Address Changes

Have you changed your address or other significant information recently? To update this information, please complete and submit a CMS 855A form. The most efficient way to submit your information is by Internet-based Provider Enrollment, Chain and Ownership System (PECOS). To make a change in your Medicare enrollment information via the Internet-based PECOS, go to https://pecos.cms.hhs.gov on the CMS website. To obtain the hard copy form plus information on how to complete and submit it – visit the Palmetto GBA website (www.PalmettoGBA.com/jja).
TOOLS THAT YOU CAN USE

Utilization of Lifetime Reserve Days Module

Lifetime Reserve (LTR) days are 60 additional days of coverage available to Medicare Part A beneficiaries who have exhausted their 90 regular coverage days (60 Full and 30 Coinsurance) during an inpatient hospital benefit period. LTR days can only be used once – they are not renewable.

To access this module and other online training courses, please go to the Self-Paced Learning Section (https://www.palmettogba.com/palmetto/providers.nsf/docsr/Providers~JJ%20Part%20A~Education~Self-Paced%20Learning) of the JJ Part A website.
Clinical Trials Coverage & Billing Module

The Clinical Trials Coverage & Billing module provides education on the following:

- Overview of policies
- UB-04 billing
- Humanitarian Device Exemption (HDE)

To access this module and other online training courses, please go to the Self-Paced Learning Section (https://www.palmettogba.com/palmetto/providers.nsf/docsr/Providers~JJ%20Part%20A~Education~Self-Paced%20Learning) of the JJ Part A website.
New Medicare Card Information

For more information about the new Medicare card, please go to the New Medicare cards Web Page on the CMS Website.

To access this page, copy and paste the following link in your browser:

### HELPFUL INFORMATION

**Contact Information for Palmetto GBA Part A**

<table>
<thead>
<tr>
<th>Department</th>
<th>Contact Information</th>
<th>Type of Inquiry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appeals</td>
<td>Palmetto GBA</td>
<td>• Request for Redeterminations</td>
</tr>
<tr>
<td></td>
<td>Part A Appeals - JJ</td>
<td>• Redetermination Form</td>
</tr>
<tr>
<td></td>
<td>Mail Code: AG-630</td>
<td></td>
</tr>
<tr>
<td></td>
<td>P.O. Box 100305</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Columbia, SC 29202-3305</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fax: (803) 870-0138</td>
<td></td>
</tr>
<tr>
<td></td>
<td>For Fed Ex/UPS/Certified Mail</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Palmetto GBA</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Part A Appeals - JJ</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mail Code: AG-630</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Building One</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2300 Springdale Drive</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Camden, SC 29020-3305</td>
<td></td>
</tr>
<tr>
<td>Checks For Overpayments</td>
<td>Palmetto GBA</td>
<td>• Overpayments</td>
</tr>
<tr>
<td></td>
<td>Medicare PartA Overpayments</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mail Code: AG-340</td>
<td>• Checks for cost report and credit balances</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 100277</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Columbia, SC 29202-3277</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Provider Inquiries:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>For inquiries regarding overpayments, please call the Provider Contact Center at</td>
<td></td>
</tr>
<tr>
<td></td>
<td>855-567-7271</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fax Numbers:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• To send any financial correspondence to the overpayment department by fax, please</td>
<td></td>
</tr>
<tr>
<td></td>
<td>fax this information to (803) 419-3275.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• To request an immediate offset, fax your request to (803) 462-2574.</td>
<td></td>
</tr>
<tr>
<td>Cost Report</td>
<td>Cost Report Filing</td>
<td></td>
</tr>
<tr>
<td>-------------</td>
<td>--------------------</td>
<td></td>
</tr>
<tr>
<td>Mailing Address</td>
<td>Palmetto GBA</td>
<td></td>
</tr>
<tr>
<td>Attn: Cost Report Acceptance</td>
<td>Mail Code: AG-390</td>
<td></td>
</tr>
<tr>
<td>P.O. Box 100307</td>
<td>Columbia, SC 29202-3307</td>
<td></td>
</tr>
<tr>
<td>Fed Ex/UPS/Certified Mail Address</td>
<td>Palmetto GBA</td>
<td></td>
</tr>
<tr>
<td>Attn: Cost Report Acceptance</td>
<td>Mail Code: AG-390</td>
<td></td>
</tr>
<tr>
<td>2300 Springdale Drive</td>
<td>Building One</td>
<td></td>
</tr>
<tr>
<td>Camden, SC 29020-1728</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost Report Overpayment Address</td>
<td>(checks only)</td>
<td></td>
</tr>
<tr>
<td>Palmetto GBA</td>
<td>JJA Checks</td>
<td></td>
</tr>
<tr>
<td>PO Box 100312</td>
<td>Columbia, SC 29202-3312</td>
<td></td>
</tr>
</tbody>
</table>

- Cost Reports
- Checks
<table>
<thead>
<tr>
<th>Credit Balance Reporting</th>
<th>Regular and Certified Mail Palmetto GBA, LLC Attn: Credit Balance Reporting Mail Code: AG-340 P.O. Box 100308 Columbia, SC 29202-3308 Fed Ex/UPS/Overnight Courier Palmetto GBA, LLC Attn: Credit Balance Reporting Mail Code: AG-340 2300 Springdale Drive Building One Camden, SC 29020-1728 Credit Balance Overpayment Address(checks only): Palmetto GBA, LLC Medicare Finance Mail Code: AG-260 P.O. Box 100312 Columbia, SC 29202-3312 Reports may be faxed to: MCBR Receipts Attn: Credit Balance Reporting (803) 870-0147 If you have questions about your Credit Balance Report, please call the Provider Contact Center at 877-567-7271.</th>
<th>• Questions or concerns regarding credit balance reports</th>
</tr>
</thead>
<tbody>
<tr>
<td>Customer Service Center (Beneficiary)</td>
<td>1-800-Medicare (1-800-633-4227) TTY: 877-486-2048 Visit the Medicare website at <a href="http://www.medicare.gov">www.medicare.gov</a></td>
<td>All questions related to the Medicare program</td>
</tr>
<tr>
<td>Electronic Data Interchange (EDI)</td>
<td>Email: <a href="mailto:Medicare.EDI@palmettogba.com">Medicare.EDI@palmettogba.com</a> Phone number: 877-567-7271</td>
<td>• EDI enrollment • Administrative Simplification and Compliance Act (ASCA) • Electronic Remittance Advice (ERA) • PC-ACE Pro 32 (billing software) • Direct Data Entry (billing software) • Other EDI-related issues</td>
</tr>
<tr>
<td>Medical Affairs</td>
<td>Palmetto GBA</td>
<td>Local coverage determinations (LCDs)</td>
</tr>
<tr>
<td>------------------------</td>
<td>------------------------------</td>
<td>-------------------------------------</td>
</tr>
<tr>
<td>Medical Affairs</td>
<td>Mail Code: AG-275</td>
<td></td>
</tr>
<tr>
<td>Mail Code: AG-275</td>
<td>P.O. Box 100305</td>
<td></td>
</tr>
<tr>
<td>Columbia, SC 29202-3305</td>
<td>Fax: (803) 870-0133</td>
<td></td>
</tr>
<tr>
<td>Send emails to <a href="mailto:A.Policy@palmettogba.com">A.Policy@palmettogba.com</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Review</td>
<td>Palmetto GBA</td>
<td>Responding to Additional Documentation Requests (ADRs)</td>
</tr>
<tr>
<td>Part A Medical Review</td>
<td>Mail Code: AG-230</td>
<td></td>
</tr>
<tr>
<td>Mail Code: AG-230</td>
<td>P.O. Box 100305</td>
<td></td>
</tr>
<tr>
<td>Columbia, SC 29202-3305</td>
<td>Please call the Provider</td>
<td></td>
</tr>
<tr>
<td>Contact Center (PCC)</td>
<td>at 877-567-7271 for Medical Review questions.</td>
<td></td>
</tr>
<tr>
<td>Fed Ex/UPS/Overnight Courier</td>
<td>Palmetto GBA</td>
<td></td>
</tr>
<tr>
<td>Mail Code: AG-230</td>
<td>2300 Springdale Drive,</td>
<td></td>
</tr>
<tr>
<td>Building One</td>
<td>Camden, SC 29020</td>
<td></td>
</tr>
<tr>
<td>Fax: (803) 870-0131</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare Secondary Payer (MSP)</td>
<td>For questions/concerns related to MSP records, contact the Benefits Coordination &amp; Recovery Center (BCRC) at: 855-798-2627 (TTY/TDD at 855-797-2627 for the hearing and speech impaired). Customer Service Representatives are available to provide you with quality service Monday through Friday from 8 a.m. to 8 p.m. ET, except holidays.</td>
<td>MSP questions</td>
</tr>
<tr>
<td>Mailing addresses are available on the CMS website.</td>
<td>Questions regarding beneficiary’s primary or secondary records</td>
<td></td>
</tr>
</tbody>
</table>
| Provider Audit | Palmetto GBA  
Provider Audit  
Mail Code: AG-390  
P.O. Box 100307  
Columbia, SC 29202-3307  
Palmetto GBA  
Cost Report Appeals and  
Reopenings  
Mail Code: AG-380  
P.O. Box 100307  
Columbia, SC 29202-3307  
Email:  
Filing of Cost Report Appeals  
JJAudit.Audit Appeal@  
PalmettoGBA.com  
Filing of Cost Report Reopenings  
JJAudit.Reopening@  
PalmettoGBA.com |
|---|---|
| • Issues related to cost reports, desk reviews, audits and settlements  
• Issues related to the filing of cost report appeals and reopenings |

| Provider Enrollment | Palmetto GBA  
Part A Provider Enrollment  
2300 Springdale Dr. Bldg. One  
Camden, SC 29020  
For inquiries regarding provider enrollment, please call the PCC at 877-567-7271. |
|---|---|
| • Enrollment (credentialing) questions  
• Request CMS-855 B, I or R forms  
• Change address, add a location or add a new member to a provider group  
• Independent Diagnostic Testing Facility (IDTF) enrollment  
• Electronic Funds Transfer (EFT) CMS 588 form  
• Medicare Participating Physician or Supplier Agreement (PAR) CMS 460 form  
• How to obtain a National Provider Identifier (NPI)  
• Participation corrections  
• IRS 1099 tax form corrections  
• Consent forms |
| Provider Outreach and Education (POE) | Palmetto GBA  
Part A POE  
Mail Code: AG-830  
P.O. Box 100238  
Columbia, SC 29202-3238  
For education, please complete the Education Request Form. To access this document, go to the Forms Web page at [www.PalmettoGBA.com/jj/forms](http://www.PalmettoGBA.com/jj/forms) | • Educational training requests  
• Request a speaker for association meetings in your state |
|---|---|---|
| Provider Reimbursement | Part A Provider Reimbursement  
Mail Code: AG-390  
P.O. Box 100307  
Columbia, SC 29202-3307  
Fax updated certificates for diabetes education, mammography and PET scan to the reimbursement department at (803) 935-0262. | • Submission of interim rate information  
• Reimbursement issues  
• Reimbursement specialist  
• Submission of certificates |
| Southeastern Unified Program Integrity Contractor (SE UPIC) | Safeguard Services (SGS)-A CMS Unified Program Integrity Contractor  
3450 Lakeside Drive, Suite 201  
Miramar, FL 33027  
Phone Number: (954) 988-2851  
Website: [www.safeguard-servicesllc.com](http://www.safeguard-servicesllc.com) | • Fraud  
• Abuse  
• Questionable billing practices |