What’s Inside...

MLN Connects ........................................................................................................................................3
Weekly Articles .......................................................................................................................................3

Special Edition Articles
Public Comments on New Product Categories for DMEPOS ..........................................................3
Competitive Bidding ............................................................................................................................3
Medicare FFS Response to the 2018 Alaska Earthquake MLN Matters Article — New .........................4

Home Health and Hospice Information .................................................................................................4
Annual Update to the Per-Beneficiary Therapy Amounts .................................................................4
Implementation of a Bundled Payment for Multi-Component Durable Medical Equipment (DME) ..............................................................6
New Medicare Beneficiary Identifier (MBI) Get It, Use It ..................................................................8
Medicare Beneficiary Identifier (MBI) Look-up Tool ........................................................................12
Help Us Improve/Enhance Our Website .............................................................................................14
Get Your Medicare News Electronically ............................................................................................16
Medicare Learning Network® (MLN) ..................................................................................................16

Applies Information .............................................................................................................................17
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 .................................................................17

Fee Schedule Information ..................................................................................................................18
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 ...........................................................................................................18
Calendar Year (CY) 2019 Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule .................................................................................................................................23

Hurricane Florence and Michael Information ......................................................................................32
Hurricane Florence and Medicare Disaster Related North Carolina, South Carolina, and the Commonwealth of Virginia Claims .................................................................................................................................32
Hurricane Michael and Medicare Disaster Related Florida and Georgia Claims ..................................37

Influenza (Flu) Vaccine Information .....................................................................................................42
Quarterly Influenza Virus Vaccine Code Update - January 2019 .........................................................42

The JM HHH Medicare Advisory contains coverage, billing and other information for Jurisdiction M HHH. This information is not intended to constitute legal advice. It is our official notice to those we serve concerning their responsibilities and obligations as mandated by Medicare regulations and guidelines. This information is readily available at no cost on the Palmetto GBA website. It is the responsibility of each facility to obtain this information and to follow the guidelines. The JM HHH 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.

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Upcoming Home Health and Hospice Educational Events

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

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 44 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) 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.

HOME HEALTH AND HOSPICE INFORMATION

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>
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<td>December 4, 2018</td>
<td>Initial article released.</td>
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Implementation of a Bundled Payment for Multi-Component Durable Medical Equipment (DME)

MLN Matters Number: MM10854
Related CR Release Date: November 21, 2018
Related CR Transmittal Number: R2206OTN
Related Change Request (CR) Number: 10854
Effective Date: January 1, 2019
Implementation Date: January 7, 2019

Provider Types Affected
This MLN Matters® Article is intended for suppliers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) who submit claims to the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for services to Medicare beneficiaries.

Provider Action Needed
CR 10854 informs providers that the Centers for Medicare & Medicaid Services (CMS) is implementing a special payment rule and a new Healthcare Common Procedure Coding System (HCPCS) code E0467 for a multi-function ventilator under the frequent and substantial servicing DME payment category. Make certain your billing staffs are aware of these changes.

Background
Under Medicare, ventilators fall under the frequent and substantial servicing DME payment category described in Section 1834(a)(3) of the Social Security Act. Payment for items falling under the frequent and substantial servicing payment category is made on a monthly rental basis until medical necessity ends and includes payment for all related accessories necessary for the effective use of the equipment. Recently, the Food & Drug Administration (FDA) cleared a new type of ventilator that integrates multiple therapies into a single device for ventilator-dependent patients. This new multi-function ventilator can also function as an oxygen concentrator, cough stimulator, aspirator and nebulizer. The multi-function ventilator replaces the multiple stand-alone devices (for example, a separate ventilator, oxygen concentrator, and so forth) that beneficiaries may need over time. CMS added a special payment rule to the regulations at 42 CFR 414.222 to address payment for this new type of multi-function ventilator.

CR10854 instructs MACs to deny claims that are:

• Submitted on the same claim or that overlap any dates of service for the new multi-function ventilator for same or similar items (for example, oxygen and oxygen equipment, nebulizers and related accessories, aspirators and related accessories, or cough stimulators and related accessories) if furnished on or after the date that the multi-function ventilator is furnished.

• For the new multi-function ventilator when the beneficiary owns any of the same or similar equipment, or has reached the 36-month cap for oxygen equipment, for equipment which has not reached the end of its reasonable useful lifetime.
Effective January 1, 2019, HCPCS code E0467 was established to describe the multi-function ventilator along with a single fee schedule amount under the frequent and substantial servicing payment category. The new multi-function ventilator policy and HCPCS code applies to beneficiaries who are prescribed and meet the medical necessity coverage criteria for a ventilator and at least one of the four additional functions (oxygen concentrator, cough stimulator, suction pump and nebulizer). If a claim is received for the rental of a multi-function ventilator under the HCPCS code E0467, claims for the rental of separate stand-alone devices and related accessories will be denied, if it is billed during a rental month of a paid separate stand-alone rental device and the date of service is on or after that of the separate stand-alone rental device. Only one item may be paid during a rental month and payment will be made for the earliest dated item billed. The separate stand-alone rental devices and accessories that are integrated into the multi-function ventilator or which represent similar equipment used for the same purpose that should be denied if billed in conjunction with the new multi-function ventilator code are:

- Nebulizers and related accessories (HCPCS codes E0565, E0570, E0572, E0585, A4619, A7003, A7004, A7005, A7006, A7007, A7012, A7013, A7014, A7015, A7017, A7525, and E1372)
- Aspirator and related accessories (HCPCS codes E0600, A4216, A4217, A4605, A4624, A4628, A7000, A7001, A7002, and A7047)
- Cough Stimulator, High Frequency Chest Wall Oscillation, Oscillatory Positive Expiratory Pressure and related accessories (HCPCS codes E0482, A7020, E0483, A7025, A7026 and E0484)
- Continuous Positive Airway Pressure (CPAP) and Respiratory Assist Devices (RADs) and related accessories (HCPCS codes E0601, E0470, E0471, E0472, A4604, A7027, A7028, A7029, A7030, A7031, A7032, A7033, A7034, A7035, A7036, A7037, A7038, A7039, A7044, A7045, A7046, E0561, and E0562)
- Oral appliance (HCPCS code E0486)
- Ventilators (HCPCS codes E0465 and E0466)

In addition, any claim for repair (HCPCS code K0739 for labor and any HCPCS code for replacement parts) of beneficiary-owned equipment identified by HCPCS codes E0482, E0565, E0570, E0572, E0585, or E0600 will be denied if the dates of service for the repair service overlaps any dates of service for the multi-function ventilator.

MACs will use the following messages when denying claims submitted with same or similar HCPCS as the HCPCS E0467 multi-function ventilator:

- Claim Adjustment Reason Code (CARC) 151: Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.
- Remittance Advice Remark Code (RARC) M3: Equipment is the same or similar to equipment already being used.
• Claim Adjustment Group Code - CO (Contractual Obligation)

Additional Information

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

Document History

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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.

**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](http://go.cms.gov/MAC-website-list).


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

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• To meet our CAPTCHA requirements, you must select the I’M NOT A ROBOT checkbox

• Click SUBMIT INQUIRY

**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

*Required Field

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**

*Lookup Status: MBI: 0X00XX0XX00

Submit Inquiry  Clear

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.

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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-jm
Tell us what you liked!

We want to hear from you!
Thanks for visiting the JM section of Palmetto GBA. You have been selected to participate in a brief survey to help us improve your browsing experience. It will only take you a couple of minutes to complete and will appear at the conclusion of your visit.

No, thanks

Yes, I'll give feedback

This survey is conducted by an independent company, ForeSee, on behalf of Palmetto GBA.
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: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/index.html

- MLN Catalog: is a free interactive downloadable document that lists all MLN products by media format. To access the catalog, scroll to the “Downloads” section and select “MLN Catalog.” Once you have opened the catalog, you may either click on the title of a product or you can click on the type of “Formats Available.” This will link you to an online version of the product or the Product Ordering Page.
• MLN Product Ordering Page: allows you to order hard copy versions of various products. These products are available to you for free. To access the MLN Product Ordering Page, scroll to the “Related Links” and select “MLN Product Ordering Page.”

• MLN Product of the Month: highlights a Medicare provider education product or set of products each month along with some teaching aids, such as crossword puzzles, to help you learn more while having fun!

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

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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.

### 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](http://go.cms.gov/MAC-website-list).

### Document History

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
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<tbody>
<tr>
<td>December 3, 2018</td>
<td>Initial article released.</td>
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### 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 Section1834 (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](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](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](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

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WA $25.01  $34.28  $40.73  
WI $15.70  $23.37  $31.77  
WV $15.70  $23.37  $31.77  
WY $21.90  $31.19  $44.29

Additional Information

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

Document History

<table>
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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](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.


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.


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<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 Florida.
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.

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.

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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.

**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.

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**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**

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

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**LEARNING AND EDUCATION INFORMATION**

**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

**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.

| Medical Review Hot Topic Targeted Probe and Educate Teleconference          |
|-----------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Date                        | March 4, 2019 | June 3, 2019 | September 3, 2019 | December 2, 2019 |
| Time                        | 2:00 p.m. -  | 2:00 p.m. -  | 2:00 p.m. -      | 2:00 p.m. -      |
| Participation Number        | (877) 789-3907 | (877) 789-3907 | (877) 789-3907 | (877) 789-3907 |
| Confirmation ID Number      | 8778149      | 1291838      | 5369828          | 6879568          |

This schedule is also available on the Palmetto GBA Event Registration Portal at https://www.palmettogba.com/event/pgbaevent.nsf/SeriesDetails.xsp?EventID=B74TM73304

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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/DocsCat/JM-Home-Health-and-Hospice~AH2JQU8321

| 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 1-855-696-0705.

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/hhh.

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](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/hhh](http://www.PalmettoGBA.com/hhh)).


**TOOLS THAT YOU CAN USE**

**Limitations on the Recoupment of Medicare Overpayments Web Based Training**

To access this module and other online training courses, please go to the Self-Paced Learning Section ([https://www.palmgba.com/elearn/limits_on_recoups/ie7/index.html?dhtmlActivation=inplace](https://www.palmgba.com/elearn/limits_on_recoups/ie7/index.html?dhtmlActivation=inplace)) of the JJM HHH website.

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Limitations on the Recoupment of Medicare Overpayments

Start

Revised 02.27.17
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 Home Health and Hospice*

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<td></td>
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<td></td>
<td>Columbia, SC 29202-3238</td>
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<tr>
<td></td>
<td>2300 Springdale Drive</td>
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<tr>
<td></td>
<td>Camden, SC 29020</td>
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<td>• Explanation of denial reasons</td>
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<td>Columbia, SC 29202-3238</td>
<td>• IVR resources</td>
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<td>Provider Contact Center: 855-696-0705</td>
<td>• MSP resources</td>
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<td>Our PCC representatives are ready to answer your questions about billing problems and other issues. Please see the following links for more guidance about the HHH Interactive Voice Response (IVR) and contacting the Contact Center:</td>
<td>• Modifier guidelines</td>
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<tr>
<td></td>
<td>IVR Conversion Tool</td>
<td></td>
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<td></td>
<td><strong>HHH PCC Hours:</strong> 8 a.m. to 5 p.m. ET</td>
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<td><a href="mailto:Email%20HHH">Email HHH</a> to have your inquiry answered. Please do not include any Protected Health Information.</td>
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| Fed Ex/UPS/Certified Mail Address | Palmetto GBA  
Attn: Cost Report Acceptance  
Mail Code: AG-330  
2300 Springdale Drive  
Building One  
Camden, SC 29020-1728 |
| Cost Report Overpayments Address (checks only) | Palmetto GBA  
Medicare Finance  
Mail Code: AG-260  
P.O. Box 100277  
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| Fed Ex/UPS/Overnight Courier | Palmetto GBA  
Credit Balance Reporting  
2300 Springdale Drive  
Building One  
Camden, SC 29020 |
| Reports may be faxed to: | MCBR Receipts  
Attn: Credit Balance Reporting  
(803) 419-3277 |
|  | If you have questions about your Credit Balance Report,  
|  | please call the Provider Contact Center at: 855-696-0705.  
|  | All email inquiries may be sent to: Credit.Balance@PalmettoGBA.com |

| Customer Service Center (Beneficiary) | 1-800-Medicare (1-800-633-4227)  
TTY: 877-486-2048  
Visit the Medicare website at www.medicare.gov.  
| All questions related to the Medicare Program  |

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<table>
<thead>
<tr>
<th>Electronic Data Interchange (EDI)</th>
<th>Email: <a href="mailto:EDIPartA.ENROLL@PalmettoGBA.com">EDIPartA.ENROLL@PalmettoGBA.com</a></th>
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</thead>
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<tr>
<td>Provider Contact Center: 855-696-0705</td>
<td>• EDI enrollment</td>
</tr>
<tr>
<td></td>
<td>• Administrative Simplification and Compliance Act (ASCA)</td>
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<td></td>
<td>• Electronic Remittance Advice (ERA)</td>
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<td></td>
<td>• PC-ACE Pro 32 (billing software)</td>
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<td></td>
<td>• Direct Data Entry (billing software)</td>
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<td>• Other EDI-related issues</td>
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| DDE Hours of Availability | • Monday to Friday 6 am - 8 pm ET |
|                          | • Saturday 6 am - 4 pm ET |
|                          | • Sunday: Not Available |

<table>
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<tr>
<th>Financial correspondence with/without checks</th>
<th>Palmetto GBA</th>
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<tbody>
<tr>
<td></td>
<td>PO Box 100277</td>
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<td></td>
<td>Columbia, SC 29202</td>
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<table>
<thead>
<tr>
<th>Freedom of Information Act (FOIA) Requests</th>
<th>Palmetto GBA – HHH</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>FOIA Coordinator</td>
</tr>
<tr>
<td></td>
<td>Mail Code: AG-840</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 100190</td>
</tr>
<tr>
<td></td>
<td>Columbia, SC 29202-3190</td>
</tr>
<tr>
<td></td>
<td>Email: <a href="mailto:FOIA@PalmettoGBA.com">FOIA@PalmettoGBA.com</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medical Affairs</th>
<th>Palmetto GBA</th>
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<tbody>
<tr>
<td>Medical Affairs</td>
<td>Mail Code: AG-275</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 100238</td>
</tr>
<tr>
<td></td>
<td>Columbia, SC 29202-3238</td>
</tr>
<tr>
<td></td>
<td>Fax: 803-462-2652</td>
</tr>
<tr>
<td></td>
<td>Email: <a href="mailto:a.policy@palmettogba.com">a.policy@palmettogba.com</a></td>
</tr>
</tbody>
</table>

| Medical Affairs | • Local coverage determinations (LCDs) |

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| Medical Review | Palmetto GBA  
|                | HHH Medical Review  
|                | Mail Code: AG-230  
|                | P.O. Box 100238  
|                | Columbia, SC 29202-3238  
|                |  
|                | Please call the Provider Contact Center (PCC) at 855-696-0705 for Medical Review questions.  
| Fed Ex/UPS/Overnight Courier | Palmetto GBA  
|                | Mail Code: AG-230  
|                | 2300 Springdale Drive, Building One  
|                | Camden, SC 29020  
|                | Fax: (803) 699-2436  
|                |  
| Medicare Secondary Payer (MSP) | Palmetto GBA  
|                | Mail Code: AG-230  
|                |  
|                | For questions/concerns related to MSP records, contact the Benefits Coordination & 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.  
|                | Mailing addresses are available on the [CMS website](https://www.cms.gov).  
| Provider Inquiries | Palmetto GBA  
|                | Mail Code: AG-340  
|                | P.O. Box 100277  
|                | Columbia, SC 29202-3277  
|                |  
|                | For inquiries regarding overpayments, please call the Provider Contact Center at 855-696-0705.  
| Fax Numbers |  
|                | • To send any financial correspondence to the overpayment department by fax, please fax this information to (803) 419-3275  
|                | • To request an immediate offset, fax your request to (803) 462-2574  
|                |  
| Overpayments | Palmetto GBA  
|                | HHH Overpayments  
|                | Mail Code: AG-340  
|                | P.O. Box 100277  
|                | Columbia, SC 29202-3277  
|                |  
|                | • Overpayments  
|                | • Checks for cost reports and credit balances  
|                |  
|                |  
|                | • Responding to Additional Documentation Requests (ADRs)  
|                | • Responses to our requests for medical records  

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| Provider Audit | Palmetto GBA  
Provider Audit  
Mail Code: AG-320  
P.O. Box 100144  
Columbia, SC 29202-3144 | • Issues related to cost reports, desk reviews, audits and settlements  
• Issues related to the filing of cost report appeals and reopenings |
| --- | --- | --- |
|  | Palmetto GBA  
Cost Report Appeals and Reopenings  
Mail Code: AG-380  
P.O. Box 100144  
Columbia, SC 29202-3144 |  |
|  | Email:  
Filing of Cost Report Appeals  
CostReport.Appeals@PalmettoGBA.com  
Filing of Cost Report Reopenings  
CostReport.Reopening@PalmettoGBA.com |  |
| Provider Enrollment | Palmetto GBA  
HHH Provider Enrollment  
Mail Code: AG-331  
P.O. Box 100144  
Columbia, SC 29202-3144 | • Enrollment (credentialing) questions  
• Request CMS-855 B, I or R forms  
• Change address, add a location, 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 |
|  | For inquiries regarding provider enrollment, please call the Provider Contact Center at 855-696-0705. |  |
| Provider Outreach and Education (POE) | Palmetto GBA  
HHH 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/hhh/forms](http://www.PalmettoGBA.com/hhh/forms). | • Educational training requests  
• Request a speaker for association meetings in your state |
| Provider Reimbursement | Palmetto GBA  
Provider Reimbursement  
Mail Code: AG-330  
P.O. Box 100144  
Columbia, SC 29202-3144  

Provider inquiries, please call (803) 382-6104.  

Fax updated certificates for diabetes education to the reimbursement department at (803) 935-0262. | • Submission of interim rate information  
• Reimbursement issues  
• Reimbursement specialist  
• Submission of certificates |
| Unified Program Integrity Contractor (UPIC) | **Alabama, Arkansas, Georgia, Louisiana, Mississippi, North Carolina, South Carolina and Tennessee home health and hospice providers**  
AdvanceMed, an NCI Company  
520 Royal Parkway, Suite 100  
Nashville, TN 37214  
Website: [www.nciinc.com/about-us/advancemed](http://www.nciinc.com/about-us/advancemed)  
Phone Number: (615) 871-2361  

**New Mexico, Oklahoma and Texas home health and hospice providers**  
Health Integrity, LLC  
Website: [www.healthintegrity.org](http://www.healthintegrity.org)  
Phone Number: (972) 383-0000  

**Florida home health and hospice providers**  
Safeguard Services (SGS)  
Website: [http://www.safeguard-servicesllc.com/](http://www.safeguard-servicesllc.com/)  
Phone Number: (954) 624-3999 | • Fraud  
• Abuse  
• Questionable billing practices |