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

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

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CMS Quarterly Provider Update

The Quarterly Provider Update is a comprehensive resource published by the Centers for Medicare & Medicaid Services (CMS) on the first business day of each quarter. It is a listing of all non-regulatory changes to Medicare including program memoranda, manual changes and any other instructions that could affect providers. Regulations and instructions published in the previous quarter are also included in the update. The purpose of the Quarterly Provider Update is to:

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

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

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

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

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

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

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

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

- Medicare incentive programs
- 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](http://tinyurl.com/PalmettoGBAListserv) and select “Register Now.” Complete and submit the online form. Be sure to select the specialties that interest you so information can be sent.

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

We’d Love Your Feedback!

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

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

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

MLN Educational Products Electronic Mailing List

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

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

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

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Next Generation Accountable Care Organization (NGACO)
Year Three Benefit Enhancements

MLN Matters Number: MM10044
Related Change Request (CR) Number: 10044
Related CR Release Date: August 4, 2017
Effective Date: January 1, 2018
Related CR Transmittal Number: R177DEMO
Implementation Date: January 2, 2018

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

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

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

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

Asynchronous Telehealth
CMS is expanding the current telehealth waiver to include asynchronous (also known as “storeand-forward”) telehealth in the specialties of teledermatology and teleophthalmology. Asynchronous telehealth includes the transmission of recorded health history (for example, retinal scanning and digital images) through a secure electronic communications system to a practitioner, usually a specialist, who uses the information to evaluate the case or render a service outside of a real-time interaction. Asynchronous telecommunications system in single media format does not include telephone calls, images transmitted via facsimile machines, and text messages without visualization of the patient (electronic mail). Photographs must be specific to the patients’ condition and adequate for rendering or confirming a diagnosis or treatment plan.

Payment will be permitted for telemedicine when asynchronous telehealth in single or multimedia formats, is used as a substitute for an interactive telecommunications system for dermatology and opthalmology services.

Continued >>
Distant site practitioners will bill for these new services using new codes, and the distant site practitioner must be an NGACO Participant or Preferred Provider.

**Asynchronous Telehealth Based on Intra-Service + 5 Minutes Post-Service Time**

- Code 1: G9868 – Receipt and analysis of remote, asynchronous images for dermatologic and/or ophthalmologic evaluation, for use under the Next Generation ACO model, less than 10 minutes.
- Code 2: G9869 – Receipt and analysis of remote, asynchronous images for dermatologic and/or ophthalmologic evaluation, for use under the Next Generation ACO model, 10-20 minutes.
- Code 3: G9870 – Receipt and analysis of remote, asynchronous images for dermatologic and/or ophthalmologic evaluation, for use under the Next Generation ACO model, 20 or more minutes.

**ADDITIONAL INFORMATION**


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Suppression of the Standard Paper Remittance Advice (SPR) in 45 days if also Receiving Electronic Remittance Advice (ERA)

MLN Matters Number: MM10151
Related CR Release Date: August 4, 2017
Related CR Transmittal Number: R1890OTN
Related Change Request (CR) Number: 10151
Effective Date: January 1, 2018
Implementation Date: January 2, 2018

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

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

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

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


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ADDITIONAL INFORMATION

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eServices Eligibility

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

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

For more information about eServices and the many services it offers, please visit our website at http://www.PalmettoGBA.com/eServices.

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Claim Status Category and Claim Status Codes Update

MLN Matters Number: MM10132
Related Change Request (CR) Number: 10132
Related CR Release Date: August 18, 2018
Effective Date: January 1, 2018
Related CR Transmittal Number: R3839CP
Implementation Date: January 2, 2018

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

PROVIDER ACTION NEEDED
Change Request (CR) 10132 updates, as needed, the Claim Status and Claim Status Category Codes used for the Accredited Standards Committee (ASC) X12 276/277, Health Care Claim Status Request and Response and ASC X12 277 Health Care Claim Acknowledgment transactions. Make sure your billing staffs are aware of these updates.

BACKGROUND
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires all covered entities to use only Claim Status Category Codes and Claim Status Codes approved by the National Code Maintenance Committee in the ASC X12 276/277 Health Care Claim Status Request and Response transaction standards adopted under HIPAA for electronically submitting health care claims status requests and responses. These codes explain the status of submitted claim(s). Proprietary codes may not be used in the ASC X12 276/277 transactions to report claim status.

The National Code Maintenance Committee meets at the beginning of each ASC X12 trimester meeting, held each year in January or February, June, and in September or October. At these meetings, the Committee makes decisions about additions, modifications, and retirement of existing codes. The Committee has decided to allow the industry 6 months for implementation of newly added or changed codes.

The code sets are available at http://www.wpc-edi.com/reference/codelists/healthcare/claimstatus-category-codes/ and http://www.wpc-edi.com/reference/codelists/healthcare/claim-statuscodes/. Included in the code lists are specific details, including the date when a code was added, changed, or deleted.

All code changes approved during the September/October 2017 Committee meeting shall be posted on the above websites on or about November 1, 2017.

The Centers for Medicare & Medicaid Services (CMS) will issue instructions to the MACs who then must update their claims systems to ensure that the current version of these codes is used in their claim status responses.

Continued >>

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These code changes are to be used in editing of all ASC X12 276 transactions processed on or after the date of implementation and to be reflected in the ASC X12 277 transactions issued on and after the date of implementation of CR10132. References in CR10132 to “277 responses,” and “claim status responses,” encompass both the ASC X12 277 Health Care Claim Status Response and the ASC X12 277 Healthcare Claim Acknowledgment transactions.

ADDITIONAL INFORMATION

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Prohibition on Billing Dually Eligible Individuals Enrolled in the Qualified Medicare Beneficiary (QMB) Program

MLN Matters® Number: SE1128
Revised Related Change Request (CR) #: N/A
Release Date of Revised Article: August 23, 2017
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

Note: This article was revised on August 23, 2017, to highlight upcoming system changes that identify the QMB status of beneficiaries and exemption from Medicare cost-sharing, recommend key ways to promote compliance with QMB billing rules, and remind certain types of providers that they may seek reimbursement for unpaid deductible and coinsurance amounts as a Medicare bad debt.

Provider Types Affected
This article pertains to all Medicare physicians, providers and suppliers, including those serving beneficiaries enrolled in Original Medicare or a Medicare Advantage (MA) plan.

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

Look for new information and messages in CMS’ HIPAA Eligibility Transaction System (HETS) and the Provider Remittance Advice (RA) to identify patients’ QMB status and exemption from cost-sharing prior to billing. If you are an MA provider, contact the MA plan for more information about verifying the QMB status of plan members.

Implement key measures to ensure compliance with QMB billing requirements. Ensure that billing procedures and third-party vendors exempt individuals enrolled in the QMB program from Medicare charges. If you have erroneously billed an individual enrolled in the QMB program, recall the charges (including referrals to collection agencies) and refund the invalid charges he or she paid. For information about obtaining payment for Medicare cost-sharing, contact the Medicaid agency in the States in which you practice. Refer to the Background and Additional Information Sections below for further details and important steps to promote compliance.

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

Continued >>
Billing of QMBs Is Prohibited by Federal Law

Federal law bars Medicare providers and suppliers from billing an individual enrolled in the QMB program for Medicare Part A and Part B cost-sharing under any circumstances (see Sections 1902(n)(3)(B), 1902(n)(3)(C), 1905(p)(3), 1866(a)(1)(A), and 1848(g)(3)(A) of the Social Security Act [the Act]). The QMB program is a State Medicaid benefit that assists low-income Medicare beneficiaries with Medicare Part A and Part B premiums and cost-sharing, including deductibles, coinsurance, and copays. In 2015, 7.2 million individuals (more than one out of 10 beneficiaries) were enrolled in the QMB program. See the chart at the end of this article for more information about the QMB benefit.

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

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

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

Inappropriate Billing of QMB Individuals Persists

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

Ways to Promote Compliance with QMB Billing Rules

Take the following steps to ensure compliance with QMB billing prohibitions:
1. Establish processes to routinely identify the QMB status of your Medicare patients prior to billing for items and services.
   • Beginning November 4, 2017, providers and suppliers can use Medicare eligibility data provided to Medicare providers, suppliers, and their authorized billing agents (including clearinghouses and third party vendors) by CMS’ HETS to verify a patient’s QMB status and exemption from cost-sharing charges. For more information on HETS, see https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/index.html.
   • Starting October 3, 2017, original Medicare providers and suppliers can readily identify the QMB status of patients and billing prohibitions from the Medicare Provider RA, which will contain new

Continued >>

• MA providers and suppliers should also contact the MA plan to learn the best way to identify the QMB status of plan members.

• Providers and suppliers may also verify a patient’s QMB status through State online Medicaid eligibility systems or other documentation, including Medicaid identification cards and documents issued by the State proving the patient is enrolled in the QMB program.

2. Ensure that billing procedures and third-party vendors exempt individuals enrolled in the QMB program from Medicare charges and that you remedy billing problems should they occur. If you have erroneously billed an individual enrolled in the QMB program, recall the charges (including referrals to collection agencies) and refund the invalid charges he or she paid.

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

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

• Understand the processes you need to follow to request payment for Medicare cost-sharing amounts if they are owed by your State. You may need to complete a State Provider Registration Process and be entered into the State payment system to bill the State.

Important Reminders Concerning QMB Billing Requirements
Be aware of the following policy clarifications on QMB billing requirements:

1. All original Medicare and MA providers and suppliers—not only those that accept Medicaid—must abide by the billing prohibitions.

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

3. Note that individuals enrolled in QMB cannot choose to “waive” their QMB status and pay Medicare cost-sharing. The Federal statute referenced above supersedes Section 3490.14 of the State Medicaid Manual, which is no longer in effect.

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QMB Eligibility and Benefits

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<tr>
<th>Program</th>
<th>Income Criteria*</th>
<th>Resources Criteria*</th>
<th>Medicare Part A and Part B Enrollment</th>
<th>Other Criteria</th>
<th>Benefits</th>
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<tr>
<td>QMB Only</td>
<td>≤100% of FPL</td>
<td>≤3 times SSI resource limit, adjusted annually in accordance with increases in Consumer Price Index</td>
<td>Part A***</td>
<td>Not Applicable</td>
<td>• Medicaid pays for Part A (if any) and Part B premiums, and may pay for deductibles, coinsurance, and copayments for Medicare services furnished by Medicare providers to the extent consistent with the Medicaid State Plan (even if payment is not available under the State plan for these charges, QMBs are not liable for them)</td>
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| QMB Plus           | ≤100% of FPL     | Determined by State  | Part A***                             | Meets financial and other criteria for full Medicaid benefits | • Full Medicaid coverage
• Medicaid pays for Part A (if any) and Part B premiums, and may pay for deductibles, coinsurance, and copayments to the extent consistent with the Medicaid State Plan (even if payment is not available under the State plan for these charges, QMBs are not liable for them) |

* States can effectively raise these Federal income and resources criteria under Section 1902(r)(2) of the Act at [https://www.ssa.gov/OP_Home/ssact/title19/1902.htm](https://www.ssa.gov/OP_Home/ssact/title19/1902.htm).

*** To qualify as a QMB or a QMB plus, individuals must be enrolled in Part A (or if uninsured for Part A, have filed for premium-Part A on a “conditional basis”). For more information on this process, refer to Section

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Additional Information

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<td>August 23, 2017</td>
<td>The article was revised to highlight upcoming system changes that identify the QMB status of beneficiaries and exemption from Medicare cost-sharing, recommend key ways to promote compliance with QMB billing rules, and remind certain types of providers that they may seek reimbursement for unpaid deductible and coinsurance amounts as a Medicare bad debt.</td>
</tr>
<tr>
<td>May 12, 2017</td>
<td>This article was revised on May 12, 2017, to modify language pertaining to billing beneficiaries enrolled in the QMB program. All other information is the same.</td>
</tr>
<tr>
<td>January 12, 2017</td>
<td>This article was revised to add a reference to MLN Matters article MM9817 (<a href="https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9817.pdf">https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9817.pdf</a>), which instructs Medicare Administrative Contractors to issue a compliance letter instructing named providers to refund any erroneous charges and recall any existing billing to QMBs for Medicare cost sharing.</td>
</tr>
<tr>
<td>February 4, 2016</td>
<td>The article was revised on February 4, 2016, to include updated information for 2016 and a correction to the second sentence in paragraph 2 under Important Clarifications Concerning QMB Balance Billing Law on page 3.</td>
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<tr>
<td>February 1, 2016</td>
<td>The article was revised to include updated information for 2016 and a clarifying note regarding eligibility criteria in the table on page 4.</td>
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<tr>
<td>March 28, 2014</td>
<td>The article was revised on to change the name of the Coordination of Benefits Contractor (COBC) to BCRC.</td>
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A Physician’s Guide to Medicare Part D Medication Therapy Management (MTM) Programs

MLN Matters® Number: SE1229
Revised Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

Note: This article was revised on August 24, 2017, to provide updated information, primarily in the new “Part D Enhanced Medication Therapy Management Model” section on page 5. All other information is unchanged.

Provider Types Affected
This MLN Matters® Article Special Edition about Medication Therapy Management (MTM) services is intended for physicians, pharmacists, nurses, and other health care providers who treat Medicare beneficiaries with Part D coverage.

Provider Action Needed
This MLN release is intended to make you aware of Medicare Part D MTM programs that will affect your patients, and introduce you to three MTM forms that your patients are likely to share with you.

Your patients may ask you if they would benefit from MTM services. If you have patients enrolled in Part D MTM programs, you may also be contacted by MTM providers who are required to monitor patients’ medication therapies from all their health care providers. This may result in recommendations that are shared with you about unsafe or dangerous interactions and therapeutic alternatives. Your patients may also receive recommendations about how to use their medications properly.

MTM Providers Are Important Partners with You
MTM providers work with physicians to deliver the best medication therapy to patients and to coordinate their medication therapy across multiple practitioners. The latest clinical information is used by MTM providers when reviewing patients’ medication therapy, such as updates to the Beers criteria for high-risk medications and revised monographs for old and new medications. MTM providers also listen to patients’ concerns about their medications and may offer recommendations to physicians and patients to help achieve their goals of therapy. As always, physicians make the final decisions about changes in drug therapy.

When Will MTM Providers Contact You?
Your patients enrolled in MTM may receive an interactive comprehensive medication review (CMR) any time during the year.

- The MTM provider may reach out to you in order to clarify your patient’s medical history prior to a review or information received from your patient during the review, such as why and how they are supposed to use their medications.
- After a CMR, the MTM provider may contact you with questions or recommendations about your patient’s medications, or your patient may call you to discuss suggestions they received from the MTM provider.

Continued >>
Targeted medication reviews (TMRs) are processed throughout the year, at least quarterly, to identify specific or potential medication-related problems. You may be contacted by the MTM provider if a TMR identifies a potential medication-related problem for your patient.

Other communications may be sent to you periodically throughout the year. These communications are intended to help resolve other potential medication-related problems or identify other opportunities to optimize your patient’s medication use.

What Materials Will My Patients Receive?

If your patients are enrolled in a Part D MTM program, they will receive a printed standardized summary, Form CMS-10396, as a reference about their CMR. This summary will include a Cover Letter, Medication Action Plan, and Personal Medication List. Your patients are encouraged to share these documents with you and other healthcare providers at their regular visits and request updates as needed. Examples of the three forms follow:

Cover Letter

- The Cover Letter reminds your patient of their CMR, introduces the Medication Action Plan and Personal Medication List, and describes how to contact the MTM program.

January 30, 2017

Mr. John Smith
345 Sunset Road
Washington, DC 20008

Dear Mr. Smith:

Thank you for talking with me on January 30, 2017 about your health and medications. Medicare’s MTM (Medication Therapy Management) program was designed to help you understand your medications and use them safely.

This letter includes an action plan (Medication Action Plan) and medication list (Personal Medication List). The action plan has steps you should take to help you get the best results from your medications. The medication list will help you keep track of your medications and how to use them the right way:

- Have your action plan and medication list with you when you talk with your doctors, pharmacists, and other healthcare providers in your care team.
- Ask your doctors, pharmacists, and other healthcare providers to update the action plan and medication list at every visit.
- Take your medication list with you if you go to the hospital or emergency room.
- Give a copy of the action plan and medication list to your family or caregivers.

If you want to talk about this letter or any of the papers with me, please call Dr. Jane Doe at 1-800-123-4567 between the hours of 8am and 5pm, Monday through Friday. I look forward to meeting with you, your doctors, and other healthcare providers to help you stay healthy through the Birchwood Medicare Plan MTM program.

Sincerely,

Jane Doe, PharmD
Pharmacy Manager

Continued >>

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Medication Action Plan
• The Medication Action Plan describes the specific action items for your patient to help resolve issues of current drug therapy and achieve the goals of medication treatment. Your patient can keep notes of their progress and use it to clarify and discuss any concerns about their medications and treatment plans with you.
• The MTM provider will send separate recommendations to you if needed.

Personal Medication List
• The Personal Medication List is a reconciled list of the medications used by your patient at the time of the review. Information from your patient, Medicare Part D claims data, or other sources may be used to develop the list. It is intended to help your patient understand their medications and how they relate to their treatment plans. Your patient can make notes on their Personal Medication List such as when and why they stopped taking a medication.
• You can use the Personal Medication List as verification of your patient’s current medication regimen and provide written adjustments, as needed. The medication list can also improve communication with you and other healthcare providers seen by your patient.
How Do You Refer Patients to MTM Services?

Calling the prescription drug plan directly is the best way to find out if your patient is eligible for that plan’s MTM services. You can also refer your patient to their local State Health Insurance Assistance Program (SHIP) office. A local SHIP counselor can be found by searching the following website: [https://www.shiptacenter.org](https://www.shiptacenter.org).

**Part D Enhanced Medication Therapy Management Model**

Certain plans in Arizona, Florida, Iowa, Louisiana, Minnesota, Montana, Nebraska, North Dakota, South Dakota, Virginia, and Wyoming are participating in a new test to determine if expanded MTM services can help improve health outcomes and reduce health care expenditures. Participating plans are permitted to target enrollees using a different criteria than the standard MTM program and offer additional services beyond the CMR and TMR to improve their medication usage. If one of your patients is enrolled in a participating plan, the Part D plan may reach out to you to better coordinate care and improve information sharing.

**Summary**

Medicare Part D MTM programs promote coordinated care and improve medication use through services that engage the patient, their physicians, and other healthcare providers. You may see three forms that your patients will receive if they are enrolled in a Part D MTM program and have received a CMR. These forms are intended to provide the patient with information about their medication use and also be used as a platform for discussion with you and their other health care providers.

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Additional Information
For additional information about Medicare Part D MTM programs and the standardized CMR summary documents, go to

Please send any general questions about Part D MTM programs to PartD_MTM@cms.hhs.gov. Questions about a specific plan’s MTM services or eligibility criteria should be addressed to that Part D plan.

Document History

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<tr>
<td>October 11, 2012</td>
<td>Initial Article issued</td>
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October 2017 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions To Prior Quarterly Pricing Files

MLN Matters Number: MM10187
Related CR Release Date: July 21, 2017
Related CR Transmittal Number: R3809CP
Related Change Request (CR) Number: 10187
Effective Date: October 1, 2017
Implementation Date: October 2, 2017

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

WHAT YOU NEED TO KNOW
Change Request (CR) 10187 instructs MACs to download and implement the October 2017 and, if released, the revised July 2017, April 2017, January 2017, and October 2016, ASP drug pricing files for Medicare Part B drugs via the Centers for Medicare & Medicaid Services (CMS) Data Center (CDC). Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after October 1, 2017, with dates of service October 1, 2017, through December 31, 2017. Make sure your billing staffs are aware of these changes.

BACKGROUND
The ASP methodology is based on quarterly data submitted to the CMS by manufacturers. CMS will supply contractors with the ASP and not otherwise classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the Outpatient Prospective Payment System (OPPS) are incorporated into the Outpatient Code Editor (OCE) through separate instructions available in Chapter 4, section 50 of the Medicare Claims Processing Manual, at https://www.cms.gov/regulations-and-Guidance/Guidance/Manuals.downloads/clm104c04.pdf.

- File: October 2017 ASP and ASP NOC -- Effective Dates of Service: October 1, 2017, through December 31, 2017
- File: July 2017 ASP and ASP NOC -- Effective Dates of Service: July 1, 2017, through September 30, 2017
- File: April 2017 ASP and ASP NOC -- Effective Dates of Service: April 1, 2017, through June 30, 2017
- File: January 2017 ASP and ASP NOC -- Effective Dates of Service: January 1, 2017, through March 31, 2017
- File: October 2016 ASP and ASP NOC -- Effective Dates of Service: October 1, 2016, through December 31, 2016

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

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or biological not listed in the ASP or NOC drug-pricing files that is billed with the KD modifier, contractors shall determine the payment allowance limits in accordance with instructions for pricing and payment changes for infusion drugs furnished through an item of Durable Medical Equipment (DME) on or after January 1, 2017, associated with the passage of the 21st Century Cures Act.

ADDITIONAL INFORMATION

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<td>Initial Article Released</td>
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eServices Makes Asking a Medicare Question Easier!

The eServices Secure eChat option allows providers to interact with designated Palmetto GBA staff so they can receive real-time assistance locating information on any topics or specialties they are searching for on the Palmetto GBA website or within the eServices online portal. The Secure eChat feature also allows users to dialogue with an online operator who can assist with patient or provider specific inquiries or address questions that require the sharing of PHI information! Using Secure eChat is simple! This free portal is available to all Medicare providers as long as you have a signed Electronic Data Interchange (EDI) Enrollment Agreement on file with Palmetto GBA. Once in the eServices portal, from the bottom right corner select either Medicare Inquiries or eServices Help. If you do not have an eServices account, you can get started by clicking this eServices link https://www.onlineprovidersservices.com/ecx_improvev2/. The Secure eChat feature is available during business hours to assist providers.
Quarterly Influenza Virus Vaccine Code Update – January 2018

MLN Matters Number: MM10196 Revised  
Related CR Release Date: August 4, 2017  
Related CR Transmittal Number: R3827CP  
Related Change Request (CR) Number: 10196  
Effective Date: August 1, 2017  
Implementation Date: January 2, 2018  

Note: This article was revised on August 9, 2017, to correctly show in all appropriate places the code of Q2039. In the original article, Q0239 was mistakenly referenced in two places and that is corrected to show Q2039. All other information remains the same.

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

**PROVIDER ACTION NEEDED**  
Change Request (CR) 10196, from which this article was developed, provides instructions for payment and edits for the Common Working File (CWF) and the Fiscal Intermediary Shared System (FISS) to include and update new or existing influenza virus vaccine codes. The influenza virus vaccine code set is updated on a quarterly basis. This update will include one new influenza virus vaccine code: 90756. Please make sure your billing stafs are aware of this update.

**BACKGROUND**

Effective for claims processed with dates of service (DOS) on or after January 1, 2018, influenza virus vaccine code 90756 (Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, antibiotic free, 0.5mL dosage, for intramuscular use) will be payable by Medicare. This new code will be included on the 2018 Medicare Physician Fee Schedule Database file update and the annual Healthcare Common Procedure Coding System (HCPCS) update.

During the interim period of August 1, 2017, through December 31, 2017, MACs will use code Q2039 (Influenza virus vaccine, not otherwise specified) to handle bills for this new influenza virus vaccine product (Influenza virus vaccine, quadrivalent (ccIIV4). Q2039 is already an active code.

The new influenza virus vaccine code 90756 will then be implemented with the January 2018 release for DOS on or after January 1, 2018.

Effective for dates of service on or after August 1, 2017, MACs will use the CMS Seasonal Influenza Vaccines Pricing website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html to determine the payment rate for influenza virus vaccine code Q2039 and 90756.
Medicare will issue further instructions on how to handle claims using Q2039 for the new influenza virus vaccine product between August 1, 2017, and December 31, 2017. MACs will use existing processes to handle these claims.

The new influenza virus vaccine code (90756) is not retroactive to August 1, 2017. Claims will not be accepted for influenza virus vaccine code 90756 between the DOS August 1, 2017, and December 31, 2017. **If claims are received in January 2018 with code 90756 for DOS between August 1, 2017, and December 31, 2017, claims will be rejected or returned as unprocessable.**

New Vaccine Description

Code 90756 – Long Description: Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, antibiotic free, 0.5mL dosage, for intramuscular use TOS Code: V
- Short Description: CCIIV4 VACC ABX FREE IM
- Medium Description: CCIIV4 VACCINE ANTIBIOTIC FREE 0.5 ML DOS IM USE Long

Payment Basis

Based on reasonable cost, MACs will pay for influenza virus vaccine codes Q2039 and 90756 to:
- Hospitals (Type of Bill 12X and 13X)
- Skilled Nursing Facilities (22X and 23X)
- Home Health Agencies (34X)
- Hospital-based renal dialysis facilities (72X) and
- Critical Access Hospitals (85X)

Based on the lower of the actual charge or 95 percent of the Average Wholesale Price (AWP), MACs will pay for influenza virus vaccine codes Q2039 and 90756 to:
- Indian Service Hospitals (IHS) (12X and 13X)
- IHS Hospices (81X and 82X) and
- IHS Critical Access Hospitals (85X)
- Comprehensive Outpatient Rehabilitation Facilities (CORFs) (75X), and
- Independent RDFs (72X)

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

MACS will suspend and manually price claims when the HCPC File rate is blank for:
- IHS Hospitals (12X, 13X), hospices (81X and 82X), and IHS CAHs (85X)
- CORFs (75X) and
- Independent RDFs (72X)

Messages for Denied Claims

MACs will return as unprocessable claims submitted with Q2039 for the DOS January 1, 2018, through July 31, 2018, when code 90756 should have been submitted, using the following messages:
- Claims Adjustment Reason Code (CARC): 181 – “Procedure code was invalid on the date of service.”
- Remittance Advice Remark Code (RARC): N56 – “Procedure code billed is not correct/valid for the services billed or the date of service billed.”
- Group Code: CO (Contractual Obligation)

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ADDITIONAL INFORMATION

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<td>August 9, 2017</td>
<td>This article was revised to correctly show in all appropriate places the code of Q2039. In the original article, Q0239 was mistakenly referenced in two places and that is corrected to show Q2039. All other information remains the same.</td>
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<tr>
<td>August 7, 2017</td>
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Influenza Vaccine Payment Allowances -Annual Update for 2017-2018 Season

MLN Matters Number: MM10224  
Related Change Request (CR) Number: CR 10224  
Related CR Release Date: August 18, 2018  
Effective Date: August 1, 2017  
Related CR Transmittal Number: R3837CP  
Implementation Date: No later than October 2, 2017

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

PROVIDER ACTION NEEDED
Change Request (CR) 10224 informs MACs about the payment allowances for seasonal influenza virus vaccines, which are updated on August 1 of each year. The Centers for Medicare & Medicaid Services (CMS) will post the payment allowances for influenza vaccines that are approved after the release of CR10224 at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html. Make sure your billing staffs are aware that the payment allowances are being updated.

BACKGROUND
The Medicare Part B payment allowance limits for influenza and pneumococcal vaccines are 95 percent of the Average Wholesale Price (AWP) as reflected in the published compendia except where the vaccine is furnished in a hospital outpatient department, Rural Health Clinic (RHC), or Federally Qualified Health Center (FQHC). Where the vaccine is furnished in the hospital outpatient department, RHC, or FQHC, payment for the vaccine is based on reasonable cost.

The Medicare Part B payment allowances for the following Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes below apply for the effective dates of August 1, 2017-July 31, 2018:

- CPT 90653 Payment allowance is $50.217.
- CPT 90655 Payment allowance is pending.
- CPT 90656 Payment allowance is $19.247.
- CPT 90657 Payment allowance is pending.
- CPT 90661 Payment allowance is pending.
- CPT 90685 Payment allowance is $21.198.
- CPT 90686 Payment allowance is $19.032.
- CPT 90687 Payment allowance is $9.403.
- CPT 90688 Payment allowance is $17.835.
- HCPCS Q2035 Payment allowance is $17.685.
- HCPCS Q2036 Payment allowance is pending.
- HCPCS Q2037 Payment allowance is $17.685.
- HCPCS Q2038 Payment allowance is pending.

Continued >>
Payment for the following CPT or HCPCS codes may be made if your MAC determines its use is reasonable and necessary for the beneficiary, for the effective dates of August 1, 2017 -July 31, 2018:

- CPT 90630 Payment allowance is $20.343.
- CPT 90654 Payment allowance is pending.
- CPT 90662 Payment allowance is $49.025.
- CPT 90672 Payment allowance is pending.
- CPT 90673 Payment allowance is $40.613.
- CPT 90674 Payment allowance is $24.047.
- CPT 90682 Payment allowance is $46.313. (New code)
- CPT 90756 Payment allowance is $22.793. Effective dates: 1/1/2018-7/31/2018 (Note: Providers and Medicare Administrative Contractors shall use HCPCS Q2039 for dates of service from 8/1/2017 – 12/31/2017. See special note under HCPCS Q2039 for payment amounts for this product prior to 1/1/2018.)
- HCPCS Q2039 Flu Vaccine Adult -Not Otherwise Classified. Payment allowance is to be determined by your MAC with effective dates of 8/1/2017 -7/31/2018.

Special note: Until CPT code 90756 is implemented on 1/1/2018, Q2039 shall be used for products described by the following language: influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, antibiotic free, 0.5mL dosage, for intramuscular use. The payment allowance for these products, effective for dates of service 8/1/2017 -12/31/2017 is $22.793.

CMS will post payment limits for influenza vaccines that are approved after the release date of CR10224 on the CMS Seasonal Influenza Vaccines Pricing webpage at [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html) as information becomes available. Effective dates for these vaccines shall be the date of Food and Drug Administration (FDA) approval.

The payment allowances for pneumococcal vaccines are based on 95 percent of the AWP and are updated on a quarterly basis via the Quarterly Average Sales Price (ASP) Drug Pricing Files.

Providers should note that:
- All physicians, non-physician practitioners, and suppliers who administer the influenza virus vaccination and the pneumococcal vaccination must take assignment on the claim for the vaccine.
- The annual Part B deductible and coinsurance amounts do not apply.
- Your MACs will not search their files either to retract payment for claims already paid or to retroactively pay claims. However, MACs will adjust such claims that you bring to their attention.

**ADDITIONAL INFORMATION**


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July Quarterly Update for 2017 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule

MLN Matters Number: MM10071
Revised Related Change Request (CR) # 10071
Related CR Release Date: August 2, 2017
Effective Date: July 1, 2017
Related CR Transmittal Number: R3824CP
Implementation Date: July 3, 2017

Note: This article was revised on August 3, 2017, to reflect an updated Change Request (CR). That CR updated the policy section on complex rehabilitative power wheelchair accessories & seat and back cushions (page 2 of this article). The CR release date, transmittal number and link to the CR was also changed. All other information is the same.

PROVIDER TYPE 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.

PROVIDER ACTION NEEDED
CR 10071 provides the July 2017 quarterly update for the Medicare DMEPOS fee schedule, and it includes information, when necessary, to implement fee schedule amounts for new codes and correct any fee schedule amounts for existing codes.

BACKGROUND
The DMEPOS fee schedules are updated on a quarterly basis, when necessary, in order to implement fee schedule amounts for new and existing codes, as applicable, and apply changes in payment policies. The quarterly update process for the DMEPOS fee schedule is located in the Medicare Claims Processing Manual, Chapter 23, Section 60 at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf.


Also, payment on a fee schedule basis is a regulatory requirement at 42 Code of Federal Regulations (CFR) §414.102 (https://www.ecfr.gov/cgi-bin/text-idx?SID=becd20e512ac4c175ad81e37e4583f85&mc=true&node=pt42.3.414&rgn=div5&wb=48617274=F813553A#se42.3.414_1102) for parenteral and enteral nutrition (PEN), splints and casts and intraocular lenses (IOLs) inserted in a physician’s office.

Continued >>
Additionally, Section 1834 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 (CBAs), based on information from competitive bidding programs (CBPs) for DME. The Social Security Act (§1842(s)(3)(B)) provides authority for making adjustments to the fee schedule amount for enteral nutrients, equipment and supplies (enteral nutrition) based on information from CBPs. Also, the adjusted fees apply a rural payment rule. The DMEPOS and PEN fee schedule files contain HCPCS codes that are subject to the adjustments as well as codes that are not subject to the fee schedule adjustments. Additional information on adjustments to the fee schedule amounts based on information from CBPs is available in CR 9642 (Transmittal 3551, dated June 23, 2016).

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

The Calendar Year (CY) 2017 DMEPOS and PEN fee schedules and the July 2017 DMEPOS Rural ZIP code file public use files (PUFs) will be available for State Medicaid Agencies, managed care organizations, and other interested parties shortly after the release of the data files at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched.

**KU Modifier for Complex Rehabilitative Power Wheelchair Accessories & Seat and Back Cushions**
Suppliers should continue to use the KU modifier when billing for wheelchair accessories and seat and back cushions furnished in connection with Group 3 complex rehabilitative power wheelchairs (codes K0848 through K0864) with dates of service on or after July 1, 2017. The fee schedule amounts associated with the KU modifier were not adjusted using information from the competitive bidding program in accordance with Section 2 of Patient Access and Medicare Protection Act (PAMPA) for dates of service January 1, 2016 through December 31, 2016. Section 16005 of the 21st Century Cures Act then extended the effective date through June 30, 2017. Effective for dates of service on or after July 1, 2017, taking into consideration the exclusion at section 1847(a)(2)(A) of the Social Security Act, the policy for these items is revised. As a result, payment for these items furnished in connection with a Group 3 complex rehabilitative power wheelchair and billed with the KU modifier will be based on the unadjusted fee schedule amounts updated in accordance with section 1834(a)(14) of the Act. The list of HCPCS codes associated with the KU modifier is available in Transmittal 3713, CR 9966, dated February 3, 2017. The updated DMEPOS fee schedule files have been released.

**Therapeutic Continuous Glucose Monitor (CGM)**
As part of this update, the fee schedule amounts for the following therapeutic CGM HCPCS codes are added to the DMEPOS fee schedule file effective for dates of service on or after July 1, 2017:
- K0553 -Supply allowance for therapeutic continuous glucose monitor (CGM), includes all supplies and accessories, 1 unit of service = 1 month’s supply
- K0554 -Receiver (monitor), dedicated, for use with therapeutic continuous glucose monitor system

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ADDITIONAL INFORMATION

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<td>August 2, 2017</td>
<td>The article was revised on August 3, 2017, to reflect an updated CR. That CR updated the policy section on complex rehabilitative power wheelchair accessories &amp; seat and back cushions (page 2 of this article). The CR release date, transmittal number and link to the CR were also changed.</td>
</tr>
<tr>
<td>May 2, 2017</td>
<td>Initial Article Released</td>
</tr>
</tbody>
</table>
MACtoberfest™ Workshop Conference: Innovation Today for Success Tomorrow

Date: October 11, 2017
Audience: Part B
Location: Palmetto GBA Government Programs Complex (GPC), Columbia, South Carolina
Schedule: 8 - 8:30 a.m. Registration
  8:30 a.m. - 4:30 p.m. Workshop

Palmetto GBA, the JM A/B MAC, is presenting an informative workshop in Columbia, South Carolina that will provide information related to the most common errors identified through a variety of data analysis and tips to avoid them.

This workshop is intended to keep providers apprised of Medicare guidelines as well as using technology for better results. The recommended participants are Part B administrators, billers, nurses and other healthcare professionals that submit claims to Medicare.

Topics include:
• Electronic Data Interchange (EDI)
• Medicare Part B Updates
• Appeals
• Medical Affairs
• Medical Review
• eServices Online Secure Portal
• Provider Enrollment Revalidations

This is a FREE event!

To reserve your seat and/or schedule an appointment with a representative, make sure you:
• Create a profile in the Event Registration Portal if you do not already have one
• Register yourself as well as others at your facility or provider practice
• Be sure to select “Registration and All Day Workshop”

In addition to registering for this workshop, you may also choose to sign up for a 30-minute appointment to:
• Discuss specific issues with a Provider Contact Center representative
• Attend an e-Services session with a Palmetto GBA employee. An active user ID and password are required for this session.

Each facility/office may have multiple staff members in each session. Note that if you sign up for multiple time slots for the same workshop, you will be attending the first time slot selected. Palmetto GBA reserves the right to limit the number of attendees from one facility or provider practice to assure as many providers are able to attend as possible.

Continued >>

CPT codes, descriptors and other data only are copyright 2016 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2016 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.
Due to the limited availability of appointment slots providers are asked to sign up for no more than one of each type per facility/office in order to allow other providers to have the opportunity for an appointment.

**Providers are reminded:**
- Registration is required
- Handouts will be emailed to each registrant prior to the event
- Sign in the day of the event begins no earlier than 30 minutes prior to the event start time
- Please bring your Provider Transaction Access Number (PTAN) and National Provider Identifier (NPI)
- Bringing a light jacket or sweater may help to assure your comfort
- Palmetto GBA will not provide refreshments but vending machines and a cafeteria are onsite for your convenience
Educational Events Where You Can Ask Questions and Get Answers from Palmetto GBA

Don’t Miss this Wonderful Opportunity!
If you are in search of an opportunity to interact with and get answers to your Medicare billing, coverage and documentation questions from Palmetto GBA’s Provider Outreach and Education (POE) department, please see these educational offerings which have a question and answer session:

<table>
<thead>
<tr>
<th>Event Title</th>
<th>Date/Time</th>
<th>Address (or link if Webinar)</th>
</tr>
</thead>
<tbody>
<tr>
<td>September 2017 Medicare Part B Updates, Changes and Reminders Webcast</td>
<td>9/7/17, 10 am, ET</td>
<td><a href="http://event.on24.com/wcc/r/1334187/9FAC14A3AF30A916EE7E4E0198E6B0CA">http://event.on24.com/wcc/r/1334187/9FAC14A3AF30A916EE7E4E0198E6B0CA</a></td>
</tr>
</tbody>
</table>

Check out these resources

Quarterly Ask the Contractor Teleconferences (ACTs) | http://tinyurl.com/jkb4458 |

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.

Proceding the presentation, providers are given an opportunity to ask questions both on the topics discussed as well as any other question they may have. While we encourage providers to submit questions prior to the call, this is not required. Just fill out the Ask the Contractor Teleconference (ACT): Submit A Question form (http://tinyurl.com/hjq84dg). Once the form is completed, please fax it to (803) 935-0140, Attention: Ask-the-Contractor Teleconference.
<table>
<thead>
<tr>
<th>Quarterly Updates Webcasts</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td><a href="http://tinyurl.com/gsr8gp">http://tinyurl.com/gsr8gp</a></td>
<td></td>
</tr>
<tr>
<td>Event Registration Portal</td>
<td>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.</td>
</tr>
<tr>
<td><a href="http://tinyurl.com/gsr8gp">http://tinyurl.com/gsr8gp</a></td>
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</table>

If you have a question that you need an answer to today or a claims specific question which requires the disclosure of PII or PHI for response, please contact the Provider Contact Center (PCC) at 1-855-696-0705.
Healthcare Provider Taxonomy Codes (HPTCs) October 2017 Code Set Update

MLN Matters Number: MM10141
Related Change Request (CR) # 10141
Related CR Release Date: August 18, 2018
Effective Date: October 1, 2017
Related CR Transmittal Number: R3842CP
Implementation Date: January 2, 2018 – Contractors with capability to do so will implement effective October 1, 2017

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

PROVIDER ACTION NEEDED
Change Request (CR) 10141 instructs MACs to obtain the most recent Healthcare Provider Taxonomy Code (HPTC) set and to update their internal HPTC tables and/or reference files.

BACKGROUND
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that covered entities comply with the requirements in the electronic transaction format implementation guides adopted as national standards. The institutional and professional claim electronic standard implementation guides (X12 837-I and 837-P) each require use of valid codes contained in the HPTC set when there is a need to report provider type or physician, practitioner, or supplier specialty for a claim.

You should note that:
1. Valid HPTCs are those codes approved by the National Uniform Claim Committee (NUCC) for current use.
2. Terminated codes are not approved for use after a specific date.
3. Newly approved codes are not approved for use prior to the effective date of the code set update in which each new code first appears.
4. Specialty and/or provider type codes issued by any entity other than the NUCC are not valid.
5. Medicare would be guilty of non-compliance with HIPAA if MACs accepted claims that contain invalid HPTCs.

The HPTC set is maintained by the NUCC for standardized classification of health care providers. The NUCC updates the code set twice a year with changes effective April 1 and October 1. The HPTC list is available for view from the Washington Publishing Company (WPC) website at www.wpc-edi.com/codes and can be downloaded from the NUCC’s website http://www.nucc.org/index.php/code-sets-mainmenu-41/provider-taxonomy-mainmenu-40.
Although the NUCC generally posts their updates on the WPC webpage 3 months prior to the effective date, changes are not effective until April 1 or October 1 as indicated in each update. The changes to the code set include the addition of a new code and addition of definitions to existing codes. When reviewing the Health Care Provider Taxonomy code set online, you can identify revisions made since the last release by color code:

- New items are green
- Modified items are orange
- Inactive items are red.

**ADDITIONAL INFORMATION**
The official instruction, CR10141, issued to your MAC regarding this change is available at

**DOCUMENT HISTORY**

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
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<tbody>
<tr>
<td>August 18, 2017</td>
<td>Initial Article Released</td>
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</tbody>
</table>
Implement Operating Rules -Phase III Electronic Remittance Advice (ERA) Electronic Funds Transfer (EFT): CORE 360 Uniform Use of Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC) and Claim Adjustment Group Code (CAGC) Rule -Update from Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE)

MLN Matters Number: MM10140
Related Change Request (CR) Number: CR10140
Related CR Release Date: August 18, 2017
Effective Date: January 1, 2018
Related CR Transmittal Number: R3841CP
Implementation Date: January 2, 2018

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

PROVIDER ACTION NEEDED
Change Request (CR) 10140 instructs MACs and Medicare’s Shared System Maintainers (SSMs) to update systems based on the CORE 360 Uniform Use of Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC) and Claim Adjustment Group Code (CAGC) Rule publication. These system updates are based on the CORE Code Combination List to be published on or about October 1, 2017.

BACKGROUND
The Department of Health and Human Services (DHHS) adopted the Phase III CAQH CORE, EFT and ERA Operating Rule Set that was implemented on January 1, 2014, under the Affordable Care Act. The Health Insurance Portability and Accountability Act (HIPAA) amended the Act by adding Part C—Administrative Simplification—to Title XI of the Social Security Act, requiring the Secretary of DHHS to adopt standards for certain transactions to enable health information to be exchanged more efficiently and to achieve greater uniformity in the transmission of health information. Through the Affordable Care Act, Congress sought to promote implementation of electronic transactions and achieve cost reduction and efficiency improvements by creating more uniformity in the implementation of standard transactions. This was done by mandating the adoption of a set of operating rules for each of the HIPAA transactions. The Affordable Care Act defines operating rules and specifies the role of operating rules in relation to the standards.

CAQH CORE will publish the next version of the Code Combination List on or about October 1, 2017. This update is based on the CARC and RARC updates as posted at the Washington Publishing Company (WPC) website on or about July 1, 2017. This will also include updates based on Market Based Review that CAQH CORE conducts once a year to accommodate code combinations that are currently being used by Health Plans

Continued >>
including Medicare as the industry needs them. See http://www.wpc-edi.com/reference for CARC and RARC updates and http://www.caqh.org/CORECodeCombinations.php for CAQH CORE defined code combination updates.

Note: The Affordable Care Act mandate all health plans including Medicare must comply with CORE 360 Uniform Use of CARCs and RARCs (835) rule or CORE developed maximum set of CARC/RARC and CAGC combinations for a minimum set of 4 Business Scenarios. Medicare can use any code combination if the business scenario is not one of the 4 CORE defined business scenarios. With the 4 CORE defined business scenarios, Medicare must use the code combinations from the lists published by CAQH CORE.

ADDITIONAL INFORMATION

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<table>
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<tr>
<td>August 18, 2018</td>
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CMS Finalizes Payment Rates for FY 2018

CMS Finalizes 2018 Payment and Policy Updates for Medicare Hospital Admissions

On August 2, CMS issued the FY 2018 Medicare Inpatient Prospective Payment System and Long-Term Care Hospital Prospective Payment System final rule, which updates 2018 Medicare payment and policies when patients are discharged from hospitals. The final rule relieves regulatory burdens for providers, supports the patient-doctor relationship in healthcare, and promotes transparency, flexibility, and innovation in the delivery of care for Medicare patients.

“This final rule will help provide flexibility for acute and long-term care hospitals as they care for Medicare’s sickest patients,” said CMS Administrator Seema Verma. “Burden reduction and payment rate increases for acute care hospitals and long-term care hospitals will help ensure those suffering from severe injuries and illnesses have access to the care they need.”

Due to the combination of payment rate increases and other policies and payment adjustments, particularly in changes in uncompensated care payments, acute care hospitals will see a total increase in Medicare spending on inpatient hospital payments of $2.4 billion in FY 2018. Based in part on the changes included in the final rule, overall payments to long-term care hospitals will decrease by $110 million in FY 2018.

In addition to the payment and policy updates for Medicare hospital admissions, the final rule addresses changes to how the public is notified of Medicare terminations of certain providers and implements the statutory extension of the Rural Community Hospital Demonstration.

For More Information:
- Fact Sheet: [https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-08-02.html](https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-08-02.html)


Inpatient Psychiatric Facilities: FY 2018 Medicare Payment and Policy Updates

On August 2, CMS issued a notice with comment period updating FY 2018 Medicare payment policies and rates for the Inpatient Psychiatric Facilities (IPF) Prospective Payment System. CMS estimates IPF payments to increase by 0.99 percent or $45 million in FY 2018. This amount reflects a 2.6 percent IPF market basket update less the productivity adjustment of 0.6 percentage point and less the 0.75 percentage point reduction required by law, for a net market basket update of 1.25 percent. Additionally, estimated payments to IPFs are reduced by 0.26 percentage point due to updating the outlier fixed-dollar loss threshold amount. CMS is also updating the IPF wage index for FY 2018.

CMS is soliciting comments on improvements that can be made to the healthcare delivery system that would reduce unnecessary burden for clinicians, providers such as IPFs, and patients and their families.
CMS Updates Medicare Payment Rates, Quality Reporting Requirements

CMS issued three final rules outlining 2018 Medicare payment rates for skilled nursing facilities, hospice, and inpatient rehabilitation facilities. The final rules are effective for FY 2018 and reflect a broader Administration strategy to streamline administrative requirements for providers; support the patient-doctor relationship in healthcare; and promote transparency, flexibility, and innovation in the delivery of care.

“These announcements take important steps to support innovation in the delivery of care in order to promote a Medicare program that is responsive to patients’ unique needs and ensure that patients have access to high-quality skilled nursing, hospice, and inpatient rehabilitative care,” said CMS Administrator Seema Verma.

“These rules update quality reporting requirements and allow providers to spend less time and fewer resources on cumbersome paperwork, so they can increase their focus on the needs of Medicare patients.”

Final Rules:


See the full text of this excerpted Press Release (issued August 1): https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2017-Press-releases-items/2017-08-01.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending&wb48617274=3CF5D242
ICD-10 Coding Revisions to National Coverage Determinations (NCDs)

MLN Matters Number: MM10184
Related CR Release Date: July 27, 2017
Related CR Transmittal Number: R1875OTN
Related Change Request Number: 10184
Effective Date: January 1, 2018
Implementation Date: September 13, 2017 for local edits; January 2, 2018 - shared systems

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

PROVIDER ACTION NEEDED
Change Request (CR) 10184 outlines edits to International Classification of Diseases, 10th Revision (ICD-10) and other coding updates specific to National Coverage Determinations (NCDs) that will be included in subsequent, quarterly releases as needed. No policy-related changes are included with these updates. Any policy-related changes to NCDs continue to be implemented via the current, long-standing NCD process. The following link provides the NCD spreadsheets included with this CR10184 at https://www.cms.gov/Medicare/Coverage/DeterminationProcess/downloads/CR10184.zip.

BACKGROUND
CR10184 constitutes a maintenance update of ICD-10 conversions and other coding updates specific to NCDs. These NCD coding changes are the result of newly available codes, coding revisions to NCDs released separately, or coding feedback received.

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

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

NOTE: The translations from ICD-9 to ICD-10 are not consistent 1-1 matches, nor are all ICD-10 codes appearing in a complete General Equivalence Mappings (GEMS) mapping guide or other mapping guides appropriate when reviewed against individual NCD policies. In addition, for those policies that expressly allow MAC discretion, there may be changes to those NCDs based on current review of those NCDs against ICD-10...
coding. For these reasons, there may be certain ICD-9 codes that were once considered appropriate prior to ICD-10 implementation that are no longer considered acceptable.

CR10084 makes coding and clarifying adjustments to the following NCDs:

- NCD160.18 - Vagus Nerve Stimulation
- NCD210.4.1 - Counseling to Prevent Tobacco Use
- NCD220.6.17 - Positron Emission Tomography (PET) for Solid Tumors
- NCD220.6.20 - PET Beta Amyloid in Dementia/Neurological Disorders
- NCD210.13 - Screening for Hepatitis C Virus

NOTE/CLARIFICATION: MACs will use default Council for Affordable Quality Healthcare Committee on Operating Rules (CAQH CORE) messages where appropriate:

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

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

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

ADDITIONAL INFORMATION

DOCUMENT HISTORY

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<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
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<tbody>
<tr>
<td>August 9, 2017</td>
<td>Initial Article Released</td>
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</table>
Screening for the Human Immunodeficiency Virus (HIV) Infection

MLN Matters® Number: MM9980 Revised
Related Change Request (CR) #: CR 9980
Related CR Release Date: August 16, 2017
Effective Date: April 13, 2015
Related CR Transmittal #: R3835CP
Implementation Date: October 2, 2017

Note: This article was revised on August 17, 2017, to reflect a revised CR9980 issued on August 16. In the article, the CR release date, transmittal number, and the Web address for accessing CR9980 are revised. All other information remains the same.

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

Provider Action Needed
Change Request (CR) 9980 informs MACs that they shall recognize the specified HCPCS codes for services related to the Screening for the Human Immunodeficiency Virus (HIV) Infection. Make sure that your billing staffs are aware of these codes.

Background
The Centers for Medicare & Medicaid Services (CMS) issued CR9403 (transmittal 3461), effective April 13, 2015, for screening for HIV infection. The guidelines are based on strong recommendations by the U.S. Preventive Services Task Force published in April 2013. The recommendations provide guidelines for screening various age groups based on risk of infection as well as for pregnant women.

Effective for claims with dates of service on or after April 13, 2015, MACs will recognize the following Healthcare Common Procedure Coding System (HCPCS) codes for claims processed on or after October 2, 2017: G0432, G0433, and G0435. Testing frequency and other functions for these codes is the same as for those listed in CR9403. A related MLN Matters article is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9403.pdf.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Descriptor</th>
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<tbody>
<tr>
<td>G0432</td>
<td>Infectious agent antibody detection by enzyme Immune assay (EIA) technique, qualitative or Semi-quantitative, multiple-step method, HIV-1 or HIV-2, screening</td>
</tr>
<tr>
<td>G0433</td>
<td>Infectious agent antibody detection by enzyme-linked immunosorbent assay (ELISA) technique, antibody, HIV-1 or HIV-2, screening.</td>
</tr>
<tr>
<td>G0435</td>
<td>Infectious agent antibody detection by rapid antibody test of oral mucosa transudate, HIV-1 or HIV-2, screening.</td>
</tr>
</tbody>
</table>

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Billing Requirements

Your MAC will calculate the next eligible date for HIV Screening to include HCPCS codes G0432, G0433, and G0435 to be included with G0475 and based on effective date of April 13, 2015.

The next eligible date will be displayed on all of Medicare’s Common Working File (CWF) provider query screens (HUQA, HIQA, HIQH, ELGA, ELGH, and PRVN). This includes MBD and NGD extract records.

When there is no next eligible date, the CWF provider query screens will display this information in the date field to indicate why there is not a next eligible date.

When the incoming HUOP or HUBC claim line having the HIV screening HCPCS code G0475, G0432, G0433, or G0435 is submitted without the required HIV Primary Diagnosis Codes of Z11.4, **OR**

When the incoming HUOP or HUBC claim line having the HIV screening HCPCS 80081 is submitted with one of the following secondary diagnosis codes denoting pregnancy, but the required HIV primary diagnosis code of Z11.4 is not present:

- Z34.00, Z34.01, Z34.02, Z34.03, Z34.80, Z34.81, Z34.82, Z34.83, Z34.90, Z34.91, Z34.92, Z34.93, O09.90, O09.91, O09.92, O09.93

The claim line item will be denied. In denying the line, MACs will use either:

- Claim Adjustment Reason Code (CARC) 167 - This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. or
- CARC 11 - This diagnosis is inconsistent with the procedure. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- Remittance Advice Remarks Code (RARC) N386 - This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at http://www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.
- Group Code CO (Contractual Obligation)

Medicare will create a new consistency edit to deny when the incoming HUOP or HUBC claim line having either the HIV HCPCS codes G0475, G0432, G0433, G0435, or the CPT HCPCS code 80081 is submitted with one of the pregnancy secondary diagnosis codes, but the Sex Code on the claim indicates ‘Male.’ The secondary diagnosis codes indicating pregnancy are:

- Z34.00, Z34.01, Z34.02, Z34.03, Z34.80, Z34.81, Z34.82, Z34.83, Z34.90, Z34.91, Z34.92, Z34.93, O09.90, O09.91, O09.92, O09.93

In denying a line for this reason, MACs will use:

- CARC 7 - The procedure/revenue code is inconsistent with the patient’s gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- Group Code CO

Medicare systems will create a consistency edit to not allow Place of Service (POS) other than 11 (Office) or 81 (Independent Lab for the HIV screenings HCPCS G0475, G0432, G0433, and ‘G0435’ effective with dates

Continued >>
of service on or after April 13, 2015. If a POS other than 11 or 81 is on the claim, the MAC will deny the line item, using:

- **CARC 171** - Payment is denied when performed/billed by this type of provider in this type of facility. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- **RARC N428** - Not covered when performed in this place of service.
- **Group Code CO**

Medicare systems will create a consistency edit to not allow Type of Bill (TOB) other than 12X, 13X, 14X, 22X, 23X, and 85x for the HIV screening HCPCS G0475, G0432, G0433, and G0435.

**Additional Information**


**Document History**

- June 6, 2017 – Initial article released.
- August 17, 2017 – Article revised to reflect revised CR9980. In the article, the CR releasedate, transmittal number, and the Web address for accessing CR9980 are revised. All other information remains the same.
National Coverage Determination (NCD 20.8.4): Leadless Pacemakers

MLN Matters Number: MM10117
Related Change Request (CR) Number: 10117
Related CR Release Date: July 28, 2017
Effective Date: January 18, 2017
Related CR Transmittal Number: R201NCD and R3815CP
Implementation Date: August 29, 2017 for local MAC system edits and January 2, 2018 for shared system edits

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

PROVIDER ACTION NEEDED
Change Request (CR) 10117 informs MACs that effective January 18, 2017, the Centers for Medicare & Medicaid Services (CMS) covers leadless pacemakers through Coverage with Evidence Development (CED) when procedures are performed in CMS-approved CED studies. Please make your billing staffs are aware of this determination.

BACKGROUND
The leadless pacemaker eliminates the need for a device pocket and insertion of a pacing lead which are integral elements of traditional pacing systems. The removal of these elements eliminates an important source of complications associated with traditional pacing systems while providing similar benefits. Leadless pacemakers are delivered via catheter to the heart, and function similarly to other transvenous single-chamber ventricular pacemakers. Prior to January 18, 2017, there was currently no National Coverage Determination (NCD) in effect.

On January 18, 2017, CMS issued an NCD to cover leadless pacemakers through CED. CMS covers leadless pacemakers when procedures are performed in studies approved by the Food and Drug Administration (FDA). CMS also covers, in prospective longitudinal studies, leadless pacemakers that are used in accordance with the FDA-approved label for devices that have either:
• An associated ongoing FDA-approved post-approval study; or
• Completed an FDA post-approval study.

For such coverage, Medicare will allow payment for claims for dates of service on or after January 18, 2017 for leadless pacemakers through CED when billed with the following CPT codes:
• 0387T – Transcatheter insertion or replacement of permanent leadless pacemaker, ventricular
• 0389T – Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report, leadless pacemaker system.
• 0390T – Peri-procedural device evaluation (in person) and programming of device system parameters before or after surgery, procedure or test with analysis, review and report, leadless pacemaker system.
• 0391T – Interrogation device evaluation (in person) with analysis, review and report, includes connection, recording and disconnection per patient encounter, leadless pacemaker system.

Continued >>
Effective for dates of service on or after January 18, 2017, MACs will allow the following ICD-10 diagnosis codes on claims for leadless pacemakers:

- **Z00.6** – Encounter for examination for normal comparison and control in clinical research program.

Effective for dates of service on or after January 18, 2017, contractors shall return claims as unprocessable with the listed procedure codes billed without ICD-10 Z00.6 and use the following messages:

- **CARC 16** - Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- **RARC M76** - Missing/incomplete/invalid diagnosis or condition

Effective for claims with dates of service on or after January 18, 2017, modifier Q0 – Investigational clinical service provided in a clinical research study that is an approved clinical research study, must also be included.

Effective for dates of service on or after January 18, 2017, MACs will return claims with the procedure codes listed billed without modifier Q0 and use the following messages:

- **CARC 4**: “The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.”
- **RARC N572**: This procedure not payable unless appropriate non-payable reporting.
- **Group Code – Contractual Obligation (CO).**

Remember to include the 8-digit clinical trial identifier on the claim. Effective for claims with dates of service on or after January 18, 2017, MACs will return claims as unprocessable that are billed with the Q0 modifier and do not contain the 8-digit clinical trial identifier in item 23 of the CMS-1500 form or the electronic equivalent. Use the following messages:

- **CARC 16**: “Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)”
- **RARC MA50**: Missing/incomplete/invalid Investigational Device Exemption number or Clinical Trial number.
- **Group Code – Contractual Obligation (CO).**

Effective for dates of service in or after January 18, 2017, MACs shall only pay claims for leadless pacemakers when services are provided in one of the following Places of Service (POS):

- **POS 06** – Indian Health Service Provider Based Facility
- **POS 21** – Inpatient Hospital
- **POS 22** – On Campus-Outpatient Hospital
- **POS 26** – Military Treatment Facility

Where the proper POS code is not included and the claim is rejected/denied, the following messaging should be used:

Continued >>
• CARC 58: Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

• RARC N386: This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.hhs.gov/mcd/search.asp. If you do have web access, you may contact the contractor to request a copy of the NCD.

• Group Code – Contractual Obligation (CO)

MACs will not search their files for claims for leadless pacemakers with dates of service between January 18, 2017, and the implementation date of CR10117, but may adjust claims that you bring to their attention.

All clinical research study protocols must address pre-specified research questions, adhere to standards of scientific integrity and be reviewed and approved by CMS. Approved studies will be posted to the CMS website at http://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/index.html. The process for submitting a clinical research study to Medicare is outlined in the NCD.

Leadless pacemakers are non-covered outside of CMS-approved studies.

Note: This revision to the Medicare NCD Manual is a National Coverage Determination (NCD). NCDs are binding on all carriers, fiscal intermediaries, and MACs with the Federal government that review and/or adjudicate claims, determinations, and/or decisions, quality improvement organizations, qualified independent MACs, the Medicare appeals council, and Administrative Law Judges (ALJs) (see 42 CFR Section 405.1060(a) (4)(2005)). An NCD that expands coverage is also binding on a Medicare Advantage organization. In addition, an ALJ may not review an NCD (see Section 1869(f)(1)(A)(i) of the Social Security Act).

ADDITIONAL INFORMATION

DOCUMENT HISTORY

<table>
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<tr>
<th>Date of Change</th>
<th>Description</th>
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<tr>
<td>August 1, 2017</td>
<td>Initial article released.</td>
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New Waived Tests

MLN Matters Number: MM10198  
Related CR Release Date: July 27, 2017  
Related CR Transmittal Number: R3812CP  
Related Change Request (CR) Number: 10198  
Effective Date: October 1, 2017  
Implementation Date: October 2, 2017

PROVIDER TYPE AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 10198 informs MACs of new Clinical Laboratory Improvement Amendments of 1988 (CLIA) waived tests approved by the Food and Drug Administration (FDA). Since these tests are marketed immediately following approval, the Centers for Medicare & Medicaid Services (CMS) must notify the MACs of the new tests so that they can accurately process claims. CR10198 lists 17 newly added waived complexity tests.

BACKGROUND

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

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

The CPT code, effective date, and description for the latest tests approved by the FDA as waived tests under CLIA include:

- 87880QW, December 8, 2016, Quidel Sofia Strep A+ FIA (from throat swab only);
- 80305QW, April 28, 2017, Alere Toxicology Services Alere iCup Rx Multi-Drug Urine Test Cup;

Continued >>
• 87804QW, May 30, 2017, Quidel Sofia 2 {Sofia Influenza A+B FIA}; and

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

ADDITIONAL INFORMATION

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October Quarterly Update to 2017 Annual Update of HCPCS Codes Used for SNF CB Enforcement

MLN Matters Number: MM10163
Related Change Request (CR) Number: 10163
Related CR Release Date: August 4, 2017
Effective Date: October 1, 2017
Related CR Transmittal Number: R3825CP
Implementation Date: October 2, 2017

PROVIDER TYPES AFFECTED
This MLN Matters® Article is intended for providers who submit claims to Medicare Administrative Contractors (MACs), including Durable Medical Equipment MACs (DME MACs), for services provided in a Skilled Nursing Facility (SNF) to Medicare beneficiaries.

PROVIDER ACTION NEEDED
Change Request (CR) 10163 provides updates to the lists of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the Consolidated Billing (CB) provision of the SNF Prospective Payment System (PPS). The CR corrects an error impacting certain claims with dates of service on or after January 1, 2015, that Medicare mistakenly denied rejected prior to implementation of CR10163. Make sure your billing staffs are aware of these changes.

BACKGROUND
CR10163 alerts providers that the Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of HCPCS codes that are excluded from the CB provision of the SNF PPS. Services excluded from SNF PPS and CB may be paid to providers, other than SNFs, for beneficiaries, even when in a SNF stay. Services not appearing on the exclusion lists submitted on claims to MACs will not be paid by Medicare to any providers other than a SNF.

For non-therapy services, SNF CB applies only when the services are furnished to a SNF resident during a covered Part A stay; however, SNF CB applies to physical and occupational therapies and speech-language pathology services whenever they are furnished to a SNF resident, regardless of whether Part A covers the stay. In order to assure proper payment in all settings, Medicare systems must edit for services provided to SNF beneficiaries both included and excluded from SNF CB. The updated lists for institutional and professional billing are available at http://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/index.html.

Certain radiation therapy codes are included as services that are not subject to SNF CB. These codes can be submitted globally (no modifier), professional component only (modifier 26), or technical component only (modifier TC).

When the codes listed below are submitted globally or just for the technical component, the claims are being rejected by Medicare’s Common Working File (CWF). That is to say, they are not allowed to pay separately outside of the consolidated payment that is made to the SNF.

Continued >>
When submitted with the 26 modifier for just the professional component, the claims have been allowed to pay. The following are the allowable HCPCS codes: 77014, 77750, 77761, 77762, 77763, 77776, 77777, 77778, 77785, 77786, 77787, 77789, 77790, 77799, 79005, 79101, and 79445.

This error is occurring because the codes were not added by CMS to the appropriate coding lists with the 2015, 2016, and 2017 SNF CB Annual Updates. CR10163 corrects this error. Therefore, when brought to their attention, your MAC will reprocess claims with dates of service on or after January 1, 2015, that were erroneously denied/rejected.

**ADDITIONAL INFORMATION**


**DOCUMENT HISTORY**

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<td>August 4, 2017</td>
<td>Initial Article Released</td>
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**Global Surgery Calculator Self-Service Tool**

This tool will allow you to calculate both 10 and 90 day global surgery periods. You can also look up your 2017 procedure code global days requirement by using this tool. Just enter the procedure code in the tool and the global surgery indicator information will appear. Access the Global Surgery Calculator tool under Forms/Tools on the home page.

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CPT codes, descriptors and other data only are copyright 2016 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. Current Dental Terminology, fourth edition (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. ©2016 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.
Percutaneous Image-guided Lumbar Decompression (PILD) for Lumbar Spinal Stenosis (LSS)

MLN Matters Number: MM10089 Revised
Related CR Release Date: July 25, 2017
Related CR Transmittal Number: R3811CP and R200NCD
Related Change Request (CR) Number: 10089
Effective Date: December 7, 2016
Implementation Date: June 27, 2017

Note: This article was revised on July 26, 2017, to reflect the revised CR10089 issued on July 25. In the article, the transmittal numbers, CR release date, implementation date, and the Web addresses for accessing the transmittals are revised. All other information remains the same.

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

PROVIDER ACTION NEEDED
Change Request (CR) 10089 announces that effective for dates of service on or after December 7, 2016, Medicare will cover Percutaneous Image-guided Lumbar Decompression (PILD) under Coverage with Evidence Development (CED) for beneficiaries with Lumbar Spinal Stenosis (LSS) who are enrolled in a Centers for Medicare & Medicaid Services (CMS)-approved prospective longitudinal study. PILD procedures using an FDA-approved/cleared device that completed a CMS-approved prospective, randomized, controlled clinical trial (RCT) that met the criteria are listed in the January 2014 NCD (CR8757, see related MLN Matters article at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8757.pdf).

BACKGROUND
CMS currently covers PILD under the CED paradigm. PILD is a posterior decompression of the lumbar spine performed under indirect image guidance without any direct visualization of the surgical area. This is a procedure proposed as a treatment for symptomatic LSS unresponsive to conservative therapy. This procedure is generally described as a non-invasive procedure using specially designed instruments to percutaneously remove a portion of the lamina and debulk the ligamentum flavum. The procedure is performed under x-ray guidance (for example, fluoroscopic, CT) with the assistance of contrast media to identify and monitor the compressed area via epiduragram.

Section 1862(a)(1)(E) of the Social Security Act (the Act) authorizes coverage for PILD for beneficiaries with LSS under CED. On January 9, 2014, CMS posted its first NCD (150.13) covering PILD for beneficiaries with LSS when provided in a RCT meeting certain conditions under CED. Clinical studies must be designed using current validated and reliable measurement instruments and clinically appropriate comparator treatments for patients randomized to the non-PILD group.

Continued >>
On April 13, 2016, CMS accepted a complete formal request for a reconsideration of the NCD that limited coverage of PILD for LSS to a CMS-approved prospective RCT. After considering the related published literature and public comments as required by Section 1862(l) of the Act, CMS will expand the January 2014 NCD to cover PILD for LSS under CED through a prospective longitudinal study that meets certain criteria listed in Chapter 1, Section 150.13 of the NCD manual (Pub. 100-03). You should refer to Chapter 1, Section 310 of the NCD Manual, as well as Chapter 32, Sections 69 and 330, of the “Medicare Claims Processing Manual” (Pub. 100-04) for more information.

NOTE: As mentioned in MM8954, there are 2 distinct procedure codes that are to be used: G0276 only for clinical trials that are blinded, randomized, and controlled, and contain a placebo procedure control arm (use CR 8954 for claims processing instructions), and 0275T for all other approved clinical trials (use CR 8757 for claims processing instructions).

CR 10089 does not replace but rather is in addition to CR 8757 and CR 8954.

ADDITIONAL INFORMATION


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MLN Matters Number: MM10176  
Related Change Request (CR) Number: 10176  
Related CR Release Date: July 27, 2017  
Effective Date: January 1, 2018  
Related CR Transmittal Number: R3814CP  
Implementation Date: January 2, 2018

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

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

**BACKGROUND**

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

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

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

On professional claims, each code designated as “always therapy”:

- Must always be furnished under an SLP, OT, or PT plan of care, regardless of who furnishes them; and, as such,
- Must always be accompanied by one of the GN, GO, or GP therapy modifiers.

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

<table>
<thead>
<tr>
<th>Code</th>
<th>CPT Short Descriptor</th>
<th>Therapy Modifier Required</th>
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<tr>
<td>92521</td>
<td>Evaluation of speech fluency</td>
<td>GN</td>
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Table 1: Codes Requiring the “GN” Therapy Modifier

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

Table 2: Codes Requiring the “GO” Therapy Modifier

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

Table 3: Codes Requiring the “GP” Therapy Modifier

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

92507 92508 92526 92608 92609 96125 97012 97016 97018 97022 97024 97026 97028 97032 97033 97034 97035 97036 97039 97110 97112 97113 97116 97124 97139 97140 97150 97530 97532 97533 97535 97537 97542 97750 97755 97760 97761 97762 97799 G0281 G0283 G0329

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

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

During analyses of Medicare claims data for OPT services, the Centers for Medicare & Medicaid Services (CMS) found that these “always therapy” codes and modifiers are not always used in a correct and consistent manner. CMS found OPT professional claims for “always therapy” codes without the required modifiers. Also,

Continued >>
CMS found claims that reported more than one therapy modifier for the same therapy service; for example, both a GP and GO modifier, when only one modifier was allowed.

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

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

ADDITIONAL INFORMATION

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<tr>
<td>July 31, 2017</td>
<td>Initial article released.</td>
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EDI Enrollment Instructions Guide Module

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

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

Remittance Advice
EDI Agreement
EDI Application
EDI Provider Authorization
CMS 1500 Claim Form
Medical Director’s Desk

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

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

To contact the Medical Affairs Department:

e-mail: B.Policy@PalmettoGBA.com
Mail: Part B Medical Affairs, AG-300
      Palmetto GBA
      PO Box 100190
      Columbia, SC 29202-3190

Continued >>
Response to Comments
Vertebroplasty/Kyphoplasty L33473
Effective Date: 9/18/17

The comment period for the Vertebroplasty/Kyphoplasty Local Coverage Determination (LCD) L33473 began on 6/5/17 and ended on 7/20/17. No comments were received from the provider community.

Chiropractic Services L37387

The comment period for the Chiropractic Services Local Coverage Determination (LCD) L37387 began on 06/05/17 and ended on 07/20/17. The notice period will begin on 8/10/2017 and will end on 9/24/2017. The LCD will become effective on 9/25/2017. The following comments were received from the provider community:

Comment 1:
Stated that there is no clinical evidence that Chiropractors can effectively identify subluxation on a clinical exam and requested that the subluxation level be removed from the Documentation Requirements section of the LCD.

Response 1:
CMS Internet-Only Manual, Pub 100-02, Medicare Benefit Policy Manual, Chapter 15, §240.1.2 defines subluxation as a motion segment, in which alignment, movement integrity, and/or physiological function of the spine are altered although contact between joint surfaces remains intact. A subluxation may be demonstrated by an x-ray or by physical examination. With this definition in the manual the Medicare contractor is unable to make this change. Requests for changes of this nature should be addressed directly to CMS.

Comment 2:
Requested that the paragraph concerning Acute Exacerbations be deleted. “Suggests that the only time a chronic condition can be treated is when there has been an acute exacerbation”. Concern was also expressed about the term “significant interference”.

Response 2:
Per CMS Internet-Only Manual, Pub 100-02, Medicare Benefit Policy Manual, Chapter 15, §30.5B Under the Medicare program, Chiropractic maintenance therapy is not considered to be medically reasonable or necessary, and is therefore not payable. Maintenance therapy is defined as a treatment plan that seeks to prevent disease, promote health, and prolong and enhance the quality of life; or therapy that is performed to maintain or prevent deterioration of a chronic condition. When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered maintenance therapy. As per this manual citation, the only time that Chiropractic therapy is covered is when there is an acute situation. The use of the phrase “acute exacerbation” with the documentation requirement of specific dates is needed to differentiate those situations, where due to additional injury or another acute event, a chronic condition is aggravated to the point that the individual has “significant interference” with their daily activities. Palmetto GBA sees no reason to change this wording.

Comment 3:
Requested that in the paragraph below the word ‘must’ be replaced with the word ‘should’. The use of objective measures at the beginning of treatment, during and/or after treatment is recommended to quantify progress and support justifications for continued treatment. Therefore, treatment effectiveness must be assessed at appropriate intervals during subsequent visits (objective measurable goals).

Response 3:
Although it is recommended that objective measures of progress be used, subjective measures properly applied may be used. However, a statement of treatment effectiveness is required to justify further therapy. Since the parenthetical statement (objective measurable goals) may be confusing in this context, it will be modified to read (measurable goals).

Comment 4:
Commenter stated that i.e. is a specific definition or requirement where the requested use of e.g. represents possible examples in the paragraph below:
Specific recommendations (i.e. ‘home program’; life style modifications; etc.) for ongoing amelioration of musculoskeletal complaints should be provided as early in the course of treatment as possible should be reinforced at each visit and documented in the medical record.

Response 4:
It is agreed that this is an appropriate change and it will be made in the document.

Continued >>
Comment 5:
Requested that the paragraph below be removed because the intent was unclear and the requirement was unnecessary.
*For patients who have not achieved the goals documented in the Plan of Care, the practitioner should conclude the episode of chiropractic care in the last visit by documenting the clinical factors that contributed to the inability to meet the stated goals in the treatment plan.*
Response 5:
The paragraph uses the word “should” which do not make this documentation mandatory, however in the interest of complete documentation a reason (in the provider’s best reasoning) for failure of the therapy would be ideal for future reference. The paragraph will not be deleted.

Comment 6:
Requested to add the phrase “Chiropractic Manipulative Treatment (CMT) to the list of phrases used to describe Manual Manipulation, in that it was felt that this phrase was in standard usage.
Response 6:
Although the phrase “Chiropractic Manipulative Treatment” is indeed in common usage, the phrase includes methods of treatment that are not covered by Medicare. Therefore, the phrase is considered too non-specific and will not be included in the list.

Comment 7:
Requested clarification of the phrase “mechanism of trauma” under Documentation Requirements with the recommendation that the reference be changed to Mechanism of trauma (e.g., raking leaves, insidious onset, fell asleep in a recliner). It was the opinion of the group that the word trauma implies a specific incident such as an automobile accident or slip and fall.
Response 7:
The dictionary definition of trauma is; “an injury to living tissue caused by an external agent.” It is not felt that additional clarification of the term is necessary.

Comment 8:
Requested rewording of requirement 4 under Documentation Requirements: Subsequent Visits. The recommendation was to change the wording to “Documentation of any way the treatment plan is being changed”.
Response 8:
As noted previously “e.g.” represents examples not specific requirements, so the specific enumeration of the visits is not necessary, but would represent ideal documentation. However there is specific need, since it is expected for the patient to be making progress within their treatment plan, to document where they stand in that plan and what changes will be necessary in that plan when required. The paragraph will not be changed.

Comment 9:
Requested removal of the requirement of a written report signed by an MD/DO of X-Rays taken in a hospital or outpatient facility. The point was made that the imaging facility can take the films and send them to the ordering Doctor of Chiropractic (DC) for them to read. They also requested that the words medical record be changed to clinical record.
Response 9:
For the outside facility to bill for the X-rays they must provide the reading or bill for the technical component only. If no reading is done, and the films are sent to the DC under a contractual agreement for their reading, then the DC will bill the professional component of the X-Ray. The requirement is that if the DC is doing the reading a formal report of that reading must be accomplished. In this circumstance, the DC is considered the physician. If there is no agreement and the x-ray comes from outside, then to be used to establish subluxation there must be a written report in the record. The use of the term medical record vs. clinical record is purely semantics and will not be changed.

Comment 10:
Requested that the requirement “Documentation of changes in the patient’s examination, status and progression must be recorded at each visit” be changed to documentation should be recorded at “appropriate intervals”.
Response 10:
Each billed visit requires documentation of the medical necessity of the visit. This documentation requirement fulfills that requirement. To allow the documentation to occur “when appropriate” would not meet that requirement.

Continued >>
Comment 11:
Requested to change the materials required when a request for documentation is received. The current statement is:

On receipt of a request for documentation, at a minimum, the practitioner must submit the Initial Visit’s Treatment Plan, the Concluding/Discharge Visit and Subsequent Visits that demonstrate any change in the History, Physical Exam or Treatment Plan.

Specifically there was concern that the concluding/discharge visit may not be available if the patient has not been discharged.

On receipt of a request for documentation, the practitioner should submit the Initial Visit’s Treatment Plan (for that course of care), the Concluding/Discharge Visit (if applicable) and any visits in between that demonstrate a change in the History, Physical Exam, or Treatment Plan.

Response 11:
We understand the commenters concern; however, it should be clear when the appropriate documentation is provided that the treatment is ongoing. We see no reason to change this wording.

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<tr>
<th>Policy Title</th>
<th>LCD Revisions</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Octreotide Acetate for Injectable Suspension</td>
<td>Under CMS National Coverage Policy deleted “medically” from the verbiage cited for Title XVIII of the Social Security Act, §1862(a)(1)(A), deleted online from the cited CMS Internet-Only Manuals, and deleted CMS Internet-Only Manual, Pub 100-08, Medicare Program Integrity Manual, Chapter 13, §§13.1-13.13.15. Under Coverage Indications, Limitations and/or Medical Necessity deleted “GI” from the second bullet. Under Sources of Information and Basis for Decision deleted M Chaplin and added “et al.”</td>
<td>7/27/17</td>
</tr>
<tr>
<td>Vestibular Function Testing</td>
<td>Under CMS National Coverage added the first paragraph, revised the verbiage for Title XVIII of the Social Security Act, §1862 (a) (7) and deleted the example cited for HCFA Ruling 95-1. The section cited for Independent diagnostic testing facility was corrected to read §410.33. Under Coverage Indications, Limitations and/or Medical Necessity deleted “the” in the second sentence of the second paragraph. Under Treating Physician/Billing Provider deleted “If” in the third sentence and corrected capitalization and punctuation. Under Scope of Practice in the first sentence, the CPT code range was revised to now read 92541-92542 and 92544-92548 and “provides” was corrected to now read “providers”. Under Hearing Testing italicized the second sentence in the second paragraph. Under Associated Information-Documentation Requirements-Utilization added “In this instance…” to the last sentence in the second paragraph and deleted CPT code 92285 from the fourth paragraph. Under Associated Information-Documentation Requirements-Utilization-Summary italicized verbiage in the second paragraph and corrected “war” to read “warm”. In the fourth paragraph added verbiage in the first sentence and revised “exam” to read “examination”. Under Sources of Information and Basis for Decision corrected the following journal citation to now read Bhattacharyya N, Baugh RF, Orvidas L, et al. Clinical practice guideline: Benign paroxysmal positional vertigo. Otolaryngol Head Neck Surg. 2008;139(5 suppl 4):S47-S81.</td>
<td>8/3/17</td>
</tr>
<tr>
<td>Oral Maxillofacial Prosthesis</td>
<td>The Oral Maxillofacial Prosthesis Local Coverage Determination (LCD) L33468 will be retired effective 09/17/17. This LCD is being retired as information included in the LCD was incorporated into the Cosmetic and Reconstructive Surgery LCD L33428 effective 09/18/17.</td>
<td>9/17/17</td>
</tr>
<tr>
<td>Transthoracic Echocardiography (TTE)</td>
<td>Transthoracic Echocardiography (TTE) Local Coverage Determination (LCD) L33472 is being retired effective 09/17/17 as this LCD is being incorporated into the Echocardiography LCD L37379 effective 09/18/17.</td>
<td>9/17/17</td>
</tr>
</tbody>
</table>

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Transesophageal Echocardiography (TEE) Local Coverage Determination (LCD) L33471 is being retired effective 09/17/17 as this LCD is being incorporated into the Echocardiography LCD L37379 effective 09/18/17.

Stress Echocardiography Local Coverage Determination (LCD) L33448 is being retired effective 09/17/17 as this LCD is being incorporated into the Echocardiography LCD L37379 effective 09/18/17.

A/B MAC Local Coverage Determinations

Response to Comments
Cosmetic and Reconstructive Surgery L33428
The comment period for the Cosmetic and Reconstructive Surgery Local Coverage Determination (LCD) L33428 began on 06/05/17 and ended on 07/20/17. No comments were received from the provider community. The notice period begins on 08/03/17 and ends on 09/17/17.
Effective Date: 9/18/17

Echocardiography L37379
The comment period for the Echocardiography Local Coverage Determination (LCD) L37379 began on 06/05/17 and ended on 07/20/17. No comments were received from the provider community. This LCD will begin the notice period on 08/03/17 and end on 09/17/17. The LCD will become effective on 09/18/17.
Effective Date: 9/18/17

Cardiac Computed Tomography & Angiography (CCTA) L33423
The comment period for the Cardiac Computed Tomography & Angiography (CCTA) Local Coverage Determination (LCD) L33423 began on 06/05/17 and ended on 07/20/17. The following comments were received from the community provider:

Comment: Heart rate limitation in the limitation number 4 is not appropriate given the equipment used today.
Response: The verbiage “Heart rate limitation in the limitation number 4 is not appropriate given the equipment used today” will be removed and the verbiage “CCTA patients must be able to lie still, follow breathing instructions, and take nitroglycerin for coronary dilatation” will be added.

Comment: Are Heartflow determinations addressed in this LCD?
Response: This LCD does not address Heartflow determinations.

Comment: References in the LCD were not complete and provided additional references.
Response: The additional references provided will be included in the LCD.

Comment: A request that an additional indication will be placed for patients with intermediate risk with discordant clinical situation (e.g. ongoing ischemic symptoms, normal stress test) which may avoid invasive coronary angiography.
Response: This statement will be added under the section Symptomatic Coronary Artery Disease (CAD) “Patients with intermediate risk and a discordant clinical situation (e.g. ongoing ischemic symptoms, normal stress test)”.

Comment: Requests that calcium scoring be removed from the LCD.
Response: Section 5 under limitations will be changed to read “Prior to the initiation of a CCTA, the physician must make an assessment of the anatomic location, degree and intensity of calcification and impact of the calcification on the utility of the test results. CCTA’s performed on patients with elevated quantitative calcium scores that preclude accurate assessment of coronary anatomy are not covered by Medicare”.

Effective Date: 9/18/2017

Non-Covered Category III CPT Codes L34555
The comment period began on 06/05/17 and ended on 07/20/17. Comments were received from the provider community. The Notice

Continued >>
Period begins on 08/17/17 and ends on 10/01/17. The LCD will become effective on 10/02/17.

**Comment:** Requested coverage of CPT Code 0398T Magnetic Resonance Guided Focused Ultrasound (MRgFUS).

**Response:** Palmetto GBA has reviewed the available published, peer-reviewed information concerning this procedure. Although the ExAblate Model 4000 Type 1.0 System (ExAblate Neuro) has received FDA approval for marketing, related to the delivery of MRgFUS to the population of individuals with medication-refractory Essential Tremor (ET), this does not automatically confer Medicare coverage.

Medicare coverage requires that items and services be “reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member”. There remain questions as to whether the treatment effect noted at 3 – 12 months post MRgFUS (e.g., improvement in hand tremor scores) is sustained over time. These questions are being addressed by the FDA’s Office of Device Evaluation (ODE) Post Approval Study requirement, noted in the FDA’s July 16, 2016 Pre-Market Approval (PMA) letter to the device’s manufacturer InSightec, Inc. The PMA letter conveyed the following:

The “Long-Term Observational Follow-Up Study of Medication Refractory Essential Tremor Subjects Treated with ExAblate Transcranial MRgFUS Thalamotomy under IDE G120246” is a long term follow-up study of patients treated in the pivotal clinical trial evaluating both safety and effectiveness of the ExAblate Neuro device to 5 years post-operative treatment.

“The purpose of this observational, prospective follow-up clinical study is to collect long-term information regarding the safety and effectiveness of medication-refractory Essential Tremor patients treated with the ExAblate Neuro. Patients from the pivotal clinical study conducted under G120246 treated with the ExAblate Neuro (75 patients) will be evaluated at 2, 3, 4 and 5 years post-operative for the following endpoints: Clinical Rating Scale for Tremor (CRST), Patient Reported Questionnaire for Essential Tremor (QUEST), and Adverse Events.”

The concerns for the temporal waning of treatment effects, together with an increased frequency of certain adverse events noted in the treatment group (e.g., gait impairment and numbness) when compared to the control group, are also echoed in the following published medical resources and articles reviewed as part of Palmetto GBA’s decision-making process:

UpToDate®: Surgical treatment of Essential Tremor, in the subsection entitled “Ultrasound Thalamotomy” Per the current document, the last update occurred on May 26, 2017 with the literature current to April 2017.


Palmetto GBA remains open to evaluating the results of the FDA long-term follow-up study and reconsidering its coverage position as new published, peer-reviewed information becomes available.

**Comment:** Received two comments expressing “broad concerns” in that the LCD “excluded a large swath of services from Medicare coverage” and requested that “Palmetto withdraw the blanket non-coverage LCD and consider coverage (or non-coverage) for these procedures individually and on their own merits moving forward.”

**Response:**

Per the AMA

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Because CPT Category III codes are intended to be used for data collection purposes to substantiate widespread usage or to provide documentation for the FDA approval process, they are not intended for services or procedures that are not accepted by the CPT Editorial Panel due to an incomplete proposal, the need for more information, or a lack of CPT Advisory Committee support.

**Per the LCD**

Title XVIII of the Social Security Act, §1862(a)(1)(A) is the basis for denying payment for types of care, specific items, services, or procedures, not excluded by any other statutory clause, meeting all technical requirements for coverage, but are determined to be any of the following:

- Not generally accepted in the medical community as safe and effective in the setting and for the condition for which it is used
- Not proven to be safe and effective based on peer review or scientific literature
- Experimental
- Not medically necessary in the particular case
- Furnished at a level, duration or frequency that is not medically appropriate
- Not furnished in accordance with accepted standards of medical practice, or
- Not furnished in a setting (such as inpatient care at a hospital or SNF, outpatient care through a hospital or physician’s office or home care) appropriate to the patient’s medical needs and condition.
- Items and services must be established as safe and effective to be considered medically necessary. That is, the items and services must be:
  - Consistent with the symptoms or diagnosis of the illness or injury under treatment;
  - Necessary for, and consistent with, generally accepted professional medical standards of care (e.g., not experimental or investigational);
  - Furnished at the most appropriate level that can be provided safely and effectively to the patient.

Medical devices that are not approved for marketing by the Food and Drug Administration (FDA) are considered investigational by Medicare and are not considered reasonable and necessary for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member. Program payment, therefore, may not be made for medical procedures and services performed using devices that have not been approved for marketing by the FDA or for those not included in an FDA-approved investigational (IDE) trial.

In the opinion of Palmetto GBA the CPT Category III codes as a group are either experimental, or have not reached the level of generally accepted standards of care, and for this reason should not be covered.

If a beneficiary, provider or other party doing business within Palmetto GBA's jurisdiction (SC, NC, VA, WVA) would like to request to have a CAT III code adopted for coverage, they may apply for a reconsideration of the inclusion of the code in this LCD by following the instructions concerning LCD Reconsiderations found in the following article: https://www.palmettogba.com/Palmetto/Providers.nsf/docsCat/JM%20Part%20B~Medical%20Policies~LCD%20Reconsideration%20Process?open&Expand=1

This article describes in detail the required documentation for consideration of the request.

**Comment:**Requested coverage of an implantable aqueous shunt for glaucoma. They noted that another contractor had a draft LCD that provides coverage for this type of device.

**Response:** Palmetto GBA has been reviewing these devices and have decided that some (if not all) should be covered for placement as part of cataract surgery. The information provided with the comment meets the documentation requirements for this particular device, and it will be incorporated into the LCD on these devices that is currently being prepared.

Since exactly which of these devices will be covered has yet to be determined, the device in question will not be removed until the pending LCD is published and becomes effective.

**Effective Date:** 8/17/17
<table>
<thead>
<tr>
<th>Policy Title</th>
<th>LCD Revisions</th>
<th>Effective Date</th>
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</thead>
<tbody>
<tr>
<td>CT of the Head</td>
<td>Under <strong>ICD-10 Codes that Support Medical Necessity</strong> added ICD-10 code R56.9.</td>
<td>8/3/17</td>
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<tr>
<td>L34417 Rev #10</td>
<td></td>
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<tr>
<td>Ophthalmic Angiography (Fluorescein and Indocyanine Green) L34426 Rev #12</td>
<td>Under <strong>CMS National Coverage Policy</strong> corrected the titles for 42 CFR §410.74, §410.75, and §410.76. Under <strong>ICD-10 Codes That Support Medical Necessity</strong> - <strong>ICD-10 Codes for Fluorescein Angiography (92235)</strong> - <strong>Group 1: Codes</strong> deleted H34.10, M05.411, M05.412, M05.421, M05.422, M05.431, M05.432, M05.441, M05.442, M05.451, M05.452, M05.461, M05.462, M05.471, M05.472, M05.49, M05.511, M05.512, M05.521, M05.522, M05.531, M05.532, M05.541, M05.542, M05.551, M05.552, M05.561, M05.562, M05.571, M05.572, M05.59, M05.711, M05.712, M05.721, M05.722, M05.731, M05.732, M05.741, M05.742, M05.751, M05.752, M05.761, M05.762, M05.771, M05.772, M05.79, M05.811, M05.812, M05.821, M05.822, M05.831, M05.832, M05.841, M05.842, M05.851, M05.852, M05.861, M05.862, M05.871, M05.872, M05.89, M06.011, M06.012, M06.021, M06.022, M06.031, M06.032, M06.041, M06.042, M06.051, M06.052, M06.061, M06.062, M06.071, M06.072, M06.08, M06.09, M06.211, M06.212, M06.221, M06.222, M06.231, M06.232, M06.241, M06.242, M06.251, M06.252, M06.261, M06.262, M06.271, M06.272, M06.28, M06.29, M06.311, M06.312, M06.321, M06.322, M06.331, M06.332, M06.341, M06.342, M06.351, M06.352, M06.361, M06.362, M06.371, M06.372, M06.38, M06.39, M06.811, M06.812, M06.821, M06.822, M06.831, M06.832, M06.841, M06.842, M06.851, M06.852, M06.861, M06.862, M06.871, M06.872, M06.88, and M06.89. Under <strong>ICD-10 Codes That Support Medical Necessity</strong> - <strong>ICD-10 Codes for Indocyanine Green Angiography (92240)</strong> - <strong>Group 2: Codes</strong> deleted H35.059 and added ICD-10 codes D31.31 and D31.32. Under <strong>Sources of Information and Basis for Decision</strong> corrected punctuation and spelling, and deleted the two National Guideline Clearinghouse citations as these were archived.</td>
<td>8/3/17</td>
</tr>
<tr>
<td>Minimally Invasive Treatment for Benign Prostatic Hyperplasia Involving Prostatic Urethral Lift (Urolift®) L36109 Rev #5</td>
<td>Under <strong>Coverage Indications, Limitations and/or Medical Necessity</strong> - <strong>Introduction</strong> fourth paragraph second sentence corrected the spelling of “terephthalate” to “terephthalate”. Under <strong>Background</strong> third paragraph third sentence added the acronym “(IPSS)” after “International Prostate Symptom Score”, revised the sentence after the sixth paragraph “A Randomized Control Trial (RCT) directly comparing UroLift® to TURP is scheduled for completion in December 2015” to now read “A Randomized Control Trial (RCT) directly comparing UroLift® to TURP was completed in January 2016 and last updated on February 18, 2016” and removed the quotations from the last sentence. Under <strong>Associated Information – Documentation Requirements</strong> - <strong>fourth bullet</strong> added the words “American Urological Association” in front of the acronym (AUA) and capitalized the words “Symptom Index”. Under <strong>Sources of Information and Basis for Decision</strong> corrected the title “Cantwell AL, Bogache WK, Richardson SF, et al. Multicentre prospective crossover study of the prostatic urethral lift for the treatment of lower urinary tract symptoms secondary to benign prostatic hyperplasia. BJU Int. 2014;113(4):615-622”.</td>
<td>7/27/17</td>
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<tr>
<td>Cardiac Computed Tomography &amp; Angiography (CCTA) L33423 Rev #5</td>
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<td>Under <strong>Coverage Indications, Limitations and/or Medical Necessity-Symptomatic Coronary Artery Disease (CAD)</strong> added a bullet with the verbiage “Patients with intermediate risk and a discordant clinical situation (e.g. ongoing ischemic symptoms, normal stress test)”. Under <strong>Limitations</strong> added verbiage in number 2. “This LCD does not address Heartflow determinations”, deleted the verbiage in number 4. “CCTA patients must be able to lie still, follow breathing instructions, take nitroglycerine for coronary dilatation and take a beta-blocker or calcium blocker to achieve heart rates less than 70 BPM” and added the verbiage and the verbiage “CCTA patients must be able to lie still, follow breathing instructions, and take nitroglycerin for coronary dilatation” and deleted the verbiage in number 5. “Prior to the initiation of a CCTA, there must be an imaging assessment of coronary calcification (calcium scoring). The physician must make an assessment of the anatomic location, degree and intensity of calcification and impact of calcification on the utility of the test results. CCTAs performed on patients with elevated quantitative calcium scores that preclude accurate assessment of coronary anatomy are <strong>not</strong> covered by Medicare” and added the verbiage “Prior to the initiation of a CCTA, the physician must make an assessment of the anatomic location, degree and intensity of calcification and impact of the calcification on the utility of the test results. CCTA’s performed on patients with elevated quantitative calcium scores that preclude accurate assessment of coronary anatomy are <strong>not</strong> covered by Medicare”. Under <strong>Sources of Information and Basis for Decision</strong> added new citations.</td>
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<td>8/03/17</td>
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<tr>
<th>White Cell Colony Stimulating Factors L37176 Rev #1</th>
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</thead>
<tbody>
<tr>
<td>Under <strong>ICD-10 Codes That Support Medical Necessity- Patients with Cancer Receiving Myelosuppressive Chemotherapy- Group 1: Codes</strong> added C90.00, C90.02, C90.10, C90.12, C81.00-C86.6 and C88.0-C88.9. This revision is retroactive to 06/12/2017.</td>
</tr>
<tr>
<td>8/10/17</td>
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<tr>
<th>Infliximab (Remicade®) L35677 Rev #16</th>
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<tbody>
<tr>
<td>Under <strong>CMS National Coverage Policy</strong> Title XVIII of the Social Security Act, §1862(a)(1)(A) revised the verbiage to read “allows coverage and payment for only those services that are considered to be medically reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member”. Under <strong>ICD-10 Codes that Support Medical Necessity</strong> added M06.9 and D86.9. Under <strong>Sources of Information and Basis for Decision</strong> added and corrected author’s initials and names, added volume numbers and corrected capitalization for numerous journal titles.</td>
</tr>
<tr>
<td>9/04/17</td>
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<tr>
<th>Non-Covered Category III CPT Codes L34555 Rev #17</th>
</tr>
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<tbody>
<tr>
<td>Under <strong>CPT/HCPCS Codes- Group 1: Codes</strong> deleted CPT codes 0387T, 0389T, 0390T, and 0391T as these are now covered for dates of service on or after 01/18/17 through Coverage with Evidence Development (CED) when procedures are performed in CMS approved CED studies, per Change Requests 10117, Transmittals 201 and 3815, dated July 28, 2017. CPT 0438T was deleted as this is now a covered procedure effective 10/02/17. CPT codes 0163T and 0165T were added effective 08/14/07. CPT codes 0101T and 0102T were added effective 08/09/17 as these were previously included in the retired <strong>Non-Coverage of Extracorporeal Shock Wave Lithotripsy for Musculoskeletal Conditions LCD L33527</strong>. CPT codes 0469T, 0470T, 0471T, 0472T, 0473T, 0475T, 0476T, 0477T, and 0478T were added and the description was changed for CPT code 0254T due to the July 2017 Quarterly CPT/HCPCS Updates effective 07/01/17.</td>
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<td>10/2/17</td>
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<table>
<thead>
<tr>
<th>Section</th>
<th>Details</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Noncovered Services other than CPT® Category III</td>
<td>Under <strong>CPT/HCPCS Codes – Group 1: Codes</strong> the code descriptions changed for 90620 and 90621. This revision is due to the Q3 CPT/HCPCS Update. This revision is retroactive to 07/01/17.</td>
<td>8/17/17</td>
</tr>
<tr>
<td>Noncovered Services L36954 Rev #3</td>
<td></td>
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<tr>
<td>Application of Skin Substitutes L36466 Rev #5</td>
<td>Under <strong>Coverage Indications, Limitations and/or Medical Necessity</strong> - Limitations bullet #6 added the verbiage “...where no documented counseling on the effects of smoking on surgical outcomes and the success of the application of skin grafts is available.”</td>
<td>8/17/17</td>
</tr>
<tr>
<td>Retired LCDs</td>
<td>The A/B MAC <strong>Non-Coverage of Extracorporeal Shock Wave Lithotripsy for Musculoskeletal Conditions Local Coverage Determination (LCD) L35627</strong> is being retired effective 08/08/17 as this LCD is being incorporated into the <strong>Non-Covered Category III CPT Codes LCD L34555</strong>.</td>
<td>8/08/17</td>
</tr>
<tr>
<td>Article Title - Articles</td>
<td><strong>Billing and Coding of Drug and Biological Infusions A55297 Rev #5</strong></td>
<td>7/20/17</td>
</tr>
<tr>
<td>Article Text</td>
<td>Under <strong>Article Text</strong> in the second paragraph the year and page number were revised for the cited reference. In the third paragraph the verbiage was corrected to read verbatim as cited in the CPT® 2017 Professional Edition. In the fifth paragraph added “s” to Title XVIII of the Social Security Act, §1861. Under <strong>Article Text-Generic Name (Trade Name) HCPCS Code</strong> in the second paragraph deleted “C9472 effective 4/1/16” for Imlygic® as the timeframe for billing this specific code has expired. Under <strong>Article Text-Infusions Chemotherapy</strong> added “Injectable” to the first sentence. Under <strong>Article Text-Generic Name (Trade Name) HCPCS Code</strong> the trademark symbol was changed to the registered symbol for the following drugs: Lemtrada®, Darzalex®, Simponi Aria®, Portrazza®, and Infllectra®. C9476 (Darzalex®), C9477 (Empliciti™), C9474 (Onivyde®), C9475 (Portrazza®), and C9480 (Yondelis®) were deleted as the timeframe for billing these specific codes has expired.</td>
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<tr>
<td>Billing and Coding Instructions for Lemtrada® (alemtuzumab) When Used in the Treatment of Relapsing Multiple Sclerosis A55310 Rev #1</td>
<td>Under <strong>Article Text</strong> second sentence added the word “consecutive” after the number “3”, under <strong>Diagnosis-(Box 66)</strong> deleted the verbiage “ICD-9 340 Multiple Sclerosis (for claims with DOS from 11/14/2014 to 9/30/2015)”, under <strong>HCPCS drug code-(Field 44)</strong> deleted the verbiage “C9399 Unclassified drugs or biologics (DOS from 11/14/2014 to 9/30/2015)” and “Q9979 Injection, alemtuzumab 1mg (DOS from 10/01/2015 to 12/31/2015)” under <strong>Diagnosis-(Box 21)</strong> deleted the verbiage “ICD-9 340 Multiple Sclerosis (for claims with DOS from 11/14/2014 to 9/30/2015)” and under <strong>HCPCS drug code-(Box 24D)</strong> deleted the verbiage “J3490 Unclassified drugs or J3590 unclassified biologics (DOS from 11/14/2014 to 9/30/2015)” and “Q9979 Injection, alemtuzumab 1mg (DOS from 10/01/2015 to 12/31/2015)”</td>
<td>8/03/17</td>
</tr>
<tr>
<td>Self-Administered Drug Exclusion List A53066 Rev #11</td>
<td>Under <strong>Excluded CPT/HCPCS Codes-Table Format</strong> added J3490 Haegarda®.</td>
<td>10/2/17</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Policy Title</th>
<th>LCD Revision</th>
<th>Effective Date</th>
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</thead>
<tbody>
<tr>
<td>MolDX: Circulating Tumor Cell Marker Assays L35071, #3</td>
<td>Added MolDX: into the title of the policy. At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.</td>
<td>7/20/17</td>
</tr>
<tr>
<td>MolDX: Oncotype DX® Breast Cancer for DCIS (Genomic Health™) L36912, #3</td>
<td>Corrected typographical error in title.</td>
<td>7/20/17</td>
</tr>
<tr>
<td>MolDX-CDD: ConfirmMDx Epigenetic Molecular Assay L35632, #6</td>
<td>Updated a typographical error in the reference numbering. At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.</td>
<td>7/20/17</td>
</tr>
<tr>
<td>MolDX: Percepta© Bronchial Genomic Classifier L36854, #2</td>
<td>Removed CDD from the title of the policy.</td>
<td>7/20/17</td>
</tr>
<tr>
<td>MolDX: Prolaris™ Prostate Cancer Genomic Assay for Men with Favorable Intermediate Risk Disease L37043, #3</td>
<td>Corrected typographical errors. Removed “,” and” from last bullet under “Criteria of Coverage” in the Summary of Evidence section. Added “PSA &gt; 20 ng/mL” as the last bullet “Clinicopathologic Findings” in the Summary of Evidence section that was erroneously deleted in an earlier version.</td>
<td>8/10/17</td>
</tr>
<tr>
<td>MolDX: Prometheus IBD sgi Diagnostic Policy L37260, #1</td>
<td>This LCD version was created as a result of DL37260 being released to a Final LCD.</td>
<td>9/26/17</td>
</tr>
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<thead>
<tr>
<th>Article Title</th>
<th>Article Revision</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>MolDX: PreDx® Coding and Billing Guidelines A53489, #3</td>
<td>Updated the CPT code and the added DEX Z-Code identifier information. Added the Part A contractor numbers.</td>
<td>7/20/17</td>
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<tr>
<td>MolDx: ResponseDX Tissue of Origin® Coding and Billing Guidelines A53108, #14</td>
<td>Added DEX Z-Code identifier information and Part A contractor numbers.</td>
<td>7/20/17</td>
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<tr>
<td>MolDX: PIK3CA Gene Tests Coding and Billing Guidelines A53558, #5</td>
<td>Added DEX Z-Code identifier information and Part A contractor numbers.</td>
<td>7/20/17</td>
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<tr>
<td>MolDX: IKBKAP Genetic Testing Coding and Billing Guidelines A53596, #5</td>
<td>Added DEX Z-Code identifier information and Part A contractor numbers.</td>
<td>7/20/17</td>
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<tr>
<td>MolDX: L1CAM Gene Sequencing Coding and Billing Guidelines A53659, #5</td>
<td>Added DEX Z-Code identifier information and Part A contractor numbers.</td>
<td>7/20/17</td>
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Continued >>
| MolDX: know error® Billing and Coding Guidelines Update A53554, #5 | Added DEX Z-Code identifier information and Part A contractor numbers. | 7/20/17 |
| MolDX: PTCH1 Gene Testing Coding and Billing Guidelines A53567, #2 | Added DEX Z-Code identifier information and Part A contractor numbers. | 7/20/17 |
| MolDX: BCR-ABL Coding and Billing Guidelines A53531, #4 | Added Part A contractor numbers and corrected formatting issue. | 7/20/17 |
| MolDX: OncoCee™ Billing and Coding Guidelines A53112, #6 | Removed old CPT stack code table and replaced with correct CPT codes. | 7/27/17 |
| MolDX: bioTheranostics Cancer TYPE ID® Update A53101, #10 | Added Part A contractor numbers. | 8/10/17 |
| MolDX: Vectra™ DA Coding and Billing Guidelines A53110, #10 | Added Part A contractor numbers. | 8/10/17 |
| MolDX: Avise PG Assay Billing/Coding Update A53100, #6,7 | Added DEX Z-Code identifier information and Part A contractor numbers | 8/10/17 |
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MLN Connects™ contains a week’s worth of Medicare-related messages instead of many different messages being sent to you throughout the week. This notification process ensures planned, coordinated messages are delivered timely about Medicare-related topics.

MLN Connects™ for July 27, 2017

MLN Connects™ for August 3, 2017

MLN Connects™ for August 10, 2017

MLN Connects™ for August 17, 2017

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

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

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https://www.cms.gov/MLNGenInfo

Palmetto GBA Medicare Customer Information and Outreach

Important Telephone Numbers

Provider Contact Center
(855) 696-0705 (Toll-Free)

Electronic Data Interchange (EDI)
Technical Support
(855) 696-0705

Medicare Beneficiary Call Center
1-800-MEDICARE (1-800-633-4227)
TTY 1-877-486-2048

Training Available
To request a Medicare Education meeting/seminar at no cost to you, complete and fax the form located on the

http://www.PalmettoGBA.com/Medicare

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

Attention: Billing Manager