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Official Information Health Care Professionals Can Trust
For Home Health Providers

Home Health No-Payment Billing (Condition Code 21)

CGS has seen instances where no payment claims are being submitted with the incorrect type of bill (TOB) 0329. No-payment claims are submitted to seek denials for the entire claim in cases where you know all services will not be covered by Medicare. Such denials allow providers to obtain a denial notice from Medicare for other payer consideration. According to CMS Pub. 100-04, Chapter 10, Section 60 (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c10.pdf), a no-payment claim must be submitted with the 0320 TOB and condition code 21. Submitting an incorrect TOB will apply an incorrect denial reason code to the claim and may cause claim processing delays. Refer to the CGS Home Health No-Payment Billing (Condition Code 21) Web page at https://www.cgsmedicare.com/hhh/education/materials/hh_nopay_billing.html for detailed billing information.

For Home Health Providers

SE17027: Clarification of Billing and Payment Policies for Negative Pressure Wound Therapy (NPWT) Using a Disposable Device

The Centers for Medicare & Medicaid Services (CMS) has revised the following Special Edition Medicare Learning Network® (MLN) Matters article. This MLN Matters article and other CMS articles can be found on the CMS website at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/

MLN Matters® Number: SE17027 Related Change Request (CR) #: N/A
Related CR Release Date: September 20, 2017 Effective Date: N/A
Related CR Transmittal #: N/A Implementation Date: N/A

Provider Type Affected
This MLN Matters® Article is intended for Home Health Agencies (HHAs) submitting claims to Home Health & Hospice Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.
What You Need to Know

This Special edition MLN Matters article is informational only and is intended to provide helpful information to providers. The article does not reflect any change in Medicare policy.

Background

The Consolidated Appropriations Act, 2016 (Pub. L. 114-113) requires a separate payment to be made to Home Health Agencies (HHAs) for disposable Negative Pressure Wound Therapy (NPWT) devices when furnished, on or after January 1, 2017, to an individual who receives home health services for which payment is made under the Medicare home health benefit. In the CY 2017 HH PPS Final Rule, the Centers for Medicare & Medicaid Services (CMS) finalized policies related to payment for furnishing NPWT using a disposable device under a home health plan of care.

Reporting NPWT Services using a Disposable Device:

Effective January 1, 2017, Medicare makes a separate payment amount for a disposable Negative Pressure Wound Therapy (NPWT) device for a patient under a home health plan of care. Payment is equal to the amount of the payment that would otherwise be made under the Outpatient Prospective Payment System (OPPS).

Disposable NPWT services are billed using the following Current Procedural Terminology® (CPT®) codes:

- 97607 - Negative pressure wound therapy, (e.g., vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters.
- 97608 - Negative pressure wound therapy, (e.g., vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters.

The HHA reports the CPT® code with one of three revenue codes, depending on the practitioner that provided the service:

- Skilled nurse – 0559
- Physical therapist – 042x
- Occupational therapy – 043x.

When using revenue codes 042x or 043x, the HHA should not use the therapy plan of care modifiers (GO or GP) for NPWT services.

There are no additional documentation requirements for the provision of NPWT using a disposable device. The HHA documentation (and any supporting documentation leading to the order for home health and NPWT using a disposable device) should support that the patient needs wound care using NPWT. The medical necessity and documentation requirements would be no different than what is currently required when patients receive wound care from a home health nurse when the patient is receiving conventional NPWT. HHAs may also follow their own internal policies and procedures for documenting clinical information in the patient’s medical record beyond those required by regulation.

Billing for NPWT Services

The (CPT®) codes for furnishing NPWT using a disposable device include both performing the service and the disposable NPWT device, which is defined as an integrated system...
When furnishing NPWT using a disposable device, both the device and the services associated with furnishing the device are paid for separately based on the OPPS amount.

When a HHA furnishes NPWT using a disposable device, the HHA is furnishing a new disposable NPWT device.

- This means the HHA provider is either initially applying an entirely new disposable NPWT device, or removing a disposable NPWT device and replacing it with an entirely new one.
- In both cases, all the services associated with NPWT—for example, conducting a wound assessment, changing dressings, and providing instructions for ongoing care—must be reported on TOB 34x with the corresponding CPT® code (that is, CPT® code 97607 or 97608); they may not be reported on the home health claim (TOB 32x).
- The reimbursement for all of these services is included in the OPPS reimbursement amount for those two CPT® codes.
- Any follow-up visits for wound assessment, wound management, and dressing changes where a new disposable NPWT device is not applied must be included on the home health claim (TOB 32x).

Some example billing scenarios for HHAs furnishing NPWT using a disposable device are provided below:

<table>
<thead>
<tr>
<th>Clinical Scenario</th>
<th>Appropriate Billing Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Scenario 1:</strong> A nurse assesses the patient’s condition, assesses the wound, and applies a new disposable NPWT device. The nurse also provides wound care education to the patient and family. On the following Monday, the nurse returns, assesses the wound, and replaces the device that was applied the week before with an entirely new disposable NPWT device.</td>
<td>All services provided by the nurse were associated with furnishing NPWT using a disposable device because the nurse applied a new disposable NPWT device during each visit. The nurse did not provide any services other than furnishing NPWT using a disposable device. Therefore, all the nursing services for both visits should be reported on TOB 34x with CPT® code 97607 or 97608. None of the services should be reported on TOB 32x.</td>
</tr>
<tr>
<td><strong>Scenario 2:</strong> On Monday, a nurse assesses a wound, applies a new disposable NPWT device, and provides wound care education to the patient and family. The nurse returns on Thursday for wound assessment and replaces the fluid management system (or dressing) for the existing disposable NPWT, but does not replace the entire device. The nurse returns the following Monday, assesses the patient’s condition and the wound, and replaces the device that had been applied on the previous Monday with a new disposable NPWT device.</td>
<td>For both Monday visits, all the services provided by the nurse were associated with furnishing NPWT using a disposable device. The nurse did not provide any services that were not associated with furnishing NPWT using a disposable device. Therefore, all the nursing services for both Monday visits should be reported on TOB 34x with CPT® code 97607 or 97608. None of the services should be reported on TOB 32x. For the Thursday visit, the nurse checked the wound, but did not apply a new disposable NPWT device, so even though the nurse provided care related to the wound, those services would not be considered furnishing NPWT using a disposable device. Therefore, the services should be reported on bill type 32x and no services should be reported on bill type 34x.</td>
</tr>
<tr>
<td><strong>Scenario 3:</strong> On Monday, the nurse applies a new disposable NPWT device. On Thursday, the nurse returns for a scheduled visit to change the beneficiary’s indwelling catheter. While there, the nurse assesses the wound and applies a new fluid management system (or dressing) for the existing disposable NPWT device, but does not replace the device entirely.</td>
<td>For the Monday visit, all the nursing services were associated with furnishing NPWT using a disposable device. The nurse did not provide any services that were not associated with furnishing NPWT using a disposable device. Therefore, the HHA should report the nursing visit on TOB 34x with CPT® code 97607 or 97608; the visit should not be reported on a 32x claim. For the Thursday visit, while the nursing services included wound assessment and application of a component of the disposable NPWT device, the nurse did not furnish a new disposable NPWT device. Therefore, the nurse did not furnish NPWT using a disposable device, so the HHA should report all the nursing services for the visit, including the catheter change and the wound care, on TOB 32x.</td>
</tr>
</tbody>
</table>
Clinical Scenario | Appropriate Billing Procedure
--- | ---
**Scenario 4:**
On Monday, the nurse applies a new disposable NPWT device, and provides instructions for ongoing wound care. During this same visit, per the HH plan of care, the nurse changes the indwelling catheter and provides troubleshooting information and teaching regarding its maintenance.
The visit included applying a new disposable NPWT device as well as services unrelated to that NPWT service, which means the HHA will submit both a TOB 34x and a TOB 32x.
For furnishing NPWT using a disposable device, that is, the application of the new disposable NPWT device and the time spent instructing the beneficiary about ongoing wound care, the HHA would bill using a TOB 34x with CPT® code 97607 or 97608.
For services not associated with furnishing NPWT using a disposable device, that is, for the replacement of the indwelling catheter and instructions about troubleshooting and maintenance, the HHA would bill under TOB 32x.

In addition to the routine, required information for submission on Medicare claims, the following identifies specific information required for HHAs to submit NPWT using a disposable device on a 34X Type of Bill (TOB).

<table>
<thead>
<tr>
<th>Field Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOB</td>
<td>34X — Performing NPWT using a disposable device (integrated system of a vacuum pump, receptacle for collecting exudate, and dressings for the purpose of wound therapy)</td>
</tr>
<tr>
<td>STMT DATES FROM/TO</td>
<td>Enter the dates of service for the billing period. NOTE: the dates should fall within the &quot;FROM&quot; and &quot;TO&quot; dates for the HH PPS episode of care provided by the primary HHA.</td>
</tr>
<tr>
<td>REV</td>
<td>Report the appropriate revenue code. Valid codes are: 0559 – Skilled nurse (report HCPCS codes 97607 or 97608) 042X – Physical therapy 043X – Occupational therapy</td>
</tr>
<tr>
<td>HCPC</td>
<td>Enter the appropriate HCPCS code (report with revenue code 0559): 97607—Negative pressure wound therapy (e.g., vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters. 97608—Negative pressure wound therapy (e.g., vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters.</td>
</tr>
<tr>
<td>TOT UNIT/COV UNIT</td>
<td>Report the number of visits.</td>
</tr>
<tr>
<td>TOT CHARGES</td>
<td>Enter the total charge for all revenue codes.</td>
</tr>
<tr>
<td>SERV DATE</td>
<td>Enter the date the service was provided.</td>
</tr>
</tbody>
</table>


Medicare home health claims using either TOB 32x or 34x are submitted to MACs using the Fiscal Intermediary Standard System (FISS). Detailed instructions on using FISS are available on the MACs’ websites. You will find your MAC’s site at [https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/](https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/).

**Note from CGS:** In addition to the information in this article, you may also reference the CGS “Billing Negative Pressure Wound Therapy (NPWT)” Web page at [https://www.cgsmedicare.com/hhh/education/materials/3118.html](https://www.cgsmedicare.com/hhh/education/materials/3118.html).
Payment for NPWT Services using a Disposable Device:

Payment for CPT® codes 97607 and 97608 is set equal to the amount of the payment that would be made under the OPPS; therefore, the payment amount will also be subject to the area wage adjustment policies in place under the OPPS in a given year.

While there is typically no coinsurance, copayment, or deductible associated with home health services and supplies, coinsurance is required for both Durable Medical Equipment (DME) and furnishing NPWT using a disposable device covered as a home health service, which is defined as 20 percent of the payment amount. The amount paid to the HHA by Medicare would be equal to 80 percent of the lesser of the actual charge or the payment amount as determined by the OPPS for the year.

### Type of Bill

| Rule |
|------|---|
| Beneficiary Under Home Health Plan of Care and Services Fall Under Plan of Care (TOB 032X) | Deductible: No
| | Coinsurance: No
| | Exception: Coinsurance applies on DME, NPWT using a disposable device, and orthotic/prosthetic claims. |
| Beneficiary Not Under Home Health Plan of Care, Services are Part B Medical and Other Health Services or Osteoporosis Injections (TOB 034x) | Deductible: Yes
| | Coinsurance: Yes
| | Exception: Deductible and coinsurance may be waived for certain preventive services. |

HHAs should conduct insurance benefit verification for CPT® codes 97607 and 97608 from both primary and secondary payers. It is required that providers bill for and make a good faith effort to collect the coinsurance from the patient’s secondary insurance. Consult the “Medicare Secondary Payer Manual” for detailed instructions: [https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019017.html](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019017.html).

HHAs are required to notify beneficiaries of any coinsurance responsibility if they do not have a secondary/supplemental insurance coverage. When coinsurance is applicable, and the patient does not have secondary insurance, the HHA should collect the appropriate amount from the patient.

As a reminder, home health billing transactions, including claims and adjustments, must be submitted no later than 12 months (or 1 calendar year) after the date the services were furnished.

### Additional Information

HHA billing staff may want to review MLN Matters article MM9736 (based on CR9736), which is available at [https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm9736.pdf](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm9736.pdf). This article contains additional details regarding the provision of NPWT using a disposable device.

If you have any questions, please contact a CGS Customer Service Representative by calling the CGS Provider Contact Center at **1.877.299.4500** and choose Option 1.

### Document History

<table>
<thead>
<tr>
<th>Date</th>
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<tbody>
<tr>
<td>September 20, 2017</td>
<td>Initial article issued.</td>
</tr>
</tbody>
</table>
For Hospice Providers

Hospice Sequential Billing Reminder: Reason Code 37402

When a hospice claim is submitted out of sequence, the claim is sent to the Return to Provider (RTP) file (T B9997) with reason code 37402. Reason code 37402 is consistently the top claim submission error (CSE) for hospice providers. From January through September 2017, CSE data showed an average of 2,380 claims per month received the out of sequence error. As a Medicare provider, you are responsible to ensure compliance with Medicare regulations; therefore, this article serves as a reminder of the sequential billing requirement. Please share this information with your billing staff and other appropriate staff.

To meet the sequential billing requirements, claims must be:

- **Submitted sequentially** – This means that January’s claim, for example, must be submitted before February’s claim can be submitted. The Fiscal Intermediary Standard System (FISS) will search claim history for a prior claim.
  - If a prior claim is not found in a finalized or suspended status/location (P B9997, R B9997, D B9997 or S XXXXX), the incoming claim will be sent to the RTP file with reason code 37402 (https://www.cgsmedicare.com/hhh/education/materials/37402.html).
  - If the prior claim is in the RTP file (T B9997) and needs correcting, the incoming claim will be sent to the RTP file with reason code 37402 (https://www.cgsmedicare.com/hhh/education/materials/37402.html). FISS does not search the RTP file (T B9997) for prior claims.

**Note:** You must correct the claims out of RTP sequentially. For example if the January claim is in RTP because of an invalid HCPC code, and the February claim was submitted, the February claim will go to RTP because no prior claim was found. You must first correct the January claim out of RTP. Once the January claim is corrected and moves to a suspended status/location, the February claim can be F9ed out of RTP.

- If the prior claim is in a suspended status/location (S XXXXX) the incoming claim will move to a suspended status/location until the prior claim has been finalized. Once the prior claim has finalized (P B9997, R B9997, or D B9997), FISS will continue processing the incoming claim.

At any time while a claim is processing, it may move to the RTP file. CGS suggests monitoring your claims on a regular basis. If a prior claim is in RTP, make any necessary corrections to the claim to allow continued processing. To determine the status/location of your claim, refer to the Checking Claim Status Web page at https://www.cgsmedicare.com/hhh/claims/checking_claim_status.html.

- **Submitted consecutively** – This means that there cannot be any skip in dates between the prior claim's “TO” date, and the next month's claim's “FROM” date.

- **Submitted monthly** – Hospices are required to bill claims monthly (see Medicare Claims Processing Manual (CMS Pub. 100-04), Ch. 11, §90 at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c11.pdf). This means providers should bill only one claim per month, for each patient. The “TO” date on the claim must be the last calendar day of the month, unless the patient died, was discharged or revoked hospice during the month.

In addition, hospice claims must conform to a calendar month (Jan 1 – Jan 31). Claims that span two months (ex. Jan 1-Feb 1) will be sent to the RTP file for you to correct.

The Hospice Sequential Billing Web page at https://www.cgsmedicare.com/hhh/education/materials/hospice_sequential_billing.html provides steps you can follow to ensure compliance.
and to avoid sequential billing errors. Please share this with your appropriate staff and consider developing an internal process to avoid this CSE, which will save you time and money.

**For Hospice Providers**

**Updated Hospice Payment Rate Calculator**

The Hospice Payment Rate Calculator has been updated with the Fiscal Year (FY) 2018 rates for hospice providers to determine their payment rates. You can access the calculator by selecting “Hospice Rates” from the “Rates and Fee Schedules” Web page at [http://www.cgsmedicare.com/hhh/claims/fees/index.html](http://www.cgsmedicare.com/hhh/claims/fees/index.html) and then select the “Hospice Payment Rates Calculator” link. You must enter the year (Fiscal year for the dates of service), state, and county or CBSA code where the services were provided. Once the information is entered, rate information for the selected county/CBSA will display.

**For Home Health and Hospice Providers**

**MM9815 (Revised):** Revision to Publication 100.06, Chapter 3, Medicare Overpayment Manual, Section 200, Limitation on Recoupment

The Centers for Medicare & Medicaid Services (CMS) issued the following Medicare Learning Network® (MLN) Matters article on September 1, 2017. Then a revision to this article was issued on September 15, 2017. The following reflects the revised article. This MLN Matters article and other CMS articles can be found on the CMS website at: [https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/)

**MLN Matters® Number:** MM9815 Revised

**Related CR Release Date:** September 14, 2017

**Related CR Transmittal #:** R293FM

**Related Change Request (CR) #:** CR 9815

**Effective Date:** April 2, 2018

**Implementation Date:** April 2, 2018

This article was revised on September 15, 2017, to reflect an updated Change Request that corrected format errors in the manual instructions. In the article, the CR release date, transmittal number, and link to the transmittal changed. 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) 9815 updates the Centers for Medicare & Medicaid Services (CMS) “Medicare Financial Management Manual,” Chapter 3, Sections 200-200.2.1, Limitation on Recoupment Overpayments. CR9815 is the first of four CRs that are forthcoming and incorporated into this manual. Make sure your billing staffs are aware of these updates that relate to the limitation on recovery of certain overpayments.

**Background**

Section 1893(f)(2)(a) of the Social Security Act and the provision in the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) prohibits recouping Medicare overpayments from a provider or supplier that seeks a reconsideration from a Qualified Independent Contractor (QIC). This provision changed how interest is to be paid to a provider
or supplier whose overpayment is reversed at subsequent administrative or judicial levels of appeal. The final rule defines the overpayments to which the limitation applies, how the limitation works in concert with the appeals process, and the change in our obligation to pay interest to a provider or supplier whose appeal is successful at levels above the QIC. This section also limits recoupment of Medicare overpayments when a provider or supplier seeks a redetermination until a redetermination decision is rendered.

The MAC will cease recoupment or not begin recoupment when the MAC receives a valid redetermination or reconsideration request timely on an overpayment subject to these limitations. The provider has until the appeal deadline to file an appeal (refer to the “Medicare Claims Processing Manual,” Chapter 29 at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c29.pdf). If a provider wants to delay recoupment, it must submit the redetermination appeal request within 30 days of the demand letter date. To continue the delayed recoupment, the provider will have 60 days from the redetermination decision to submit a reconsideration request. If the request is received before the appeal deadline but after recoupment has started, the MAC will stop the recoupment. The MAC shall not refund any monies collected back to the provider, unless otherwise directed by the Centers for Medicare & Medicaid Services (CMS). The MAC will be accountable to ensure the debts continue to age and accrue interest until the debt is paid in full.

After the first two levels of appeal are completed, the MAC shall resume recoupment and normal debt collection processes. Whether or not the provider subsequently appeals the overpayment to the Administrative Law Judge (ALJ), or subsequent levels (Department Appeals Board (DAB), or Federal court), the MAC shall initiate recoupment at 100% until the debt is satisfied in full, unless an Extended Repayment Schedule (ERS) is established. If the debt was referred to Treasury and the provider files for an appeal, the MAC shall recall the debt from Treasury while in an appeal status. If the appeal decision is unfavorable to the provider, any outstanding debt will be referred back to Treasury, unless an approved Extended Repayment Schedule (ERS) is established or the provider pays the debt in full.

Additional Information


If you have any questions, please contact a CGS Customer Service Representative by calling the CGS Provider Contact Center at 1.877.299.4500 and choose Option 1.

Document History

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Looking for a NEW Way to Submit Cost Reports?
myCGS, our secure web portal, has been enhanced to accept and send your annual Medicare cost reports! Refer to Chapter 7 of the myCGS User Guide at http://www.cgsmedicare.com/pdf/mycgs/chapter7_hhh.pdf for more information!
MM10222: Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) – October 2017 Update

The Centers for Medicare & Medicaid Services (CMS) has issued the following Medicare Learning Network® (MLN) Matters article. This MLN Matters article and other CMS articles can be found on the CMS website at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/

MLN Matters® Number: MM10222  
Related CR Release Date: August 25, 2017  
Related CR Transmittal #: R3838CP  
Related Change Request (CR) #: CR 10222  
Effective Date: January 1, 2017  
Implementation Date: October 2, 2017

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

Provider Action Needed
Change Request (CR) 10222 amends payment files that were issued to the MACs based upon the Calendar Year (CY) 2017 Medicare Physician Fee Schedule (MPFS) Final Rule. Please make sure your billing staffs are aware of these changes.

Background
Payment files are issued to the MACs based upon the CY 2017 MPFS Final Rule, published in the Federal Register on November 15, 2016, to be effective for services furnished between January 1, 2017, and December 31, 2017. Section 1848(c)(4) of the Social Security Act authorizes the Secretary of the Department of Health & Human Services (HHS) to establish ancillary policies necessary to implement relative values for physicians’ services.

This article presents a summary of the changes for the October update to the 2017 MPFSDB. Unless otherwise stated, these changes are effective for dates of service on and after January 1, 2017.

<table>
<thead>
<tr>
<th>CPT/HCPCS &amp; Mod</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>20245</td>
<td>Pre Op = 0, Intra Op = 0, Post Op = 0</td>
</tr>
<tr>
<td>36473</td>
<td>Bilateral Surg = 1</td>
</tr>
<tr>
<td>64897</td>
<td>Post Op = 0.13</td>
</tr>
<tr>
<td>93668</td>
<td>Status Indicator = C for dates of service 1/1/17 or after</td>
</tr>
<tr>
<td>A4575</td>
<td>Status Indicator = X for dates of service 4/3/17 or after</td>
</tr>
</tbody>
</table>

The following new codes have been added to the HCPCS file, effective August 1, 2017. The HCPCS file coverage code is C (carrier judgment) for these new codes. Coverage and payment will be determined by your MAC (they are not part of the MPFS).

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>0006U</td>
<td>RX MNTR 120+ DRUGS &amp; SBSTS</td>
<td>Prescription drug monitoring, 120 or more drugs and substances, definitive tandem mass spectrometry with chromatography, urine, qualitative report of presence (including quantitative levels, when detected) or absence of each drug or substance with description and severity of potential interactions, with identified substances, per date of service.</td>
</tr>
<tr>
<td>CPT Code</td>
<td>Short Descriptor</td>
<td>Long Descriptor</td>
</tr>
<tr>
<td>----------</td>
<td>------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>0007U</td>
<td>RX TEST PRSV UR W/DEF CONF</td>
<td>Drug test(s), presumptive, with definitive confirmation of positive results, any number of drug classes, urine, includes specimen verification including DNA authentication in comparison to buccal DNA, per date of service.</td>
</tr>
<tr>
<td>0008U</td>
<td>HPYLORI DETCJ ABX RSTNC DNA</td>
<td>Helicobacter pylori detection and antibiotic resistance, DNA, 16S and 23S rRNA, gyrA, rbp1, rdxA and rpoB, next generation sequencing, formalin-fixed paraffin embedded or fresh tissue, predictive, reported as positive or negative for resistance to clarithromycin, fluoroquinolones, metronidazole, amoxicillin, tetracycline and rifabutin.</td>
</tr>
<tr>
<td>0009U</td>
<td>ONC BRST CA ERBB2 AMP/ NONAMP</td>
<td>Oncology (breast cancer), ERBB2 (HER2) copy number by FISH, tumor cells from formalin fixed paraffin embedded tissue isolated using image-based dielectrophoresis (DEP) sorting, reported as ERBB2 gene amplified or non-amplified.</td>
</tr>
<tr>
<td>0010U</td>
<td>NFCT DS STRN TYP WHL GEN SEQ</td>
<td>Infectious disease (bacterial), strain typing by whole genome sequencing, phylogenetic-based report of strain relatedness, per submitted isolate.</td>
</tr>
<tr>
<td>0011U</td>
<td>RX MNTR LC-MS/MS ORAL FLUID</td>
<td>Prescription drug monitoring, evaluation of drugs present by LC-MS/MS, using oral fluid, reported as a comparison to an estimated steady-state range, per date of service including all drug compounds and metabolites.</td>
</tr>
<tr>
<td>0012U</td>
<td>GERMLN DO GENE REARGMT DETCJ</td>
<td>Germline disorders, gene rearrangement detection by whole genome next-generation sequencing, DNA, whole blood, report of specific gene rearrangement(s).</td>
</tr>
<tr>
<td>0013U</td>
<td>ONC SLD ORG NEO GENE REARGMT</td>
<td>Oncology (solid organ neoplasia), gene rearrangement detection by whole genome next-generation sequencing, DNA, fresh or frozen tissue or cells, report of specific gene rearrangement(s).</td>
</tr>
<tr>
<td>0014U</td>
<td>HEM HMTLMF NEO GENE REARGMT</td>
<td>Hematology (hematolymphoid neoplasia), gene rearrangement detection by whole genome next-generation sequencing, DNA, whole blood or bone marrow, report of specific gene rearrangement(s).</td>
</tr>
<tr>
<td>0015U</td>
<td>RX METAB ADVRS RX RXN DNA</td>
<td>Drug metabolism (adverse drug reactions), DNA, 22 drug metabolism and transporter genes, real-time PCR, blood or buccal swab, genotype and metabolizer status for therapeutic decision support.</td>
</tr>
<tr>
<td>0016U</td>
<td>ONC HMTLMF NEO RNA BCR/ABL1</td>
<td>Oncology (hematolymphoid neoplasia), RNA, BCR/ABL1 major and minor breakpoint fusion transcripts, quantitative PCR amplification, blood or bone marrow, report of fusion not detected or detected with quantitation.</td>
</tr>
<tr>
<td>0017U</td>
<td>ONC HMTLMF NEO JAK2 MUT DNA</td>
<td>Oncology (hematolymphoid neoplasia), JAK2 mutation, DNA, PCR amplification of exons 12-14 and sequence analysis, blood or bone marrow, report of JAK2 mutation not detected or detected.</td>
</tr>
</tbody>
</table>

The short descriptors for the technical and professional components of the following codes were not displaying properly on the MPFS and did not match the HCPCS file. The global procedure accurately reflects the short descriptor from the HCPCS file. This display issue has been corrected and the short descriptors for the technical and professional components now read as follows on the MPFS:

- 92978 – TC Endoluminal ivus oct c 1st
- 92978 – 26 Endoluminal ivus oct c 1st
- 92979 – TC Endoluminal ivus oct c ea
- 92979 – 26 Endoluminal ivus oct c ea
- 92979 – G0206 – TC Dx mammo incl cad uni
- 92980 – G0202 – 26 Scr mammo bi incl cad
- 92980 – G0204 – TC Dx mammo incl cad bi
- 92980 – G0204 – 26 Dx mammo incl cad bi
- 92980 – G0204 – TC Dx mammo incl cad bi
- 92980 – G0206 – TC Dx mammo incl cad uni
- 92980 – G0206 – 26 Dx mammo incl cad uni

Providers should be aware that MACs do not need to search their files to either retract payment for claims already paid or to retroactively pay claims. However, MACs will adjust claims that you bring to their attention.

**Additional Information**

For Home Health and Hospice Providers

MM10230: October 2017 Integrated Outpatient Code Editor (I/OCE) Specifications Version 18.3

The Centers for Medicare & Medicaid Services (CMS) has issued the following Medicare Learning Network® (MLN) Matters article. This MLN Matters article and other CMS articles can be found on the CMS website at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/

MLN Matters® Number: MM10230
Related CR Release Date: August 25, 2017
Related CR Transmittal #: R3852CP
Related Change Request (CR) #: CR 10230
Implementation Date: October 2, 2017

Provider Type Affected

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

Provider Action Needed

Change Request (CR) 10230 provides the Integrated Outpatient Code Editor (I/OCE) instructions and specifications that will be used under the Outpatient Prospective Payment System (OPPS) and Non-OPPS for hospital outpatient departments, community mental health centers, all non-OPPS providers, and for limited services when provided in a Home Health Agency (HHA) not under the Home Health PPS or to a hospice patient for the treatment of a non-terminal illness. This update relates to Chapter 4, Section 40.1 of the “Medicare Claims Processing Manual” (Pub. 100-04). Make sure your billing staffs are aware of these updates.

Background

CR10230 informs MACs, as well as the Fiscal Intermediary Shared System (FISS) maintainer that the I/OCE is being updated for October 1, 2017. The I/OCE routes all institutional outpatient claims (which includes non-OPPS hospital claims) through a single integrated OCE.

The I/OCE specifications will be posted at http://www.cms.gov/OutpatientCodeEdit/.

The following table summarizes the modifications of the I/OCE for the October 2017 v18.3 release. Note that some I/OCE modifications may be retroactively added to prior releases. If so, the retroactive date appears in the “Effective Date” column.

**Note:** Some I/OCE modifications in the update may be retroactively added to prior releases. If so, the retroactive date appears in the “Effective Date” column.
<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Edits Affected</th>
<th>Modification</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/1/2017</td>
<td>1, 2, 3, 5, 86</td>
<td>Updated diagnosis code editing for validity, age, gender and manifestation based on the FY 2018 ICD-10-CM code revisions to the Medicare Code Editor (MCE).</td>
</tr>
<tr>
<td>10/1/2017</td>
<td>29</td>
<td>Updated the mental health diagnosis list based on the FY 2018 ICD-10-CM code revisions.</td>
</tr>
<tr>
<td>10/1/2017</td>
<td>95</td>
<td>Modify the effective date for edit 95 to 10/1/2017.</td>
</tr>
<tr>
<td>4/1/2017</td>
<td>30, 95</td>
<td>Update the list of add-on procedure codes that are not counted towards the daily and weekly requirements for number of Partial Hospitalization Program (PHP) services. Procedure codes 90833, 90836 and 90838 are removed from the list; 90785 remains (see special processing logic, Appendix C-a flowchart and Appendix O of CR10230).</td>
</tr>
<tr>
<td>7/1/2017</td>
<td>22</td>
<td>Add ZC (Merck/ Samsung Bioepis) to the list of valid modifiers.</td>
</tr>
<tr>
<td>7/1/2017</td>
<td>94</td>
<td>Add modifier ZC as a biosimilar manufacturer modifier applicable for HCPCS J5102.</td>
</tr>
<tr>
<td>10/1/2016</td>
<td>99</td>
<td>Add HCPCS J2505 (Injection, pegfilgrastim 6mg) to the list of HCPCS excepted from requiring an OPPS procedure on the same claim (see special processing logic).</td>
</tr>
<tr>
<td>7/1/2017</td>
<td>41, 65</td>
<td>Add new revenue code 1006 to the list of valid revenue codes and to the list of revenue codes not recognized by Medicare.</td>
</tr>
<tr>
<td>10/1/2017</td>
<td></td>
<td>Update the following lists for the release (see quarterly data files):</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Edit 99 exclusion list (add new codes to exception list)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Comprehensive Ambulatory Payment Classification (APC) ranking</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Comprehensive APC Code Pairs (correction to two APC Pairs missing complexity-adjusted APC assignment retroactive for 2016 service dates)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- New data file report for Comprehensive APCs (includes list of procedures, rank and flag for eligibility of complexity-adjusted APC)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Device-procedure list (edit 92)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Terminated device-procedures for device credit (Device offset amount corrections; updated code list)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Non-standard CT Scan (updated code list)</td>
</tr>
<tr>
<td>5/25/2017</td>
<td>68</td>
<td>Implement NCD mid-quarter effective editing for procedure code 93668.</td>
</tr>
<tr>
<td>4/3/2017</td>
<td>68</td>
<td>Implement NCD mid-quarter effective editing for HCPCS A4575 and E0446.</td>
</tr>
<tr>
<td>10/1/2017</td>
<td>20, 40</td>
<td>Make all HCPCS/APC/SI changes as specified by CMS (quarterly data files).</td>
</tr>
<tr>
<td>10/1/2017</td>
<td></td>
<td>Implement version 23.3 of the NCCI (as modified for applicable outpatient institutional providers).</td>
</tr>
</tbody>
</table>

**Additional Information**


If you have any questions, please contact a CGS Customer Service Representative by calling the CGS Provider Contact Center at **1.877.299.4500** and choose Option 1.

**Document History**

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>August 29, 2017</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>
For Home Health and Hospice Providers

MM10236 (Revised): October 2017 Update of the Hospital Outpatient Prospective Payment System (OPPS)

The Centers for Medicare & Medicaid Services (CMS) issued the following Medicare Learning Network® (MLN) Matters article, then later issued a revised article. The following reflects the revised article. This MLN Matters article and other CMS articles can be found on the CMS website at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/

MLN Matters® Number: MM10236 Revised Related Change Request (CR) #: CR 10236
Related CR Release Date: September 15, 2017 Effective Date: October 1, 2017
Related CR Transmittal #: R3864CP Implementation Date: October 2, 2017

Note: The article was revised on September 15, 2017, to reflect an updated Change Request (CR) that updated the policy section (added Transurethral Waterjet Prostate Ablation Procedure) that also includes information on the revised OPPS status indicator and APC for CPT code 0421T. It also corrected an error to the OPPS status indicator for Q5102 in Table 5. In addition, a new Table 7 was added. All other information remains the same.

Provider Types Affected
This MLN Matters® Article is intended for providers and suppliers that submit claims to Medicare Administrative Contractors (MACs), including Home Health and Hospice (HH&H) MACs, for services provided to Medicare beneficiaries and paid under the Outpatient Prospective Payment System (OPPS).

Provider Action Needed
Change Request (CR) 10236 which describes changes to the OPPS to be implemented in the July 2017 update. Make sure your billing staffs are aware of these changes.

Background
This Recurring Update Notification describes changes to and billing instructions for various payment policies implemented in the October 2017 OPPS update. The October 2017 Integrated Outpatient Code Editor (I/OCE) will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in CR 10236. This Recurring Update Notification applies to Chapter 4, section 10.9.

Key changes to and billing instructions for various payment policies implemented in the October 2017 Outpatient Prospective Payment System (OPPS) updates are as follows:

Proprietary Laboratory Analyses (PLA) CPT Codes 0006U through 0017U Effective August 1, 2017
The American Medical Association CPT Editorial Panel established 12 new PLA CPT codes, specifically, CPT codes 0006U through 0017U effective August 1, 2017. Because the codes will be effective August 1, 2017, they were not included in the July 2017 OPPS Update and are instead being included in the October 2017 Update with an effective date of August 1, 2017.

Table 1 lists the long descriptors and status indicators for CPT codes 0006U through 0017U. For more information on OPPS status indicators “A” and “Q4”, refer to OPPS Addendum D1 of the CY 2017 OPPS/ASC final rule for the latest definitions.
CPT codes 0006U through 0017U have been added to the October 2017 I/OCE with an effective date of August 1, 2017. These codes, along with their short descriptors and status indicators, are also listed in the October 2017 OPPS Addendum B.

Billing for Peripheral Artery Disease (PAD) Rehabilitation

Effective May 25, 2017, the Centers for Medicare & Medicaid Services (CMS) will pay for supervised exercised therapy (SET) for beneficiaries with intermittent claudication for the treatment of symptomatic peripheral artery disease. To implement this National Coverage Determination (NCD), CMS will pay separately for CPT code 93668 under the hospital OPPS.

For purposes of Medicare coverage, services must meet all of the following eligibility criteria:

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

---

**Table 1 — Proprietary Laboratory Analyses (PLA) CPT Codes Effective August 1, 2017**

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Long Descriptor</th>
<th>OPPS SI</th>
<th>OPPS APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>0006U</td>
<td>Prescription drug monitoring, 120 or more drugs and substances, definitive tandem mass spectrometry with chromatography, urine, qualitative report of presence (including quantitative levels, when detected) or absence of each drug or substance with description and severity of potential interactions, with identified substances, per date of service</td>
<td>Q4</td>
<td>N/A</td>
</tr>
<tr>
<td>0007U</td>
<td>Drug test(s), presumptive, with definitive confirmation of positive results, any number of drug classes, urine, includes specimen verification including DNA authentication in comparison to buccal DNA, per date of service</td>
<td>Q4</td>
<td>N/A</td>
</tr>
<tr>
<td>0008U</td>
<td>Helicobacter pylori detection and antibiotic resistance, DNA, 16S and 23S rRNA, gyrA, ppgA, rdxA and rpoB, next generation sequencing, formalin-fixed paraffin embedded or fresh tissue, predictive, reported as positive or negative for resistance to clarithromycin, fluoroquinolones, metronidazole, amoxicillin, tetracycline and rifabutin</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>0009U</td>
<td>Oncology (breast cancer), ERBB2 (HER2) copy number by FISH, tumor cells from formalin fixed paraffin embedded tissue isolated using image-based dielectrophoresis (DEP) sorting, reported as ERBB2 gene amplified or non-amplified</td>
<td>Q4</td>
<td>N/A</td>
</tr>
<tr>
<td>0010U</td>
<td>Infectious disease (bacterial), strain typing by whole genome sequencing, phylogenetic-based report of strain relatedness, per submitted isolate</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>0011U</td>
<td>Prescription drug monitoring, evaluation of drugs present by LCMS/MS, using oral fluid, reported as a comparison to an estimated steady-state range, per date of service including all drug compounds and metabolites</td>
<td>Q4</td>
<td>N/A</td>
</tr>
<tr>
<td>0012U</td>
<td>Germline disorders, gene rearrangement detection by whole genome next-generation sequencing, DNA, whole blood, report of specific gene rearrangement(s)</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>0013U</td>
<td>Oncology (solid organ neoplasia), gene rearrangement detection by whole genome next-generation sequencing, DNA, fresh or frozen tissue or cells, report of specific gene rearrangement(s)</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>0014U</td>
<td>Hematology (hematolymphoid neoplasia), gene rearrangement detection by whole genome next-generation sequencing, DNA, whole blood or bone marrow, report of specific gene rearrangement(s)</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>0015U</td>
<td>Drug metabolism (adverse drug reactions), DNA, 22 drug metabolism and transporter genes, real-time PCR, blood or buccal swab, genotype and metabolizer status for therapeutic decision support</td>
<td>Q4</td>
<td>N/A</td>
</tr>
<tr>
<td>0016U</td>
<td>Oncology (hematolymphoid neoplasia), RNA, BCR/ABL1 major and minor breakpoint fusion transcripts, quantitative PCR amplification, blood or bone marrow, report of fusion not detected or detected with quantitation</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>0017U</td>
<td>Oncology (hematolymphoid neoplasia), JAK2 mutation, DNA, PCR amplification of exons 12-14 and sequence analysis, blood or bone marrow, report of JAK2 mutation not detected or detected</td>
<td>A</td>
<td>N/A</td>
</tr>
</tbody>
</table>
- Be under the direct supervision of a physician (as defined in 1861(r)(1)), physician assistant, or nurse practitioner/clinical nurse specialist (as identified in 1861(aa)(5)) who must be trained in both basic and advanced life support techniques.

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

1. MACs have the discretion to cover SET beyond 36 sessions over 12 weeks and may cover an additional 36 sessions over an extended period of time. A second referral is required for these additional sessions.

2. SET is non-covered for beneficiaries with absolute contraindications to exercise as determined by their primary physician.


Table 2 lists the long descriptor, status indicator, and APC assignment for CPT code 93668. The payment amount for CPT code 93668 is available in the October 2017 OPPS Addendum B.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Long Descriptor</th>
<th>OPPS SI</th>
<th>OPPS APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>93668</td>
<td>Peripheral arterial disease (pad) rehabilitation, per session</td>
<td>S</td>
<td>5733</td>
</tr>
</tbody>
</table>

**New Procedures Requiring the Insertion of a Device**

Since January 1, 2017, all new procedures requiring the insertion of an implantable medical device will be assigned a default device offset percentage of at least 41%, and thereby assigned device intensive status, until claims data is available. In certain rare instances, CMS may temporarily assign a higher offset percentage if warranted by additional information.

In accordance with current Medicare policy, the following code requiring the insertion of a device (listed in Table 3) will be assigned device intensive status effective October 1, 2017. CMS notes that although HCPCS code C9747, was effective under the OPPS as of July 1, 2017, its device intensive designation is not effective until October 1, 2017.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
<th>Effective Date</th>
<th>October 2017 OPPS SI</th>
<th>October 2017 OPPS APC</th>
<th>CY 2017 OPPS Payment Rate</th>
<th>CY 2017 Device Offset</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9747</td>
<td>Ablation of prostate, transrectal, high intensity focused ultrasound (HIFU), including imaging guidance</td>
<td>10-01-2017</td>
<td>J1</td>
<td>5376</td>
<td>$7,452.66</td>
<td>$3,055.60</td>
</tr>
</tbody>
</table>

**Drugs, Biologicals, and Radiopharmaceuticals**

a. **Drugs and Biologicals with Payments Based on Average Sales Price (ASP)**

   **Effective October 1, 2017**

   Payment for separately payable non pass-through drugs, biologicals and therapeutic radiopharmaceuticals (status indicator “K”) is made at a single rate of ASP + 6 percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical. In addition, a single payment of ASP + 6 percent for pass-through drugs, biologicals and radiopharmaceuticals (status indicator “G”) is made to provide payment for both the...
acquisition cost and pharmacy overhead costs of these pass-through items. Payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as ASP submissions become available. Updated payment rates effective October 1, 2017 and drug price restatements are available in the October 2017 update of the OPPS Addendum A and Addendum B at [http://www.cms.gov/HospitalOutpatientPPS/](http://www.cms.gov/HospitalOutpatientPPS/).

b. **Drugs and Biologicals Based on ASP Methodology with Restated Payment Rates**

Some drugs and biologicals paid based on the ASP methodology will have payment rates that are corrected retroactively. These retroactive corrections typically occur on a quarterly basis. The list of drugs and biologicals with corrected payments rates will be accessible on the first date of the quarter at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/OPPS-Restated-Payment-Rates.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/OPPS-Restated-Payment-Rates.html).

Providers may resubmit claims that were impacted by adjustments to previous quarter’s payment files.

c. **Drugs and Biologicals with OPPS Pass-Through Status Effective October 1, 2017**

Four drugs and biologicals have been granted OPPS pass-through status effective October 1, 2017. These items, along with their descriptors and APC assignments, are identified in Table 4.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Description</th>
<th>Long Description</th>
<th>Oct 2017 OPPS SI</th>
<th>Oct 2017 OPPS APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9491</td>
<td>Injection, avelumab</td>
<td>Injection, avelumab, 10 mg</td>
<td>G</td>
<td>9491</td>
</tr>
<tr>
<td>C9492</td>
<td>Injection, durvalumab</td>
<td>Injection, durvalumab, 10 mg</td>
<td>G</td>
<td>9492</td>
</tr>
<tr>
<td>C9493</td>
<td>Injection, edaravone</td>
<td>Injection, edaravone, 1 mg</td>
<td>G</td>
<td>9493</td>
</tr>
<tr>
<td>C9494</td>
<td>Injection, ocrelizumab</td>
<td>Injection, ocrelizumab, 1 mg</td>
<td>G</td>
<td>9494</td>
</tr>
</tbody>
</table>

d. **New Modifier for Biosimilar Biological Product**

Q5102 can be reported with either the existing modifier ZB or new modifier ZC effective July 1, 2017, see table 5. **CMS is also instructing MACs that the ZC modifier will become effective, that is, valid for claims submitted beginning October 1, 2017, and applies retroactively to dates of service on or after July 24, 2017.**

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>SI</th>
<th>APC</th>
<th>HCPCS Code Effective Date</th>
<th>Modifier</th>
<th>Modifier Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5102</td>
<td>Injection, infliximab biosimilar</td>
<td>Injection, Infliximab, Bio similar, 10 mg</td>
<td>G</td>
<td>1847</td>
<td>04/05/2016</td>
<td>ZB – Pfizer/ Hospira</td>
<td>04/01/2016</td>
</tr>
<tr>
<td>Q5102</td>
<td>Injection, infliximab biosimilar</td>
<td>Injection, Infliximab, Bio similar, 10 mg</td>
<td>G</td>
<td>1847</td>
<td>04/05/2016</td>
<td>ZC – Merck/ Samsung Bioepis</td>
<td>07/01/2017</td>
</tr>
</tbody>
</table>

e. **New Flu Vaccine**

The existing influenza vaccine CPT code 90674 (Cciiv4 vaccine, no preservative, 0.5 ml, intramuscular) with trade name Flucelvax Quadrivalent was effective January 1, 2017 and is a preservative-free and antibiotic-free vaccine. A new preservative, antibiotic-free influenza vaccine CPT code with the same trade name, Flucelvax Quadrivalent, will be effective on January 1, 2018. For the period between August 1, 2017 and December 31, 2017, Flucelvax Quadrivalent Preservative can be reported as Q2039. The permanent CPT code for the Flucelvax Quadrivalent preservative influenza vaccine will be released on a later date, see Table 6.
Table 6 – Billing for Preservative and Preservative-Free Flucelvax Quadrivalent Influenza Vaccine

<table>
<thead>
<tr>
<th>Vaccine Type</th>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>OPPS SI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flucelvax Quadrivalent Preservative-Free and</td>
<td>90674</td>
<td>Cciv4 vaccine, no preservative, 0.5</td>
<td>Influenza virus vaccine, quadrivalent (ccIV4), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use</td>
<td>L</td>
</tr>
<tr>
<td>Antibiotic-Free Flu Vaccine</td>
<td></td>
<td>ml, intramuscular</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flucelvax Quadrivalent</td>
<td>Q2039</td>
<td>Cciv4 vaccine, nos, intramuscular</td>
<td>Influenza virus vaccine, not otherwise specified</td>
<td>L</td>
</tr>
<tr>
<td>Preservative Flu Vaccine</td>
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</table>

Upper Eyelid Blepharoplasty and Blepharoptosis Repair

As indicated in Chapter VIII of the CY 2017 National Correct Coding Initiative (NCCI) Policy Manual for Medicare Services, CMS payment policy does not allow separate payments for a blepharoptosis procedure (CPT code 67901-67908) and a blepharoplasty procedure (CPT codes 15822-15823) on the ipsilateral upper eyelid. Under this policy, any removal of upper eyelid skin in the context of an upper eyelid blepharoptosis surgery was considered a part of the blepharoptosis surgery. This instruction was clarified in the July 2016 Hospital OPPS Update Change Request (Transmittal 3557, Change Request 9658 dated July 1, 2016) and the July 2016 OPPS MLN Matters Article MM9658, available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9658.pdf.

However, effective October 1, 2017, CMS is revising this policy to allow either cosmetic or medically necessary blepharoplasty to be performed in conjunction with a medically necessary upper eyelid blepharoptosis surgery. Specifically, physicians may receive payment for a medically necessary upper eyelid blepharoptosis from Medicare even when performed with (non-covered) cosmetic blepharoplasty on the same eye during the same visit. Since cosmetic procedures are not covered by Medicare, advance beneficiary notice of noncoverage (ABN) instructions would apply for cosmetic blepharoplasty. However, medically necessary blepharoplasty will continue to be bundled into the payment for blepharoptosis when performed with and as a part of a blepharoptosis surgery.

Other aspects of the July 2016 OPPS Update CR and MLN guidance on upper eyelid blepharoplasty and blepharoptosis remain unchanged. Specifically, CMS notes that Medicare does not allow separate payment for the following:

- Operating on the left and right eyes on different days when the standard of care is bilateral eyelid surgery
- Charging the beneficiary an additional amount for removing orbital fat when a blepharoplasty or a blepharoptosis repair is performed
- Performing a blepharoplasty on a different date of service than the blepharoptosis procedure for the purpose of unbundling the blepharoplasty
- Performing blepharoplasty as a staged procedure, either by one or more surgeons (note that under certain circumstances a blepharoptosis procedure could be a staged procedure)
- Billing for two procedures when two surgeons divide the work of a blepharoplasty performed with a blepharoptosis repair
- Using modifier 59 to unbundle the blepharoplasty from the ptosis repair on the claim form; this applies to both physicians and facilities.
- Treating medically necessary surgery as cosmetic for the purpose of charging the beneficiary for a cosmetic surgery
In the rare event that a blepharoplasty is performed on one eye and a blepharoptosis repair is performed on the other eye, the services must each be billed with the appropriate RT or LT modifier.

Transurethral Waterjet Prostate Ablation Procedure

On June 5, 2017, the Investigational Device Exemption (IDE) study associated with the “Waterjet Ablation Therapy for Endoscopic Resection of Prostate Tissue II” met CMS’s standards for coverage. The procedure associated with this study is currently described by CPT code 0421T. Based on the recent Medicare coverage of the IDE study, CMS is revising the OPPS status indicator (SI) for CPT code 0421T from “E1” (Not paid by Medicare when submitted on outpatient claims (any outpatient bill type)) to “J1” (Hospital Part B services paid through a comprehensive APC) and assigning the code to APC 5374 (Level 4 Urology and Related Services).

The SI and APC revision will be added to the January 2018 IOCE release with an effective date of June 5, 2017, which is the date of the Medicare approval for coverage of the IDE study.

Table 7 (below) lists the long descriptor, status indicator, and APC assignment for CPT code 0421T. The October 2017 national payment rate for APC 5374 is $2,542.56. However, as previously stated, payment for claims involving CPT code 0421T will not begin to be processed until January 1, 2018.

For more information on this approved Medicare IDE study, refer to study title “Waterjet Ablation Therapy for Endoscopic Resection of Prostate Tissue II” which can be found on the CMS IDE Studies website at: https://www.cms.gov/Medicare/Coverage/IDE/Approved-IDE-Studies.html.

For more information on Medicare's coverage related to IDE studies, refer to this CMS website: https://www.cms.gov/Medicare/Coverage/IDE/index.html.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Long Description</th>
<th>OPPS SI</th>
<th>OPPS APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>0421T</td>
<td>Transurethral waterjet ablation of prostate, including control of postoperative bleeding, including ultrasound guidance, complete (vasectomy, meatoectomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included when performed)</td>
<td>J1</td>
<td>5374</td>
</tr>
</tbody>
</table>

Coverage Determinations

As a reminder, the fact that a drug, device, procedure or service is assigned a HCPCS code and a payment rate under the OPPS does not imply coverage by the Medicare program, but indicates only how the product, procedure, or service may be paid if covered by the program. Medicare Administrative Contractors (MACs) determine whether a drug, device, procedure, or other service meets all program requirements for coverage. For example, MACs determine that it is reasonable and necessary to treat the beneficiary’s condition and whether it is excluded from payment.

Additional Information


If you have any questions, please contact a CGS Customer Service Representative by calling the CGS Provider Contact Center at 1.866.590.6703 and choose Option 1.
For Home Health and Hospice Providers

MM10248: October Quarterly Update for 2017
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule

The Centers for Medicare & Medicaid Services (CMS) has issued the following Medicare Learning Network® (MLN) Matters article. This MLN Matters article and other CMS articles can be found on the CMS website at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/

MLN Matters® Number: MM10248
Related CR Release Date: September 8, 2017
Related CR Transmittal #: R3859CP

Provider Types Affected
This MLN Matters® Article is intended for providers and suppliers submitting claims to Medicare Administrative Contractors (MACs) for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) items or services paid under the DMEPOS fee schedule.

Provider Action Needed
Change Request (CR) 10248 provides instructions regarding the October quarterly update for the 2017 DMEPOS and parenteral and enteral nutrition (PEN) fee schedules and the October 2017 DMEPOS Rural ZIP code file containing the Quarter 4, 2017 Rural ZIP code changes. 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 schedule is updated on a quarterly basis, when necessary, to implement fee schedule amounts for new codes and correct any fee schedule amounts for existing codes, and the quarterly update process for the DMEPOS fee schedule is covered in the Medicare Claims Processing Manual, Chapter 23, Section 60 at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf

Payment on a fee schedule basis is required for DMEPOS and surgical dressings by the Social Security Act, Section 1834(a), (h), and (i) at https://www.ssa.gov/OP_Home/ssact/title18/1834.htm. Also, payment on a fee schedule basis is a regulatory requirement at 42 CFR §414.102 (https://www.ecfr.gov/cgi-bin/text-idx?SID=666a01aa3d15b73356485c262fccc280a&mc=true&node=p42.3.414&rgn=dv5#se42.3.414_1102) for PEN, splints and casts, and intraocular lenses (IOLs) inserted in a physician’s office.
Additionally, the Social Security Act (Section 1834(a)(1)(F)(ii)) mandates adjustments to the fee schedule amounts for certain items furnished on or after January 1, 2016, in areas that are not competitive bid areas, based on information from competitive bidding programs (CBPs) for DME. The Social Security Act (Section 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 at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9642.pdf, 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.

Effective with the October update, code K0861 RR KF is removed from the fee schedule file. The October 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.

Additional Information


If you have any questions, please contact a CGS Customer Service Representative by calling the CGS Provider Contact Center at 1.877.299.4500 and choose Option 1.

Document History

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<tr>
<th>Date</th>
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<tr>
<td>September 12, 2017</td>
<td>Initial article released.</td>
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If you have any questions, please contact a CGS Customer Service Representative by calling the CGS Provider Contact Center at 1.877.299.4500 and choose Option 1.

For Home Health and Hospice Providers


The Centers for Medicare & Medicaid Services (CMS) has issued the following Medicare Learning Network® (MLN) Matters article. This MLN Matters article and other CMS articles can be found on the CMS website at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/

<table>
<thead>
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<th>MLN Matters® Number: MM10262</th>
<th>Related Change Request (CR) #: CR 10262</th>
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<tr>
<td>Related CR Release Date: September 8, 2017</td>
<td>Effective Date: January 1, 2018</td>
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<tr>
<td>Related CR Transmittal #: R3857CP</td>
<td>Implementation Date: January 2, 2018</td>
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This newsletter should be shared with all health care practitioners and managerial members of the provider/supplier staff. Newsletters are available at no cost from our website at http://www.cgsmedicare.com. © 2017 Copyright, CGS Administrators, LLC.
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 & Hospice (HH&H) MACs and Durable Medical Equipment (DME) MACs, for services provided to Medicare beneficiaries who are in a Part A covered Skilled Nursing Facility (SNF) stay.

Provider Action Needed
Change Request (CR) 10262 makes changes to Healthcare Common Procedure Coding System (HCPCS) codes and Medicare Physician Fee Schedule designations that will be used to revise Common Working File (CWF) edits to allow A/B MACs to make appropriate payments in accordance with policy for SNF CB in Chapter 6, Section 110.4.1 and Chapter 6, Section 20.6 in the “Medicare Claims Processing Manual.”

Background
The Common Working File (CWF) currently has edits in place for claims received for beneficiaries in a Part A covered SNF stay as well as for beneficiaries in a non-covered stay. These edits allow only those services that are excluded from consolidated billing to be separately paid. Barring any delay in the Medicare Physician Fee Schedule, the new code files will be provided to CWF by November 1, 2017.

By the first week in December 2017, new code files will be posted at https://www.cms.gov/SNFConsolidatedBilling/. The files will be applicable to claims with dates of service on or after January 1, 2018, through December 31, 2018. It is important and necessary for the provider/contractor community to view the “General Explanation of the Major Categories” file located at the bottom of each year’s update in order to understand the Major Categories including additional exclusions not driven by HCPCS codes.

Additional Information

If you have any questions, please contact a CGS Customer Service Representative by calling the CGS Provider Contact Center at 1.877.299.4500 and choose Option 1.

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<td>September 8, 2017</td>
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For Home Health and Hospice Providers
CGS Website Updates

CGS has recently made updates to their website, giving providers additional resources to assist with billing Medicare-covered services appropriately.

Please review the following updates:

- The Self-Service Options Web page at https://www.cgsmedicare.com/hhh/tools/index.html was updated to include the description and link to the Provider Enrollment Interactive Help Tool.
• The Hospice Payment Rates Calculator Web page at https://www.cgsmedicare.com/medicare_dynamic/Hospice_Rate_Calculator/Index.asp was updated with the FY 2018 rates and wage index information.

• The Hospice Payment Rates Web page at https://www.cgsmedicare.com/hhh/claims/fees/hospice_rates.html was updated to include links to the FY 2018 wage index and the MLN that includes the FY 2018 hospice rates.

• The Jurisdiction 15 Home Health & Hospice Provider Outreach and Education (POE) Advisory Group Web page at https://www.cgsmedicare.com/hhh/education/advisory_groups.html was updated with a revised meeting date for the upcoming home health POE AG members.

• The Top Claim Submission Errors (Reason Codes) and How to Resolve Web page at https://www.cgsmedicare.com/hhh/education/materials/cses.html was updated with the August 2017 claim submission error data.

• The ICD-10 CM/PCS Web page at https://www.cgsmedicare.com/hhh/claims/5010.html was updated to remove outdated ICD-10 implementation resources and providing the link to the CMS ICD-10 page.

• The Hospice Sequential Billing Web page at https://www.cgsmedicare.com/hhh/education/materials/hospice_sequential_billing.html was updated to better explain what happens to an incoming claim when a prior claim is in the Return to Provider (RTP) file.

• The Remittance Advice (RA)/Electronic Remittance Advice (ERA) Web page at https://www.cgsmedicare.com/hhh/claims/ra_era.html was updated to remove the CMS resource, “Remittance Advice Resources Fact Sheet” which is no longer available. The information was consolidated in with the CMS Remittance Advice Resources and FAQs Booklet resource.

• The Hospice Expedited Determination Process Web page at https://www.cgsmedicare.com/hhh/coverage/coverage_guidelines/expedited_determination_process.html was updated to correct the link to the CMS ‘FFS Expedited Determination Notices’ Web page. The link was also corrected on the Hospice Guidelines of the ABN of Noncoverage and Expedited Determination quick resource tool at https://www.cgsmedicare.com/hhh/education/materials/pdf/hospice_guidelines_abn_noncoverage.pdf.

• The myCGS User Manual, Chapter 4: Eligibility Tab at https://www.cgsmedicare.com/pdf/mycgs/chapter4.pdf was revised to provide a corrected Hospice/Home Health screen print on page 15 and field name and descriptions on page 16.

• The Fiscal Intermediary Standard System Claims Processing Issues Web page at https://www.cgsmedicare.com/hhh/claims/fiss_claims_processing_issues.html was updated.

• The Billing Negative Pressure Wound Therapy (NPWT) Web page at https://www.cgsmedicare.com/hhh/education/materials/3118.html was updated to add a link to the “MLN Matters article SE17027 “Clarification of Billing and Payment Policies for Negative Pressure Wound Therapy (NPWT) Using a Disposable Device” under the Additional Resources heading.

• The following Web pages were updated to include the MLN Matters articles MM10224 “Influenza Vaccine Payment Allowances – Annual Update for 2017-2018 Season” and SE17026 “2017-2018 Influenza (Flu) Resources for Health Care Professionals” in the Additional Resources section.
  - Home Health Immunization Reimbursement - https://www.cgsmedicare.com/hhh/claims/fees/hh_ir.html
Billing Individual Influenza and Pneumococcal Pneumonia Vaccines - [https://www.cgsmedicare.com/hhh/education/materials/biippv.html](https://www.cgsmedicare.com/hhh/education/materials/biippv.html)


The new Targeted Probe & Educate Process Web page at [https://www.cgsmedicare.com/hhh/medreview/tpe_process.html](https://www.cgsmedicare.com/hhh/medreview/tpe_process.html) was developed to explain the process based on Change Request 10249. Other new Targeted Probe & Educate (TPE) related Web pages include:

- Medical Review Activity Log at [https://www.cgsmedicare.com/hhh/medreview/activitylog.html](https://www.cgsmedicare.com/hhh/medreview/activitylog.html)
- Targeted Probe and Educate FAQs at [https://www.cgsmedicare.com/hhh/education/faqs/tpe_faqs.html](https://www.cgsmedicare.com/hhh/education/faqs/tpe_faqs.html)

**For Home Health and Hospice Providers**

**MLN Connects® Weekly News**

The MLN Connects® is the official news from the Medicare Learning Network and contains a weeks worth of Medicare-related messages. These messages ensure planned, coordinated messages are delivered timely about Medicare-related topics. The following provides access to the weekly messages. Please share with appropriate staff. If you wish to receive the listserv directly from CMS, refer to [https://public.govdelivery.com/accounts/USCMS/subscriber/new?pop=t&topic_id=USCMS_7819](https://public.govdelivery.com/accounts/USCMS/subscriber/new?pop=t&topic_id=USCMS_7819).


**For Home Health and Hospice Providers**

**Provider Contact Center (PCC) Training**

Medicare is a continuously changing program, and it is important that we provide correct and accurate answers to your questions. To better serve the provider community, the Centers for Medicare & Medicaid Services (CMS) allows the provider contact centers the opportunity to offer training to our customer service representatives (CSRs). The list below indicates when the home health and hospice PCC at **1.877.299.4500** (option 1) will be closed for training.

<table>
<thead>
<tr>
<th>Date</th>
<th>PCC Training/Closures</th>
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<tbody>
<tr>
<td>Friday, November 10, 2017 (Veterans Day)</td>
<td>PCC Closed 8:00 a.m. – 4:30 p.m. Central Time</td>
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<tr>
<td>Thursday, November 23, 2017 (Thanksgiving)</td>
<td>PCC Closed 8:00 a.m. – 4:30 p.m. Central Time</td>
</tr>
<tr>
<td>Friday, November 24, 2017 (Day after Thanksgiving)</td>
<td>PCC Closed 8:00 a.m. – 4:30 p.m. Central Time</td>
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</table>

Internet portal, myCGS, is available to access eligibility information through the Internet. For additional information, go to [https://www.cgsmedicare.com/hhh/index.html](https://www.cgsmedicare.com/hhh/index.html) and click the “myCGS” button on the left side of the Web page.

For your reference, access the “Home Health & Hospice 2017 Holiday/Training Closure Schedule” at [https://www.cgsmedicare.com/hhh/help/pdf/2017_hhh_calendar_FINAL.pdf](https://www.cgsmedicare.com/hhh/help/pdf/2017_hhh_calendar_FINAL.pdf) for a complete list of PCC closures.

**For Home Health and Hospice Providers**

**SE17016: Modernized National Plan and Provider Enumeration System**

The Centers for Medicare & Medicaid Services (CMS) has issued the following *Special Edition Medicare Learning Network* (MLN) Matters article. This MLN Matters article and other CMS articles can be found on the CMS website at: [https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/)

**MLN Matters® Number:** SE17016  
**Related CR Release Date:** June 27, 2017  
**Related CR Transmittal #:** N/A  
**Related Change Request (CR) #:** N/A  
**Effective Date:** N/A  
**Implementation Date:** N/A

**Provider Types Affected**

This MLN Matters® Article is intended for all health care providers -- users of the National Plan and Provider Enumeration System (NPPES) to obtain, or update a National Provider Identifier (NPI) and to maintain their NPI account. This includes all physicians, providers and suppliers—it is not limited or restricted to Medicare.

**Provider Action Needed**

The Centers for Medicare & Medicaid Services has modernized the NPPES (NPPES 3.0) that now has unified login for Type 1 and Type 2 providers which increases security, provides new surrogacy functionality, has a more responsive User Interface (UI) and a streamlined NPI application process. All NPPES users who obtain and manage NPI account information should be aware of these new and improved features/processes, especially those who support Type 2 providers. NPPES has implemented a more efficient way of accessing Type 2 NPI accounts so providers no longer need separate credentials for Type 2 accounts and are no longer inclined to share these credentials.

**Background**

The NPI is the standard for a unique identifier for health care providers for use in the health care system. NPPES is the application that health care providers must use to be awarded an NPI number. Within the NPPES, there are two types of providers:

- **Type 1 Providers** – Health care providers who are individuals, including physicians, dentists, and all sole proprietors (An individual is eligible for only one NPI.)
- **Type 2 Providers** – Health care providers who are organizations, including physician groups, hospitals, nursing homes, and the corporation formed when an individual incorporates him/herself.

New NPPES Impact on Type 1 Providers
Type 1 providers who already have an account in the Identity & Access (I&A) Management System may login to NPPES without incident. Type 1 providers who do not have an I&A account will need to create an account by visiting https://nppes.cms.hhs.gov/IAWeb/login.do.

Under the modernized NPPES, surrogates of Type 1 providers will have access to their Type 1 provider’s NPI records.


New NPPES Impact on Type 2 Providers
In the past, the sharing of login credentials between Type 2 providers and surrogates posed great security risks including fraud and provider identity theft. The new unified login and surrogacy helps lessen these risks and increase account security. Type 2 provider users will need I&A authentication credentials to access the modernized NPPES. Users may obtain these in the I&A system by going to https://nppes.cms.hhs.gov/IAWeb/login.do.

The Authorized Officials (AO) and Delegated Officials (DO) in I&A of Type 2 providers will be able to access all NPIs under the Employer Identification Number (EIN) on the Type 2 provider with an organization EIN. Users can claim NPIs using their legacy Type 2 usernames and passwords after they login with an I&A account. As an additional convenience, large organizations can contact the enumerator to get access to their NPIs. More information on the types of possible user roles is available at https://nppes.cms.hhs.gov/IAWebContent/Quick_Reference_Guide.pdf.

Key Features of the Modernized NPPES
Some of the key features of the modernized and more responsive UI include:

- If users have an I&A user ID and password, they now can use those credentials to login to NPPES and they can access all NPIs from one unified account.
- Users can save applications that are not fully complete and may continue where they left off when they return to the NPPES.
- NPPES will have smart filters that only display entries containing the data entered by users to filter away unnecessary information.
- Users may add more than one practice location to their NPI application.
- All taxonomy information may be completed on one page due to the smart filter technology of NPPES 3.0.
- Surrogacy allows administrative users the ability to update records in NPPES on behalf of a provider.
- NPPES 3.0 provides a help option to give assistance to the user based on the screen on which they are working.
- Increased security because NPPES now uses surrogacy functionality for Type 2 NPIs to prevent sharing of Type 2 login credentials.

Electronic File Interchange (EFI) Features
NPPES 3.0 will continue to allow providers and surrogates to submit multiple NPI applications at one time using Comma Separated Values (CSV) files. To use the EFI feature, the users will need to apply for EFI access. This can be done by logging into NPPES and clicking the ‘Manage EFI’ button on the bottom of the NPPES homepage. The EFI access application is prepopulated with some of the user’s information pre-filled when it is generated. For more
information on EFI functionality please visit https://nppes.cms.hhs.gov/webhelp/nppeshelp/EFI%20HELP%20PAGE.html.

Data Dissemination File (DDS) Enhancements
NPPES will generate weekly and monthly Org Other Name, Practice Location Addresses, and Endpoint Information Files. The weekly files will have updates of the information that changes from week to week, while the monthly files will generate regardless of updated information. DDS files with PII will continue to be delivered to stakeholders, while DDS files without PII will continue to be delivered to http://download.cms.gov/nppes/NPI_Files.html.

New Optional Fields in NPPES 3.0
The following new fields will allow the user to give more information about the provider and the practice location:

- Primary languages
- Secondary languages
- Race and ethnicity
- Accessibility of the location to users with mobility disabilities
- Provider’s office hours of operation
- Provider’s direct email address

Frequently Asked Questions
Feel free to visit the NPPES Web help guide to see solutions to frequently asked questions. That guide is available at https://nppes.cms.hhs.gov/webhelp/nppeshelp/NPPES%20FAQS.html.

Additional Information
Additional Information on NPPES is available at the following links:

- https://www.youtube.com/watch?v=BOJCAj1P2u8&feature=youtu.be
- https://nppes.cms.hhs.gov/webhelp/nppeshelp/NPPES%20FAQS.html#How-can-I-gain-access-to-my-Type-2-NPI

If you have any questions, please contact the NPI enumerator by phone at 1.800.465.3203 (NPI Toll-Free) or 1.800.692.2326 (NPI TTY), by email at customerservice@npienumerator.com or by regular mail at:

NPI Enumerator
PO Box 6059
Fargo, ND 58108-6059

Document History

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<th>Date</th>
<th>Description</th>
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<tr>
<td>June 27, 2017</td>
<td>Initial article released.</td>
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</table>
For Home Health and Hospice Providers

SE17018: Billing in Medicare Secondary Payer (MSP) Liability Insurance Situations

The Centers for Medicare & Medicaid Services (CMS) has issued the following Special Edition Medicare Learning Network® (MLN) Matters article. This MLN Matters article and other CMS articles can be found on the CMS website at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/

MLN Matters® Number: SE17018
Related CR Release Date: September 19, 2017
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Provider Types Affected
This MLN Matters® Article is intended for all providers, physicians, and other suppliers who bill in a situation where liability insurance (including self-insurance) is a consideration. The article is of particular importance for those who elect not to file the claim with Medicare, and instead seek payment for their services from a Medicare beneficiary’s liability insurance (including self-insurance) claim.

Provider Action Needed
This article is based on information received from Medicare beneficiaries, their legal counsel and other entities that assist these individuals, indicating that providers, physicians, and other suppliers that elect to seek payment from the beneficiary’s liability insurance claim instead of submitting the claim for items or services to Medicare have not generally billed in accordance with the instructions provided or referenced in this article. The FAQs in this article are intended to remind providers, physicians, and other suppliers of the fundamental guidance governing billing where liability insurance (including self-insurance) is involved. Please review your billing practices to be sure they are in line with the information below.

Background
Liability insurance (including self-insurance), no-fault insurance, and workers’ compensation benefits are primary payers to Medicare. However, CMS’ regulations and policy for liability insurance billing are distinct from those for no-fault insurance and workers’ compensation benefits. Because the liability insurance billing rules are different and place distinct obligations on providers, physicians, and other suppliers (including termination of liens tied to the expiration of Medicare’s timely filing requirements), it is important that these rules be reviewed in detail.

The options when seeking payment from the liability insurance, and the obligations and restrictions that accompany them, are discussed with more specificity in the “Internet Only Medicare Secondary Payer Manual” (Pub 100-05), Chapter 2, Section 40.2 found at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/msp105c02.pdf. See also, MLN Matters Article MM7355 “Clarification of Medicare Conditional Payment Policy and Billing Procedures for Liability, No-Fault, and Workers’ Compensation (WC) Medicare Secondary Payer (MSP) Claims”. This article is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7355.pdf. (Although not the subject of this article, the instructions for situations involving no-fault insurance or workers’ compensation benefits can be found in Chapter 3 of the MSP Manual.)

FAQs for Liability Insurance (Including Self-Insurance) Billing
Q1. What are the “promptly period” rules and do they apply when billing in situations involving liability insurance (including self-insurance)?
A1. The “promptly period” is 120 days after the earlier of: 1) the date the claim is filed with an insurer or a lien is filed against a potential liability settlement; or 2) the date the service was furnished or, in the case of inpatient hospital services, the date of discharge. The “promptly period” does apply even when a provider, physician, or other supplier is aware that liability insurance may end up indirectly funding the defendant’s settlement. However, following expiration of the 120 days or during that time if it is demonstrated (for example, a bill/claim that had been submitted but not paid) that liability insurance will not pay during the promptly period, the provider, physician, or other supplier has an option (with certain limitations) to bill Medicare or maintain a claim/lien against the liability insurance/beneficiary’s liability insurance settlement.

Q2. Who do I bill...Medicare or the liability insurance/beneficiary’s liability insurance settlement? (I hear so many different things. My patient was in an accident and I need to know whether to bill Medicare or the patient. My other patient is suing some manufacturer, what do I do about my bill for services to this patient?)

A2. Once the “promptly period” has expired, with the exception of the special rule for Oregon (see below), the provider, physician, or other supplier may bill either Medicare or the liability insurer/beneficiary’s liability insurance settlement as long as the Medicare timely filing period has not expired. Billing both Medicare and maintaining a claim against the liability insurance/beneficiary’s liability insurance settlement is not permitted. Once Medicare has been billed, the provider, physician, or other supplier is limited to Medicare’s approved amount or the limiting charge if the claim is non-assigned, even if they subsequently return any payment made by Medicare. Claims/liens against the liability insurance/beneficiary’s liability settlement must be dropped once Medicare’s timely filing period has expired. See also the Q’s/A’s below for more detail.

Q3. What is the Oregon rule?

A3. By court order, there are very specific alternative billing rules for Oregon. Generally speaking, the provider, physician, or other supplier may bill either Medicare or the liability insurance if the liability insurer pays within 120 days. See the MSP Manual (CMS Pub. 100-05), Chapter 2, Section 40.2 for specifics on the Oregon rule.

Q4. Do Medicare’s timely filing rules still apply if the timely filing period expires while the provider, physician, or other supplier is waiting for the liability insurance payment/beneficiary’s liability insurance settlement? (It’s been 3 years and the patient’s case still hasn’t settled. Can I bill Medicare now?)

A4. The existence of a liability insurance or potential liability insurance situation does not change or extend Medicare’s timely filing requirements. If Medicare is not billed within the applicable timely filing period, the claim will be denied. Additionally, see the information below regarding the requirement that claims/liens against the liability insurance/beneficiary’s liability insurance settlement (with certain exceptions) be withdrawn once the timely filing period has expired.

Q5. How long can a claim/lien be maintained against the liability insurer/the beneficiary’s liability insurance settlement? (Can I direct bill/maintain my lien once Medicare’s timely filing period has expired?)

A5. CMS’ liability insurance billing policy is that providers are required to drop their claims/liens and terminate all billing efforts to collect from a liability insurer or a beneficiary once the Medicare timely filing period expires, unless the liability insurance claim was paid or settled prior to the expiration of the Medicare timely filing period.

- All such claims/liens must be withdrawn (except for claims related to items or services not covered by Medicare and for Medicare deductibles and co-insurance) when the provider,
physician, or other supplier bills Medicare or when Medicare’s timely filing period has expired – whichever occurs first.

• If there is a settlement, judgment, award, or other payment before the timely filing period expires, the provider, physician, or supplier may maintain its claim/lien despite the expiration of the timely filing period.

• All such claims/liens are limited by state lien laws/requirements. The MSP provisions do not create lien rights when those rights do not exist under state law.

• Under the Oregon rule all such claims/liens must be withdrawn following the expiration of the applicable 120 day period.

Q6. How much can the provider, physician or other supplier bill the liability insurance/beneficiary’s liability insurance settlement? (What if the beneficiary’s case settled, but the amount was not large enough to pay everyone? What if Medicare and the attorney were paid, but because very little remained the attorney asked all the doctors and other providers to take reduced amounts; do we have to?; what about our bill?)

A6. Where Medicare has a recovery claim, Medicare’s claim has the priority right of recovery. In general, the provider, physician, or other supplier:

• Is limited to the Medicare approved amount (limiting charge when non-assigned) once they have billed Medicare, even if they return any payment received from Medicare.

• May charge actual charges but is limited to the amount available from the settlement less applicable procurement costs (for example, attorney fees, other litigation costs).

• May only bill for non-covered services, or co-insurance and deductibles, if Medicare timely filing has expired before payment or settlement. (In this context, non-covered services are the program exclusions such as measuring of eye refractions or services rendered to family members. Medical necessity denials are not included and are not billable in the example.)

• May not collect from the beneficiary until the proceeds are available to the beneficiary.

Q7. What about physician and other suppliers who do not participate in Medicare and do not submit an assigned claim (and would not be required to submit an assigned claim if they submitted a claim to Medicare) – what can they pursue?

A7. Such physicians and other suppliers can pursue liability insurance, but the amount may not exceed the limiting charge.

Q8. Are there risks involved in deciding whether to pursue the liability insurance vs. billing Medicare once the promptly period has expired?

A8. Providers, physicians, and other suppliers who do not file a Medicare claim once the “promptly period” has expired (and before timely filing has expired) run the risk that insurance proceeds will not be available or may be less than Medicare’s payment would have been if Medicare had been billed. They also run the risk that they will be limited to billing for co-insurance and deductibles if there is no payment or settlement before Medicare’s timely filing expires.

Q9. Are there additional rules if a patient receives both Medicare and Medicaid or other benefits?

A9. If the individual receives assistance from the state, additional regulations govern provider billing. If a Medicare beneficiary received Medicaid benefits at the time the services were rendered, providers should contact their state Medicaid office to obtain the state’s policy on provider billing.

Q10. What if the items or services in question are not covered by Medicare?
A10. If the items or services rendered are services that are not covered by the Medicare program, providers, physicians, and other suppliers may charge and collect actual charges without regard to whether the proceeds of the liability insurance are available to the beneficiary. (In this context, non-covered services are the program exclusions such as measuring of eye refractions or services rendered to family members. Medical necessity denials are not included and are not billable in the example.)

Additional Information

If you have any questions, please contact a CGS Customer Service Representative by calling the CGS Provider Contact Center at 1.877.299.4500 and choose Option 1.

For Home Health and Hospice Providers

SE17020 Revised: Hurricane Harvey and Medicare Disaster Related Texas Claims

The Centers for Medicare & Medicaid Services (CMS) issued the following Special Edition Medicare Learning Network® (MLN) Matters article. CMS then issued revisions to this article. The following reflects the revised information. This MLN Matters article and other CMS articles can be found on the CMS website at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/

MLN Matters® Number: SE17020 Revised  Related Change Request (CR) #: N/A
Related CR Release Date: September 19, 2017  Effective Date: N/A
Related CR Transmittal #: N/A  Implementation Date: N/A

Note: This article was revised on September 19, 2017, to include information about replacement prescription fills of covered Part B drugs. All other information remains the same.

Provider Types Affected

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

Provider Information Available

On August 26, 2017, pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act, President Trump declared that, as a result of the effects of Hurricane Harvey, an emergency exists in the State of Texas, retroactive to August 25, 2017. Also on August 26, 2017, Secretary Price of the Department of Health & Human Services declared that a public health emergency exists in the State of Texas and authorized waivers and modifications under Section 1135 of the Social Security Act (the Act), retroactive to August 25, 2017.

Under Section 1135 or 1812(f) of the Social Security Act, the Centers for Medicare & Medicaid Services (CMS) has issued several blanket waivers in the impacted counties and geographical areas of Texas. These waivers will prevent gaps in access to care for beneficiaries impacted by the emergency. Providers do not need to apply for an individual waiver if blanket waiver has been issued. Providers can request an individual Section 1135 waiver, if there is no blanket waiver, by following the instructions available at https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Requesting-an-1135-Waiver-Updated-11-16-2016.pdf.
Additional blanket waiver requests are being reviewed. The most current waiver information can be found under Administrative Actions at https://www.cms.gov/About-CMS/Agency-Information/Emergency/Hurricanes.html. This article will be updated as additional waivers are approved. See the Background section of this article for more details.

Background

Section 1135 and Section 1812(f) Waivers

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

1. Change Request (CR) 6451 (Transmittal 1784, Publication 100-04) issued on July 31, 2009, applies to items and services furnished to Medicare beneficiaries within the State of Texas from August 25, 2017, for the duration of the emergency. In accordance with CR6451, use of the “DR” condition code and the “CR” modifier are mandatory on claims for items and services for which Medicare payment is conditioned on the presence of a “formal waiver” including, but not necessarily limited to, waivers granted under either Section 1135 or Section 1812(f) of the Act.

2. The most current information can be found at https://www.cms.gov/emergency. Medicare FFS Questions & Answers (Q&As) posted in the downloads section at the bottom of the Emergency Response and Recovery Web page and also referenced below are applicable for items and services furnished to Medicare beneficiaries within the State of Texas. These Q&As are displayed in two files:

   - The first listed file addresses policies and procedures that are applicable without any Section 1135 or other formal waiver. These policies are always applicable in any kind of emergency or disaster, including the current emergency in Texas.

   - The second file addresses policies and procedures that are applicable only with approved Section 1135 waivers or, when applicable, approved Section 1812(f) waivers. These Q&As are applicable for approved Section 1135 blanket waivers and approved individual 1135 waivers requested by providers and are effective August 25, 2017, for Texas.

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

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

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

Blanket Waivers Issued by CMS

Under the authority of Section 1135 (or, as noted below, Section 1812(f)), CMS has issued blanket waivers in the affected area of Texas. Individual facilities do not need to apply for the following approved blanket waivers:

Skilled Nursing Facilities

• Section 1812(f): Waiver of the requirement for a 3-day prior hospitalization for coverage of a skilled nursing facility (SNF) stay provides temporary emergency coverage of SNF services without a qualifying hospital stay, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of Hurricane Harvey in the State of Texas in 2017. In addition, for certain beneficiaries who recently exhausted their SNF benefits, it authorizes renewed SNF coverage without first having to start a new benefit period. (Blanket waiver for all impacted facilities)
HOME HEALTH & HOSPICE

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

Home Health Agencies

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

• Home health agencies should monitor information posted at https://www.cms.gov/About-CMS/Agency-Information/Emergency/Hurricanes.html under Administrative Actions for updates on waivers.

Critical Access Hospitals

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

Housing Acute Care Patients In Excluded Distinct Part Units

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

Emergency Durable Medical Equipment, Prosthetics, Orthotics, and Supplies for Medicare Beneficiaries Impacted by an Emergency or Disaster

As a result of Hurricane Harvey, CMS has determined it is appropriate to issue a blanket waiver to suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) where DMEPOS is lost, destroyed, irreparably damaged, or otherwise rendered unusable. Under this waiver, the face-to-face requirement, a new physician’s order, and new medical necessity documentation are not required for replacement.

Suppliers must still include a narrative description on the claim explaining the reason why the equipment must be replaced and are reminded to maintain documentation indicating that the DMEPOS was lost, destroyed, irreparably damaged or otherwise rendered unusable as a result of the hurricane.


Application Deadline Extended for Reclassifications Submission to MGCRB

In accordance with Waiver or Modification of Requirements under Section 1135 of the Social Security Act issued August 26, 2017 by Secretary Price, CMS is modifying the September 1, 2017, deadline for applications for FY 2019 reclassifications to be submitted to the Medicare Geographic Classification Review Board (MGCRB). CMS is currently granting a 31-day extension to the deadline at § 412.256(a)(2) for the State of Texas. Applications for FY 2019 reclassifications from hospitals in these areas must be received by the MGCRB not later than October 2, 2017.
Deadline Extended for IPPS Wage Index Requests

Regarding the FY 2019 wage index, CMS is modifying the September 1, 2017, deadline specified in the FY 2019 Hospital Wage Index Development Time Table for these hospitals to request revisions to and provide documentation for their FY 2015 Worksheet S-3 wage data and CY 2016 occupational mix data, as included in the May 18, 2017, and July 12, 2017, preliminary PUFs, respectively. CMS is currently granting an extension for hospitals in the State of Texas until October 2, 2017. MACs must receive the revision requests and supporting documentation by this date. If hospitals encounter difficulty meeting this extended deadline of October 2, 2017, hospitals should communicate their concerns to CMS via their MAC, and CMS may consider an additional extension if CMS determines it is warranted.

Facilities Quality Reporting

CMS is granting exceptions under certain Medicare quality reporting and value-based purchasing programs without having to submit an extraordinary circumstances exception request if they are located in one of the Texas counties, all of which have been designated by the Federal Emergency Management Agency (FEMA) (https://www.fema.gov/hurricane-harvey?utm_source=hp_promo&utm_medium=web&utm_campaign=disaster) as a major disaster county. Further information can be found in the memo on applicability of reporting requirements to certain providers in the Downloads section at https://www.cms.gov/About-CMS/Agency-Information/Emergency/Hurricanes.html.

Medicare-dependent small, rural hospitals (MDHs)

In accordance with Waivers or Modifications of Requirements under Section 1135 of the Social Security Act issued August 26, 2017 by Secretary Price, CMS is modifying the September 1, 2017 deadline for Medicare-dependent small, rural hospitals (MDHs) to apply for sole community hospital (SCH) status in advance of the expiration of the MDH program with an effective date of an approval of SCH status that is the day following the expiration date of the MDH program (that is, September 30, 2017 under current law). CMS is currently granting a 31-day extension to the deadline at § 412.92(b)(2)(v) for the State of Texas. If a hospital located in these areas that is classified as an MDH applies for classification as an SCH under the provisions of § 412.92(b)(2)(v), and that hospital's SCH status is approved, the effective date of approval of SCH status will be the day following the expiration date of the MDH program if such hospital applies for classification as a SCH not later than October 2, 2017.

Low-volume hospital

In accordance with Waivers or Modifications of Requirements under Section 1135 of the Social Security Act issued August 26, 2017 by Secretary Price, CMS is modifying the September 1, 2017 deadline for hospitals to make a written request for low-volume hospital status that is received by its Medicare Administrative Contractor (MAC) in order for the 25-percent low-volume hospital payment adjustment to be applied to payments for its discharges beginning on or after the start of the Federal fiscal year (FY) 2018. CMS is currently granting a 31-day extension to the deadline established in the FY 2018 Inpatient Prospective Payment System (IPPS)/LTCH PPS Long-Term Care Hospital Prospective Payment System (LTCH PPS) final rule (82 FR 38186) for the State of Texas. Requests for low-volume hospital status for FY 2018 from a hospital located in these areas must be received by the MAC no later than October 2, 2017 in order for the low-volume hospital payment adjustment to be applied beginning with the start of the FY 2018 (that is, for discharges occurring on or after October 1, 2017).

Appeal Administrative Relief for Areas Affected by Hurricane Harvey

If you were affected by Hurricane Harvey and are unable to file an appeal within 120 days from the date of receipt of the Remittance Advice (RA) that lists the initial determination or will
have an extended period of non-receipt of remittance advices that will impact your ability to file an appeal, please contact your Medicare Administrative Contractor.

Replacement Prescription Fills – This information added on September 19, 2017.

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

Moratoria on Part B Non-emergency Ambulance Suppliers

CMS has authority under 42 C.F.R. § 424.570(d) to lift a moratorium at any time if the President declares an area a disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act. On August 25, 2017, the President of the United States signed the Presidential Disaster Declaration for several counties in the State of Texas. As a result of the President’s declaration CMS has carefully reviewed the potential impact of continued moratorium in Texas and is lifting the temporary enrollment moratoria on Part B non-emergency ambulance suppliers in Texas in order to aid in the disaster response. This lifting applies to Medicare, Medicaid and the Children’s Health Insurance Program (CHIP) and became effective on September 1, 2017. CMS will also publish a document in the Federal Register to announce that the moratoria on Part B non-emergency ambulance suppliers has been lifted. Providers and suppliers that were unable to enroll because of the moratorium will be designated to CMS’ high screening level under 42 CFR § 424.518(c)(3)(iii) to the extent these providers and suppliers enroll in Medicare in the future.

Requesting an 1135 Waiver

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

Additional Information

If you have any questions, please contact a CGS Customer Service Representative by calling the CGS Provider Contact Center at 1.877.299.4500 and choose Option 1.


Document History

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<th>Date</th>
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<tr>
<td>September 19, 2017</td>
<td>The article was revised to include information about replacement prescription fills of covered Part B drugs. All other information remains the same.</td>
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<tr>
<td>September 7, 2017</td>
<td>The article was revised to include additional waiver information about emergency durable medical equipment, prosthetics, orthotics, and supplies for Medicare beneficiaries impacted by Hurricane Harvey. All other information remains the same.</td>
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<tr>
<td>September 5, 2017</td>
<td>The article was revised on September 5, 2017, to include additional information about housing acute care patients in excluded distinct part units and lifting the temporary enrollment moratoria on Part B non-emergency ambulance suppliers in Texas. In addition, information has been added to the Facilities Quality Reporting Section and the second paragraph of the Provider Information Available section is modified to clarify that waivers prevent gaps in access to care.</td>
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For Home Health and Hospice Providers

SE17021 Revised: Tropical Storm Harvey and Medicare Disaster Related Louisiana Claims

The Centers for Medicare & Medicaid Services (CMS) issued the following Special Edition Medicare Learning Network® (MLN) Matters article. CMS then issued revisions to this article. The following reflects the revised information. This MLN Matters article and other CMS articles can be found on the CMS website at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/

MLN Matters® Number: SE17021 Revised
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Note: This article was revised on September 19, 2017, to include information on replacement prescription fills of covered Part B drugs. All other information remains the same.

Provider Types Affected

This MLN Matters® Special Edition Article is intended for providers and suppliers who submit claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries in the State of Louisiana who were affected by Tropical Storm Harvey.

Provider Information Available

On August 28, 2017, pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act, President Trump declared that, as a result of the effects of Tropical Storm Harvey, an emergency exists in the State of Louisiana, retroactive to August 27, 2017. Also on August 28, 2017, Secretary Price of the Department of Health & Human Services declared that a public health emergency exists in the State of Louisiana and authorized waivers and modifications under Section 1135 of the Social Security Act (the Act), retroactive to August 27, 2017.

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

Additional blanket waiver requests are being reviewed. The most current waiver information can be found under Administrative Actions at https://www.cms.gov/About-CMS/Agency-Information/Emergency/Hurricanes.html. This article will be updated as additional waivers are approved. See the Background section of this article for more details.
Background

Section 1135 and Section 1812(f) Waivers

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

1. Change Request (CR) 6451 (Transmittal 1784, Publication 100-04) issued on July 31, 2009, applies to items and services furnished to Medicare beneficiaries within the State of Louisiana from August 27, 2017, for the duration of the emergency. In accordance with CR6451, use of the “DR” condition code and the “CR” modifier are mandatory on claims for items and services for which Medicare payment is conditioned on the presence of a “formal waiver” including, but not necessarily limited to, waivers granted under either Section 1135 or Section 1812(f) of the Act.

2. The most current information can be found at https://www.cms.gov/emergency. Medicare FFS Questions & Answers (Q&As) posted in the downloads section at the bottom of the Emergency Response and Recovery Web page and also referenced below are applicable for items and services furnished to Medicare beneficiaries within the State of Louisiana. These Q&As are displayed in two files:

   - The first listed file addresses policies and procedures that are applicable without any Section 1135 or other formal waiver. These policies are always applicable in any kind of emergency or disaster, including the current emergency in Louisiana.

   - The second file addresses policies and procedures that are applicable only with approved Section 1135 waivers or, when applicable, approved Section 1812(f) waivers. These Q&As are applicable for approved Section 1135 blanket waivers and approved individual 1135 waivers requested by providers and are effective August 27, 2017, for Louisiana.

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

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

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

Blanket Waivers Issued by CMS

Under the authority of Section 1135 (or, as noted below, Section 1812(f)), CMS has issued blanket waivers in the affected area of Louisiana. Individual facilities do not need to apply for the following approved blanket waivers:

Skilled Nursing Facilities

- Section 1812(f): Waiver of the requirement for a 3-day prior hospitalization for coverage of a skilled nursing facility (SNF) stay provides temporary emergency coverage of SNF services without a qualifying hospital stay, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of Tropical Storm Harvey in the State of Louisiana in 2017. In addition, for certain beneficiaries who recently exhausted their SNF benefits, it authorizes renewed SNF coverage without first having to start a new benefit period. (Blanket waiver for all impacted facilities)

- 42 CFR 483.20: Waiver provides relief to Skilled Nursing Facilities on the timeframe requirements for Minimum Data Set assessments and transmission. (Blanket waiver for all impacted facilities)
Home Health Agencies

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

Critical Access Hospitals

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

Housing Acute Care Patients In Excluded Distinct Part Units

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

Emergency Durable Medical Equipment, Prosthetics, Orthotics, and Supplies for Medicare Beneficiaries Impacted by an Emergency or Disaster

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


Application Deadline Extended for Reclassifications Submission to MGCRB

In accordance with Waiver or Modification of Requirements under Section 1135 of the Social Security Act issued August 28, 2017, by Secretary Price, CMS is modifying the September 1, 2017, deadline for applications for FY 2019 reclassifications to be submitted to the Medicare Geographic Classification Review Board (MGCRB). CMS is currently granting a 31-day extension to the deadline at § 412.256(a)(2) for the State of Louisiana. Applications for FY 2019 reclassifications from hospitals in these areas must be received by the MGCRB not later than October 2, 2017.

Deadline Extended for IPPS Wage Index Requests

Regarding the FY 2019 wage index, CMS is modifying the September 1, 2017, deadline specified in the FY 2019 Hospital Wage Index Development Time Table for these hospitals to request revisions to and provide documentation for their FY 2015 Worksheet S-3 wage data and CY 2016 occupational mix data, as included in the May 18, 2017, and July 12, 2017, preliminary PUFs, respectively. CMS is currently granting an extension for hospitals in the State of Louisiana until October 2, 2017. MACs must receive the revision requests and
supporting documentation by this date. If hospitals encounter difficulty meeting this extended
deadline of October 2, 2017, hospitals should communicate their concerns to CMS via their
MAC, and CMS may consider an additional extension if CMS determines it is warranted.

Facilities Quality Reporting

CMS is granting exceptions under certain Medicare quality reporting and value-based
purchasing programs without having to submit an extraordinary circumstances exception
request if they are located in one of the Louisiana parishes, all of which have been designated
by the Federal Emergency Management Agency (FEMA) (https://www.fema.gov/hurricane-
harvey?utm_source=hp_promo&utm_medium=web&utm_campaign=disaster) as
a major disaster county. Further information can be found in the memo on applicability of
reporting requirements to certain providers in the Downloads section at https://www.cms.gov/
About-CMS/Agency-Information/Emergency/Hurricanes.html.

Medicare-dependent small, rural hospitals (MDHs)

In accordance with Waivers or Modifications of Requirements under Section 1135 of
the Social Security Act issued August 28, 2017 by Secretary Price, CMS is modifying the
September 1, 2017 deadline for Medicare-dependent small, rural hospitals (MDHs) to apply
for sole community hospital (SCH) status in advance of the expiration of the MDH program
with an effective date of an approval of SCH status that is the day following the expiration
date of the MDH program (that is, September 30, 2017 under current law). CMS is currently
granting a 31-day extension to the deadline at § 412.92(b)(2)(v) for the State of Louisiana. If
a hospital located in these areas that is classified as an MDH applies for classification as an
SCH under the provisions of § 412.92(b)(2)(v), and that hospital’s SCH status is approved,
the effective date of approval of SCH status will be the day following the expiration date of
the MDH program if such hospital applies for classification as a SCH not later than
October 2, 2017.

Low-volume hospital

In accordance with Waivers or Modifications of Requirements under Section 1135 of
the Social Security Act issued August 28, 2017 by Secretary Price, CMS is modifying
the September 1, 2017 deadline for hospitals to make a written request for low- volume
hospital status that is received by its Medicare Administrative Contractor (MAC) in order
for the 25-percent low-volume hospital payment adjustment to be applied to payments for
its discharges beginning on or after the start of the Federal fiscal year (FY) 2018. CMS is
currently granting a 31-day extension to the deadline established in the FY 2018 Inpatient
Prospective Payment System (IPPS)/LTCH PPS Long-Term Care Hospital Prospective
Payment System (LTCH PPS) final rule (82 FR 38186) for the State of Louisiana. Requests
for low-volume hospital status for FY 2018 from a hospital located in these areas must be
received by the MAC no later than October 2, 2017 in order for the low-volume hospital
payment adjustment to be applied beginning with the start of the FY 2018 (that is, for
discharges occurring on or after October 1, 2017).

Appeal Administrative Relief for Areas Affected by Tropical Storm Harvey

If you were affected by Tropical Storm Harvey and are unable to file an appeal within 120
days from the date of receipt of the Remittance Advice (RA) that lists the initial determination
or will have an extended period of non-receipt of remittance advices that will impact your
ability to file an appeal, please contact your Medicare Administrative Contractor.

Replacement Prescription Fills – This information added on September 19, 2017.

Medicare payment may be permitted for replacement prescription fills (for a quantity up to
the amount originally dispensed) of covered Part B drugs in circumstances where dispensed
medication has been lost or otherwise rendered unusable by damage due to the emergency.
Requesting an 1135 Waiver

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

Additional Information

If you have any questions, please contact a CGS Customer Service Representative by calling the CGS Provider Contact Center at 1.877.299.4500 and choose Option 1.


Document History

<table>
<thead>
<tr>
<th>Date</th>
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<tbody>
<tr>
<td>September 19, 2017</td>
<td>The article was revised to include information regarding replacement prescription fills of covered Part B drugs. All other information remains the same.</td>
</tr>
<tr>
<td>September 7, 2017</td>
<td>The article was revised to include additional waiver information about emergency durable medical equipment, prosthetics, orthotics, and supplies for Medicare beneficiaries impacted by Hurricane Harvey. All other information remains the same.</td>
</tr>
<tr>
<td>September 5, 2017</td>
<td>The article was revised on September 5, 2017, to include additional information about housing acute care patients in excluded distinct part units. In addition, information has been added to the Facilities Quality Reporting Section on page 4 and the second paragraph of the Provider Information Available section is modified to clarify that waivers prevent gaps in access to care.</td>
</tr>
<tr>
<td>September 1, 2017</td>
<td>The article was revised to include additional waiver information for Medicare-dependent small, rural hospitals and for low-volume hospitals. Information regarding administrative relief related to timely filing of appeals was added. All other information remained the same.</td>
</tr>
<tr>
<td>August 31, 2017</td>
<td>Initial article released.</td>
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For Home Health and Hospice Providers

**SE10722 (Revised): Hurricane Irma and Medicare Disaster Related United States Virgin Islands, Commonwealth of Puerto Rico and State of Florida Claims**

The Centers for Medicare & Medicaid Services (CMS) has issued the following Special Edition Medicare Learning Network® (MLN) Matters article. CMS then issued revisions to this article. The following reflects the revised information. This MLN Matters article and other CMS articles can be found on the CMS website at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/.

MLN Matters® Number: SE17022 Revised
Related CR Release Date: September 19, 2017
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A
Provider Type Affected
This MLN Matters® Special Edition Article is intended for providers and suppliers who submit claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries in the United States Virgin Islands, Commonwealth of Puerto Rico and State of Florida who were affected by Hurricane Irma.

Provider Information Available

On September 7, 2017, the Administrator of the Centers for Medicare & Medicaid Services (CMS) authorized waivers under Section 1812(f) of the Social Security Act for the United States Virgin Islands, Commonwealth of Puerto Rico and State of Florida, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of Hurricane Irma in 2017.

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

Additional blanket waiver requests are being reviewed. The most current waiver information can be found under Administrative Actions at https://www.cms.gov/About-CMS/Agency-Information/Emergency/Hurricanes.html. This article will be updated as additional waivers are approved. See the Background section of this article for more details.

Background
Section 1135 and Section 1812(f) Waivers
As a result of the aforementioned declaration, CMS has instructed the MACs as follows:

1. Change Request (CR) 6451 (Transmittal 1784, Publication 100-04) issued on July 31, 2009, applies to items and services furnished to Medicare beneficiaries within the United States Virgin Islands and Commonwealth of Puerto Rico from September 5, 2017, and the State of Florida from September 4, 2017, for the duration of the emergency. In accordance with CR6451, use of the “DR” condition code and the “CR” modifier are mandatory on claims for items and services for which Medicare payment
is conditioned on the presence of a “formal waiver” including, but not necessarily limited to, waivers granted under either Section 1135 or Section 1812(f) of the Act.

2. The most current information can be found at https://www.cms.gov/emergency. Medicare FFS Questions & Answers (Q&As) posted in the downloads section at the bottom of the Emergency Response and Recovery Web page and also referenced below are applicable for items and services furnished to Medicare beneficiaries within the United States Virgin Islands, Commonwealth of Puerto Rico and State of Florida. These Q&As are displayed in two files:

- The first listed file addresses policies and procedures that are applicable without any Section 1135 or other formal waiver. These policies are always applicable in any kind of emergency or disaster, including the current emergency in the United States Virgin Islands, Commonwealth of Puerto Rico and State of Florida.

- The second file addresses policies and procedures that are applicable only with approved Section 1135 waivers or, when applicable, approved Section 1812(f) waivers. These Q&As are applicable for approved Section 1135 blanket waivers and approved individual 1135 waivers requested by providers and are effective September 5, 2017, for the United States Virgin Islands and Commonwealth of Puerto Rico and September 4, 2017, for the State of Florida.

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

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

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

Blanket Waivers Issued by CMS

Under the authority of Section 1135 (or, as noted below, Section 1812(f)), CMS has issued blanket waivers in the affected area of the United States Virgin Islands, Commonwealth of Puerto Rico and State of Florida. Individual facilities do not need to apply for the following approved blanket waivers:

Skilled Nursing Facilities

- Section 1812(f): Waiver of the requirement for a 3-day prior hospitalization for coverage of a skilled nursing facility (SNF) stay provides temporary emergency coverage of SNF services without a qualifying hospital stay, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of Hurricane Irma in the United States Virgin Islands, Commonwealth of Puerto Rico and State of Florida in 2017. In addition, for certain beneficiaries who recently exhausted their SNF benefits, it authorizes renewed SNF coverage without first having to start a new benefit period. (Blanket waiver for all impacted facilities).

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

Home Health Agencies

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

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

Housing Acute Care Patients In Excluded Distinct Part Units

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

Care for Excluded Inpatient Psychiatric Unit Patients in the Acute Care Unit of a Hospital – This information added on September 19, 2017.

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

Care for Excluded Inpatient Rehabilitation Unit Patients in the Acute Care Unit of a Hospital – This information added on September 19, 2017.

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

Emergency Durable Medical Equipment, Prosthetics, Orthotics, and Supplies for Medicare Beneficiaries Impacted by an Emergency or Disaster

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

For more information refer to the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies for Medicare Beneficiaries Impacted by an Emergency or Disaster fact sheet at
Facilities Quality Reporting – This information added on September 19, 2017.

CMS is granting exceptions under certain Medicare quality reporting and value-based purchasing programs without having to submit an extraordinary circumstances exception request if they are located in one of the Florida counties, Puerto Rico municipios, or U.S. Virgin Islands county-equivalents, all of which have been designated by the Federal Emergency Management Agency (FEMA) (https://www.fema.gov/disaster/4332) as a major disaster county, municipio, or county-equivalent. Further information can be found in the memo on applicability of reporting requirements to certain providers in the Downloads section at https://www.cms.gov/About-CMS/Agency-Information/Emergency/Hurricanes.html.

Appeal Administrative Relief for Areas Affected by Hurricane Irma

If you were affected by Hurricane Irma and are unable to file an appeal within 120 days from the date of receipt of the Remittance Advice (RA) that lists the initial determination or will have an extended period of non-receipt of remittance advices that will impact your ability to file an appeal, please contact your Medicare Administrative Contractor.

Replacement Prescription Fills – This information added on September 19, 2017.

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

Requesting an 1135 Waiver

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

Additional Information

If you have any questions, please contact a CGS Customer Service Representative by calling the CGS Provider Contact Center at 1.877.299.4500 and choose Option 1.


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<tr>
<td>September 19, 2017</td>
<td>The article was revised to include new waivers regarding care for excluded inpatient psychiatric unit patients in the acute care unit of a hospital and care for excluded inpatient rehabilitation unit patients in the acute care unit of a hospital, to add information on replacement prescription fills of covered Part B drugs, and information on Facilities Quality Reporting. All other information remains the same. All other information remains the same.</td>
</tr>
<tr>
<td>September 8, 2017</td>
<td>Initial article released.</td>
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</table>
Special Edition Medicare Learning Network® (MLN) Matters article. CMS then issued revisions to the article. The following reflects the revised information. This MLN Matters article and other CMS articles can be found on the CMS website at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/

MLN Matters® Number: SE17024 Revised Related Change Request (CR) #: N/A
Related CR Release Date: September 19, 2017 Effective Date: N/A
Related CR Transmittal #: N/A Implementation Date: N/A

Note: This article was revised on September 19, 2017, to include new waivers regarding care for excluded inpatient psychiatric unit patients in the acute care unit of a hospital and care for excluded inpatient rehabilitation unit patients in the acute care unit of a hospital and to add information on replacement prescription fills of covered Part B drugs. All other information remains the same.

Provider Types Affected

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

Provider Information Available

On September 7, 2017, pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act, President Trump declared that, as a result of the effects of Hurricane Irma, an emergency exists in the State of South Carolina. On September 8, 2017, pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act, President Trump declared that, as a result of the effects of Hurricane Irma, an emergency exists in the State of Georgia. Also on September 8, 2017, Secretary Price of the Department of Health & Human Services declared that a public health emergency exists in the States of South Carolina and Georgia and authorized waivers and modifications under Section 1135 of the Social Security Act (the Act), retroactive to September 6, 2017, for the State of South Carolina and retroactive to September 7, 2017, for the State of Georgia.

On September 8, 2017, the Administrator of the Centers for Medicare & Medicaid Services (CMS) authorized waivers under Section 1812(f) of the Social Security Act for the States of South Carolina and Georgia, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of Hurricane Irma in 2017.

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

The most current waiver information can be found under Administrative Actions at https://www.cms.gov/About-CMS/Agency-Information/Emergency/Hurricanes.html. See the Background section of this article for more details.
Background

Section 1135 and Section 1812(f) Waivers

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

1. Change Request (CR) 6451 (Transmittal 1784, Publication 100-04) issued on July 31, 2009, applies to items and services furnished to Medicare beneficiaries within the State of South Carolina from September 6, 2017, and the State of Georgia from September 7, 2017, for the duration of the emergency. In accordance with CR6451, use of the “DR” condition code and the “CR” modifier are mandatory on claims for items and services for which Medicare payment is conditioned on the presence of a “formal waiver” including, but not necessarily limited to, waivers granted under either Section 1135 or Section 1812(f) of the Act.

2. The most current information can be found at https://www.cms.gov/emergency. Medicare FFS Questions & Answers (Q&As) posted in the downloads section at the bottom of the Emergency Response and Recovery Web page and also referenced below are applicable for items and services furnished to Medicare beneficiaries within the States of South Carolina and Georgia. These Q&As are displayed in two files:
   - The first listed file addresses policies and procedures that are applicable without any Section 1135 or other formal waiver. These policies are always applicable in any kind of emergency or disaster, including the current emergency in the States of South Carolina and Georgia.
   - The second file addresses policies and procedures that are applicable only with approved Section 1135 waivers or, when applicable, approved Section 1812(f) waivers. These Q&As are applicable for approved Section 1135 blanket waivers and approved individual 1135 waivers requested by providers and are effective September 6, 2017, for the State South Carolina and September 7, 2017, for the State of Georgia.

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

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

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

Blanket Waivers Issued by CMS

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

Skilled Nursing Facilities

- Section 1812(f): Waiver of the requirement for a 3-day prior hospitalization for coverage of a skilled nursing facility (SNF) stay provides temporary emergency coverage of SNF services without a qualifying hospital stay, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of Hurricane Irma in the States of South Carolina and Georgia in 2017. In addition, for certain beneficiaries who recently exhausted their SNF benefits, it authorizes renewed SNF coverage without first having to start a new benefit period. (Blanket waiver for all impacted facilities)
Home Health Agencies

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

Critical Access Hospitals

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

Housing Acute Care Patients In Excluded Distinct Part Units

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

Care for Excluded Inpatient Psychiatric Unit Patients in the Acute Care Unit of a Hospital – This information added on September 19, 2017.

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

Care for Excluded Inpatient Rehabilitation Unit Patients in the Acute Care Unit of a Hospital – This information added on September 19, 2017.

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

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies for Medicare Beneficiaries Impacted by an Emergency or Disaster

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


**Appeal Administrative Relief for Areas Affected by Hurricane Irma**

If you were affected by Hurricane Irma and are unable to file an appeal within 120 days from the date of receipt of the Remittance Advice (RA) that lists the initial determination or will have an extended period of non-receipt of remittance advices that will impact your ability to file an appeal, please contact your Medicare Administrative Contractor.

**Replacement Prescription Fills** – This information added on September 19, 2017.

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

**Requesting an 1135 Waiver**

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

**Additional Information**

If you have any questions, please contact a CGS Customer Service Representative by calling the CGS Provider Contact Center at 1.877.299.4500 and choose Option 1.


Providers may also want to view the Survey and Certification Frequently Asked Questions at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/index.html

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<tr>
<td>September 11, 2017</td>
<td>Initial article released.</td>
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SE17026: 2017-2018 Influenza (Flu)
Resources for Health Care Professionals

The Centers for Medicare & Medicaid Services (CMS) has issued the following Special Edition Medicare Learning Network® (MLN) Matters article. This MLN Matters article and other CMS articles can be found on the CMS website at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/

MLN Matters® Number: SE17026
Related CR Release Date: September 21, 2017
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Provider Types Affected
All health care professionals who order, refer, or provide flu vaccines and vaccine administration to Medicare beneficiaries.

What You Need To Know
• Keep this Special Edition MLN Matters® article and refer to it throughout the 2017 - 2018 flu season.
• Take advantage of each office visit as an opportunity to encourage your patients to protect themselves from the flu and serious complications by getting a flu shot.
• Continue to provide the flu shot if you have vaccine available, even after the new year.
• Remember to immunize yourself and your staff.

Background
The Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that Medicare Part B reimburses health care providers for flu vaccines and their administration. (Medicare provides coverage of the flu vaccine without any out-of-pocket costs to the Medicare patient. No deductible or copayment/coinsurance applies.)

You can help your Medicare patients reduce their risk for contracting seasonal flu and serious complications by using every office visit as an opportunity to recommend they take advantage of Medicare’s coverage of the annual flu shot. As a reminder, please help prevent the spread of flu by immunizing yourself and your staff!

Know What to Do About the Flu!

Payment Rates for 2017-2018
Each year, CMS updates the Medicare Healthcare Common Procedure Coding System (HCPCS) and Current Procedure Terminology (CPT) codes and payment rates for personal flu and pneumococcal vaccines. Payment allowance limits for such vaccines are 95 percent of the Average Wholesale Price (AWP), except where the vaccine is furnished in a hospital outpatient department, Rural Health Clinic (RHC), or Federally Qualified Health Center (FQHC). In these cases, the payment for the vaccine is based on reasonable cost.

Annual Part B deductible and coinsurance amounts do not apply. 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 following Medicare Part B payment allowances for HCPCS and CPT codes apply:
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<tr>
<td>CPT 90687*</td>
<td>$22.793</td>
<td>1/1/2018-7/31/2018</td>
</tr>
<tr>
<td>HCPCS Q2039**</td>
<td>** See Note below **</td>
<td>8/1/2017-7/31/2018</td>
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<tr>
<td>HCPCS Q2035</td>
<td>$17.685</td>
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<tr>
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* Until CPT code 90756 is implemented on 1/1/2018, Q2039 will be used for products described by the following language: influenza virus vaccine, quadrivalent (clLV4), derived from cell cultures, subunit, antibiotic free, 0.5mL dosage, for intramuscular use. The payment allowance for these products, effective for dates of service from 8/1/2017 to 12/31/2017, is $22.793.

** Providers and MACs will use HCPCS Q2039 for dates of service from 8/1/2017-12/31/2017. HCPCS Q2039 Flu Vaccine Adult – Not Otherwise Classified. The payment allowance will be determined by the local claims processing contractor with effective dates of 8/1/2017-7/31/2018.


Also, updates to payment limits and effective dates, when necessary, will be posted at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html.

Additional Information

If you have any questions, please contact a CGS Customer Service Representative by calling the CGS Provider Contact Center at 1.877.299.4500 and choose Option 1.

Educational Products for Health Care Professionals

The Medicare Learning Network® (MLN) has developed a variety of educational resources to help you understand Medicare guidelines for seasonal flu vaccines and their administration.

1. MLN Influenza Related Products for Health Care Professionals
2. Other CMS Resources


- **Prevention General Information** - [http://www.cms.gov/Medicare/Prevention/PreventionGenInfo/index.html](http://www.cms.gov/Medicare/Prevention/PreventionGenInfo/index.html)


3. Other Resources

The following non-CMS resources are just a few of the many available in you may find useful information and tools for the 2016 – 2017 flu season:

- **Advisory Committee on Immunization Practices** - [http://www.cdc.gov/vaccines/acip/index.html](http://www.cdc.gov/vaccines/acip/index.html)

  ▪ Other sites with helpful information include:

  - **Centers for Disease Control and Prevention** - [http://www.cdc.gov/flu](http://www.cdc.gov/flu)

  - **Flu.gov** - [http://www.flu.gov](http://www.flu.gov)

  - **Food and Drug Administration** - [http://www.fda.gov](http://www.fda.gov)

  - **Immunization Action Coalition** - [http://www.immunize.org](http://www.immunize.org)

  - **Indian Health Services** - [http://www.ihs.gov](http://www.ihs.gov)

  - **National Alliance for Hispanic Health** - [http://www.hispanichealth.org](http://www.hispanichealth.org)

  - **National Foundation For Infectious Diseases** - [http://www.nfid.org/influenza](http://www.nfid.org/influenza)


  - **National Vaccine Program** - [http://www.hhs.gov/nvpo](http://www.hhs.gov/nvpo)


  - **World Health Organization** - [http://www.who.int/en](http://www.who.int/en)

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**Document History**

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<td>September 21, 2017</td>
<td>Initial article released.</td>
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SE17028: Hurricane Maria and Medicare Disaster Related United States Virgin Islands and Commonwealth of Puerto Rico Claims

The Centers for Medicare & Medicaid Services (CMS) has issued the following Special Edition Medicare Learning Network® (MLN) Matters article. This MLN Matters article and other CMS articles can be found on the CMS website at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/

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MLN Matters® Number: SE17026  
Related CR Release Date: September 21, 2017  
Related CR Transmittal #: N/A  
Related Change Request (CR) #: N/A  
Effective Date: N/A  
Implementation Date: N/A

Provider Types Affected

This MLN Matters® Special Edition Article is intended for providers and suppliers who submit claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries in the United States Virgin Islands and the Commonwealth of Puerto Rico who were affected by Hurricane Maria.

Provider Information Available

On September 18, 2017, pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act, President Trump declared that, as a result of the effects of Hurricane Maria, an emergency exists in the United States Virgin Islands and the Commonwealth of Puerto Rico. Also on September 19, 2017, Secretary Price of the Department of Health & Human Services declared that a public health emergency exists in the United States Virgin Islands and the Commonwealth of Puerto Rico and authorized waivers and modifications under Section 1135 of the Social Security Act (the Act), retroactive to September 16, 2017, for the United States Virgin Islands and retroactive to September 17, 2017, for the Commonwealth of Puerto Rico.

On September 19, 2017, the Administrator of the Centers for Medicare & Medicaid Services (CMS) authorized waivers under Section 1812(f) of the Social Security Act for the United States Virgin Islands and the Commonwealth of Puerto Rico, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of Hurricane Maria in 2017.

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

The most current waiver information can be found at https://www.cms.gov/About-CMS/Agency-Information/Emergency/Hurricanes.html. See the Background section of this article for more details.
Background

Section 1135 and Section 1812(f) Waivers

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

1. Change Request (CR) 6451 (Transmittal 1784, Publication 100-04) issued on July 30, 2009, applies to items and services furnished to Medicare beneficiaries within the United States Virgin Islands from September 16, 2017, and the Commonwealth of Puerto Rico from September 17, 2017, for the duration of the emergency. In accordance with CR6451, use of the “DR” condition code and the “CR” modifier are mandatory on claims for items and services for which Medicare payment is conditioned on the presence of a “formal waiver” including, but not necessarily limited to, waivers granted under either Section 1135 or Section 1812(f) of the Act.

2. The most current information can be found at https://www.cms.gov/emergency. Medicare FFS Questions & Answers (Q&As) posted in the downloads section at the bottom of the Emergency Response and Recovery Web page and also referenced below are applicable for items and services furnished to Medicare beneficiaries within the United States Virgin Islands and the Commonwealth of Puerto Rico. These Q&As are displayed in two files:

   - One file addresses policies and procedures that are applicable without any Section 1135 or other formal waiver. These policies are always applicable in any kind of emergency or disaster, including the current emergency in the United States Virgin Islands and the Commonwealth of Puerto Rico.

   - Another file addresses policies and procedures that are applicable only with approved Section 1135 waivers or, when applicable, approved Section 1812(f) waivers. These Q&As are applicable for approved Section 1135 blanket waivers and approved individual 1135 waivers requested by providers and are effective September 16, 2017, for the United States Virgin Islands and September 17, 2017, for the Commonwealth of Puerto Rico.

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

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

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

Blanket Waivers Issued by CMS

Under the authority of Section 1135 (or, as noted below, Section 1812(f)), CMS has issued blanket waivers in the affected area of the United States Virgin Islands and Commonwealth of Puerto Rico. Individual facilities do not need to apply for the following approved blanket waivers:

Skilled Nursing Facilities

- Section 1812(f): Waiver of the requirement for a 3-day prior hospitalization for coverage of a skilled nursing facility (SNF) stay provides temporary emergency coverage of SNF services without a qualifying hospital stay, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of Hurricane Maria in the United States Virgin Islands and the Commonwealth of Puerto Rico in 2017. In addition,
for certain beneficiaries who recently exhausted their SNF benefits, it authorizes renewed SNF coverage without first having to start a new benefit period. (Blanket waiver for all impacted facilities)

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

**Home Health Agencies**

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

**Critical Access Hospitals**

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

**Housing Acute Care Patients In Excluded Distinct Part Units**

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

**Care for Excluded Inpatient Psychiatric Unit Patients in the Acute Care Unit of a Hospital**

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

**Care for Excluded Inpatient Rehabilitation Unit Patients in the Acute Care Unit of a Hospital**

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

**Emergency Durable Medical Equipment, Prosthetics, Orthotics, and Supplies for Medicare Beneficiaries Impacted by an Emergency or Disaster**

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


Appeal Administrative Relief for Areas Affected by Hurricane Maria

If you were affected by Hurricane Maria and are unable to file an appeal within 120 days from the date of receipt of the Remittance Advice (RA) that lists the initial determination or will have an extended period of non-receipt of remittance advices that will impact your ability to file an appeal, please contact your Medicare Administrative Contractor.

Replacement Prescription Fills

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

Requesting an 1135 Waiver

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

Additional Information

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For Home Health and Hospice Providers

Upcoming Educational Events

The CGS Provider Outreach and Education department offers educational events through webinars and teleconferences throughout the year. Registration for live events is required. For upcoming events, please refer to the Calendar of Events Home Health & Hospice Education Web page at https://www.cgsmedicare.com/hhh/education/Education.html. CGS suggests that you bookmark this page and visit it often for the latest educational opportunities.