FOR HOME HEALTH PROVIDERS

MM10303: 2018 Annual Update to the Therapy Code List... 3
MM10308: Annual Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement ... 5
MM10310: Home Health Prospective Payment System (HH PPS) Rate Update for Calendar Year (CY) 2018 ... 6
MM10341: Therapy Cap Values for Calendar Year (CY) 2018 ........................................................... 10
MM10374: Quarterly Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement ... 11

FOR HOME HEALTH AND HOSPICE PROVIDERS

CGS Website Updates .................................................. 12
Change in Frequency of CGS Listserv Notifications ... 14
Medicare Credit Balance Quarterly Reminder .............. 14
MLN Connects® Weekly News ..................................... 15
MM9893 (Rescinded): New Common Working File (CWF) Medicare Secondary Payer (MSP) Type for Liability Medicare Set-Aside Arrangements (LMSAs) and No-Fault Medicare Set-Aside Arrangements (NFMSAs) ..... 16
MM9911 (Revised): Qualified Medicare Beneficiary Indicator in the Medicare Fee-For-Service Claims Processing System .................................................. 16

MM10098 (Revised): Common Working File (CWF) to Modify CWF Provider Queries to Only Accept National Provider Identifier (NPI) as Valid Provider Number .......... 19
MM10124: Revision of PWK (Paperwork) Fax/Mail Cover Sheets ......................................................................................................................... 20
MM10230 (Revised): October 2017 Integrated Outpatient Code Editor (IOCE) Specifications Version 18.3 .......... 21
MM10268: Implement Operating Rules - Phase III Electronic Remittance Advice (ERA) Electronic Funds Transfer (EFT): CORE 360 Uniform Use of Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC), and Claim Adjustment Group Code (CAGC) Rule - Update from Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) .................................................. 23
MM10270: Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP), and PC Print Update .......... 24
MM10271: Claim Status Category Codes and Claim Status Codes Update .................................................. 26
New Medicare Card: New Web Page Information ............... 27
Provider Contact Center (PCC) Training ...................... 27
Quarterly Provider Update ........................................... 28
SE1128 (Revised): Prohibition on Billing Dually Eligible Individuals Enrolled in the Qualified Medicare Beneficiary (QMB) Program ........................................ 29
SE17019 (Reissued): Accepting Payment from Patients with a Medicare Set-Aside Arrangement ............... 33
SE17035 (Revised): Medicare Fee-for-Service (FFS) Response to the 2017 California Wildfires ............... 34
Stay Informed and Join the CGS Listserv Notification Service .................................................. 37
Upcoming Educational Events ........................................ 37
Unsolicited/Voluntary Refunds .................................... 38
Updated 2018 Amount in Controversy (AIC) for Administrative Law Judge Hearings or Federal District Court Appeals .................................................. 38

COMING IN 2018!

New Medicare cards with new numbers. Are you ready? #NewCardNewNumber

For Home Health Providers

**MM10303: 2018 Annual Update to the Therapy Code List**

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/index.html](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html)

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<th>Related Change Request (CR) Number: CR 10303</th>
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<tr>
<td>Related CR Release Date: November 16, 2017</td>
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</tr>
<tr>
<td>Related CR Transmittal Number: R3924CP</td>
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**Provider Types Affected**

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

**Provider Action Needed**

Change Request (CR) 10303 updates the list of codes that sometimes or always describe therapy services and their associated policies. The additions, changes, and deletions to the therapy code list reflect those made in the Calendar Year (CY) 2018 Healthcare Common Procedure Coding System and Current Procedural Terminology, Fourth Edition (HCPCS/CPT-4). The therapy code listing is available at [http://www.cms.gov/Medicare/Billing/TherapyServices/index.html](http://www.cms.gov/Medicare/Billing/TherapyServices/index.html). Make sure your billing staffs area aware of these updates.

**Background**

The Social Security Act (Section 1834(k)(5)), available at [https://www.ssa.gov/OP_Home/ssact/title18/1834.htm](https://www.ssa.gov/OP_Home/ssact/title18/1834.htm), requires that all claims for outpatient rehabilitation therapy services and all Comprehensive Outpatient Rehabilitation Facility (CORF) services be reported using a uniform coding system. The Calendar Year (CY) 2018 Healthcare Common Procedure Coding System and Current Procedural Terminology, Fourth Edition (HCPCS/CPT-4) is the coding system used for the reporting of these services.

The policies implemented in CR10303 were discussed in CY 2018 Medicare Physician Fee Schedule (MPFS) rulemaking. CR10303 updates the therapy code list and associated policies for CY 2018, as follows:
• The Current Procedural Terminology (CPT) Editorial Panel revised the set of codes physical and occupational therapists use to report orthotic and prosthetic management and training services by differentiating between initial and subsequent encounters through: (a) addition of the term “initial encounter” to the code descriptors for CPT codes 97760 and 97761, (b) creation of CPT code 97763 to describe all subsequent encounters for orthotics and/or prosthetics management and training services, and (c) deletion of CPT code 97762. The new long descriptors for CPT codes 97760 and 97761 – now intended only to be reported for the initial encounter with the patient – are:
  - CPT code 97760 (Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes)
  - CPT code 97761 (Prosthetic(s) training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes)
• The Centers for Medicare & Medicaid Services (CMS) will add CPT code 97763 to the therapy code list and CPT code 97762 will be deleted.
• The panel also created, for CY 2018, CPT code 97127 to replace/delete CPT code 97532. CMS will recognize HCPCS code G0515, instead of CPT code 97127, and add HCPCS code G0515 to the therapy code list. CPT code 97127 will be assigned a Medicare Physician Fee Schedule (MPFS) payment status indicator of “I” to indicate that it is “invalid” for Medicare purposes and that another code is used for reporting and payment for these services.
• Just as its predecessor code was, CPT code 97763 is designated as “always therapy” and must always be reported with the appropriate therapy modifier, GN, GO or GP, to indicate whether it’s under a Speech-language pathology (SLP), Occupational Therapy (OT) or Physical Therapy (PT) plan of care, respectively.
• HCPCS code G0515 is designated as a “sometimes therapy” code, which means that an appropriate therapy modifier – GN, GO or GP, to reflect it’s under an SLP, OT, or PT plan of care – is always required when this service is furnished by therapists; and, when it’s furnished by or incident to physicians and certain Nonphysician Practitioners (NPPs), that is, nurse practitioners, physician assistants, and clinical nurse specialists when the services are integral to an SLP, OT, or PT plan of care. Accordingly, HCPCS code G0515 is sometimes appropriately reported by physicians, NPPs, and psychologists without a therapy modifier when it is appropriately furnished outside an SLP, OT, or PT plan of care. When furnished by psychologists, the services of HCPCS code G0515 are never considered therapy services and may not be reported with a GN, GO, or GP therapy modifier.
• The therapy code list is updated with one new “always therapy” code and one new “sometimes therapy” code, using their HCPCS/CPT long descriptors, as follows:
  - CPT code 97763 – This “always therapy” code replaces/deletes CPT code 97762.
  - CPT code 97763: Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes
  - HCPCS code G0515 – This “sometimes therapy” code replaces/deletes CPT code 97532.
  - HCPCS code G0515: Development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct (one-on-one) patient contact, each 15 minutes
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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For Home Health Providers

MM10308: Annual Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement

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/index.html

MLN Matters Number: MM10308  Related Change Request (CR) Number: CR 10308
Related CR Release Date: October 6, 2017  Effective Date: January 1, 2018
Related CR Transmittal Number: R3877CP  Implementation Date: January 2, 2018

Provider Types Affected
This MLN Matters® Article is intended for Home Health Agencies (HHAs) and other providers submitting claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries in a home health period of coverage.

Provider Action Needed
Change Request (CR) 10308 provides the 2018 annual update to the list of Healthcare Common Procedure Coding System (HCPCS) codes used by Medicare systems to enforce consolidated billing of home health services. Make sure your billing staffs are aware of these updates.

Background
The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of HCPCS codes that are subject to the consolidated billing provision of the Home Health Prospective Payment System (HH PPS). With the exception of therapies performed by physicians, supplies incidental to physician services and supplies used in institutional settings, services appearing on this list that are submitted on claims to MACs will not be paid separately on dates when a beneficiary for whom such a service is being billed is in a home health episode (that is, under a home health plan of care administered by an HHA).

In such cases, Medicare will only directly reimburse the primary HHAs that have opened such episodes during the episode periods. Therapies performed by physicians, supplies incidental to physician services, and supplies used in institutional settings are not subject to HH consolidated billing.

The HH consolidated billing code lists are updated annually to reflect the yearly changes to the HCPCS code set itself. Additional updates may occur as frequently as quarterly in order
to reflect the creation of temporary HCPCS codes (for example, “K” codes) throughout the calendar year. The new coding identified in each update describes the same services that were used to determine the applicable HH PPS payment rates. No additional services will be added by these updates. That is, new updates are required by changes to the coding system, not because the services subject to HH consolidated billing are being redefined.

Section 1842(b)(6) of the Social Security Act requires that payment for HH services provided under a HH plan of care is made to the HHA. This requirement is in Medicare regulations at 42 CFR 409.100 and in Medicare instructions in Chapter 10, Section 20 of the Medicare Claims Processing Manual.

The recurring updates in CR10308 provide annual HH consolidated billing updates effective January 1, 2018. The following HCPCS codes are added to the HH consolidated billing therapy code list:

- 97763 – Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minute
  - This code replaces 97762.
- G0515 – Development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct (one-on-one) patient contact, each 15 minute
  - This code replaces 97532.

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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**For Home Health Providers**

**MM10310: Home Health Prospective Payment System (HH PPS) Rate Update for Calendar Year (CY) 2018**

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/index.html](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html)

**MLN Matters Number:** MM10310
**Related Change Request (CR) Number:** CR 10310
**Related CR Release Date:** October 20, 2017
**Effective Date:** January 1, 2018
**Related CR Transmittal Number:** R3888CP
**Implementation Date:** January 2, 2018

**Provider Type Affected**

This MLN Matters Article is intended for Home Health Agencies (HHAs) billing Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.
What You Need To Know

Change Request (CR) 10310 updates the 60-day national episode rates, the national per-visit amounts, Low Utilization Payment Adjustment (LUPA) add-on amounts, the non-routine medical supply payment amounts, and the cost-per-unit payment amounts used for calculating outlier payments under the HH PPS for Calendar Year (CY) 2018. Be sure your billing staffs are aware of these changes.

Background

The CY 2018 HH PPS rate update includes the third year of a 3-year phase-in of a reduction to the national, standardized 60-day episode payment amount to account for estimated case-mix growth unrelated to increases in patient acuity (that is, nominal case-mix growth) between CY 2012 and CY 2014. The nominal case-mix growth reduction is 0.97 percent. The changes described in MM10310 are implemented through the Home Health Pricer software used by Medicare contractor standard systems.

Market Basket Update

Section 411(d) of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) amended Section 1895(b)(3)(B) of the Social Security Act (the Act) such that, for home health payments for CY 2018, the market basket percentage increase shall be 1 percent. Section 1895(b)(3)(B) of the Act requires that the home health payment update be decreased by 2 percentage points for those HHAs that do not submit quality data as required by the Secretary of the Department of Health & Human Services (HHS). For HHAs that do not submit the required quality data for CY 2018, the home health payment update would be -1 percent (1 percent minus 2 percentage points).

National, Standardized 60-Day Episode Payment

As described in the CY 2018 HH PPS final rule, in order to calculate the CY 2018 national, standardized 60-day episode payment rate, the Centers for Medicare & Medicaid Services (CMS) applies a wage index budget neutrality factor of 1.0004 and a case-mix budget neutrality factor of 1.0160 to the previous calendar year’s national, standardized 60-day episode rate. To account for nominal case-mix growth from CY 2012 to CY 2014, CMS applies a payment reduction of 0.97 percent to the national, standardized 60-day episode payment rate. Lastly, the national, standardized 60-day episode payment rate is updated by the CY 2018 HH payment update percentage of 1 percent for HHAs that submit the required quality data and by 1 percent minus 2 percentage points, or -1 percent, for HHAs that do not submit quality data. These two-episode payment rates are shown in Tables 1 and 2. These payments are further adjusted by the individual episode’s case-mix weight and by the wage index.

Table 1: For HHAs that DO Submit Quality Data – National, Standardized 60-Day Episode Amount for CY 2018

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>$2,989.97</td>
<td>X 1.0004</td>
<td>X 1.0160</td>
<td>X 0.9903</td>
<td>X 1.01</td>
<td>$3,039.64</td>
</tr>
</tbody>
</table>

Table 2: For HHAs that DO NOT Submit Quality Data – National, Standardized 60-Day Episode Amount for CY 2018

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>$2,989.97</td>
<td>X 1.0004</td>
<td>X 1.0160</td>
<td>X 0.9903</td>
<td>X 0.99</td>
<td>$2,979.45</td>
</tr>
</tbody>
</table>
**National Per-Visit Rates**

To calculate the CY 2018 national per-visit payment rates, CMS starts with the CY 2017 national per-visit rates. CMS applies a wage index budget neutrality factor of 1.0010 to ensure budget neutrality for LUPA per-visit payments after applying the CY 2018 wage index. The per-visit rates are then updated by the CY 2018 HH payment update of 1 percent for HHAs that submit the required quality data and by -1 percent for HHAs that do not submit quality data. The per-visit rates are shown in Tables 3 and 4.

<table>
<thead>
<tr>
<th>HH Discipline Type</th>
<th>CY 2017 Per-Visit Payment</th>
<th>Wage Index Budget Neutrality Factor</th>
<th>CY 2018 HH Payment Update</th>
<th>CY 2018 Per-Visit Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Aide</td>
<td>$64.23</td>
<td>X 1.0010</td>
<td>X 1.01</td>
<td>$64.94</td>
</tr>
<tr>
<td>Medical Social Services</td>
<td>$227.36</td>
<td>X 1.0010</td>
<td>X 1.01</td>
<td>$229.86</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>$156.11</td>
<td>X 1.0010</td>
<td>X 1.01</td>
<td>$157.83</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>$155.05</td>
<td>X 1.0010</td>
<td>X 1.01</td>
<td>$156.76</td>
</tr>
<tr>
<td>Skilled Nursing</td>
<td>$141.84</td>
<td>X 1.0010</td>
<td>X 1.01</td>
<td>$143.40</td>
</tr>
<tr>
<td>Speech-Language Pathology</td>
<td>$168.52</td>
<td>X 1.0010</td>
<td>X 1.01</td>
<td>$170.38</td>
</tr>
</tbody>
</table>

**Non-Routine Supply Payments**

Payments for Non-Routine Supplies (NRS) are computed by multiplying the relative weight for a particular NRS severity level by an NRS conversion factor. To determine the CY 2018 NRS conversion factors, CMS updates the CY 2017 NRS conversion factor by the CY 2018 HH payment update of 1 percent for HHAs that submit the required quality data and by -1 percent for HHAs that do not submit quality data. CMS does not apply any standardization factors as the NRS payment amount calculated from the conversion factor is neither wage nor case-mix adjusted when the final payment amount is computed. The NRS conversion factor for CY 2018 payments for HHAs that do submit the required quality data is shown in Table 5a and the payment amounts for the various NRS severity levels are shown in Table 5b. The NRS conversion factor for CY 2018 payments for HHAs that do not submit quality data is shown in Table 6a and the payment amounts for the various NRS severity levels are shown in Table 6b.

<table>
<thead>
<tr>
<th>CY 2017 NRS Conversion Factor</th>
<th>CY 2018 HH Payment Update</th>
<th>CY 2018 NRS Conversion Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>$52.50</td>
<td>X 1.01</td>
<td>$53.03</td>
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</table>
### Table 5b: CY 2018 Relative Weights and Payment Amounts for the 6-Severity NRS System for HHAs that DO Submit Quality Data

<table>
<thead>
<tr>
<th>Severity Level</th>
<th>Points (Scoring)</th>
<th>Relative Weight</th>
<th>CY 2018 NRS Payment Amounts</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>0.2698</td>
<td>$14.31</td>
</tr>
<tr>
<td>2</td>
<td>1 to 14</td>
<td>0.9742</td>
<td>$51.66</td>
</tr>
<tr>
<td>3</td>
<td>15 to 27</td>
<td>2.6712</td>
<td>$141.65</td>
</tr>
<tr>
<td>4</td>
<td>28 to 48</td>
<td>3.9686</td>
<td>$210.45</td>
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<tr>
<td>5</td>
<td>49 to 98</td>
<td>6.1198</td>
<td>$324.53</td>
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<td>6</td>
<td>99+</td>
<td>10.5254</td>
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### Table 6a: CY 2018 NRS Conversion Factor for HHAs that DO NOT Submit the Required Quality Data

<table>
<thead>
<tr>
<th>CY 2017 NRS Conversion Factor</th>
<th>CY 2018 HH Payment Update Percentage Minus 2 Percentage Points</th>
<th>CY 2018 NRS Conversion Factor</th>
</tr>
</thead>
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<tr>
<td>$52.50</td>
<td>X 0.99</td>
<td>$51.98</td>
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### Table 6b: CY 2018 Relative Weights and Payment Amounts for the 6-Severity NRS System for HHAs that DO NOT Submit Quality Data

<table>
<thead>
<tr>
<th>Severity Level</th>
<th>Points (Scoring)</th>
<th>Relative Weight</th>
<th>CY 2018 NRS Payment Amounts</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>0.2698</td>
<td>$14.02</td>
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<tr>
<td>2</td>
<td>1 to 14</td>
<td>0.9742</td>
<td>$50.64</td>
</tr>
<tr>
<td>3</td>
<td>15 to 27</td>
<td>2.6712</td>
<td>$138.85</td>
</tr>
<tr>
<td>4</td>
<td>28 to 48</td>
<td>3.9686</td>
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<tr>
<td>5</td>
<td>49 to 98</td>
<td>6.1198</td>
<td>$318.11</td>
</tr>
<tr>
<td>6</td>
<td>99+</td>
<td>10.5254</td>
<td>$547.11</td>
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</table>

### Sunset of the Rural Add-On Provision

Section 210 of MACRA extended the rural add-on of a 3-percent increase in the payment amount for HH services provided in a rural area for episodes and visits ending before January 1, 2018. Therefore, for episodes and visits that end on or after January 1, 2018, a rural add-on payment will not apply.

### Methodology for Calculating Outlier Payments

In the CY 2017 HH PPS final rule (81 FR 76702), CMS finalized changes to the methodology used to calculate outlier payments, using a cost-per-unit approach rather than a cost-per-visit approach. This change in methodology allows for more accurate payment for outlier episodes, accounting for both the number of visits during an episode of care and also the length of the visits provided. Using this approach, CMS now converts the national per-visit rates into per 15-minute unit rates. These per 15-minute unit rates are used to calculate the estimated cost of an episode to determine whether the claim will receive an outlier payment and the amount of payment for an episode of care. The cost-per-unit payment rates used for the calculation of outlier payments are shown in Tables 7a and 7b. The Fixed Dollar Loss (FDL) ratio remains 0.55 and the loss-sharing ratio remains 0.80.

### Table 7a - Cost-Per-Unit Rates for Calculating Outlier Payments for HHAs that DO Submit Required Quality Data

<table>
<thead>
<tr>
<th>HH Discipline</th>
<th>Average Minutes per Visit</th>
<th>CY2018 Per-Visit Payment</th>
<th>Cost per Unit (1 unit = 15 minutes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Aide</td>
<td>63.0</td>
<td>$64.94</td>
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<td>Medical Social Services</td>
<td>56.5</td>
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<td>47.1</td>
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<td>Physical Therapy</td>
<td>46.6</td>
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<td>$50.46</td>
</tr>
<tr>
<td>Skilled Nursing</td>
<td>44.8</td>
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<td>$48.01</td>
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<tr>
<td>Speech-Language Pathology</td>
<td>48.1</td>
<td>$170.38</td>
<td>$53.13</td>
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</table>
Table 7b - Cost-Per-Unit Rates for Calculating Outlier Payments for HHAs that DO NOT Submit Required Quality Data

<table>
<thead>
<tr>
<th>HH Discipline</th>
<th>Average Minutes per Visit</th>
<th>CY2018 Per-Visit Payment</th>
<th>Cost per Unit (1 unit = 15 minutes)</th>
</tr>
</thead>
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<tr>
<td>Home Health Aide</td>
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<td>$63.65</td>
<td>$15.15</td>
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<td>Medical Social Services</td>
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<td>$59.82</td>
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<td>47.1</td>
<td>$154.70</td>
<td>$49.27</td>
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<tr>
<td>Physical Therapy</td>
<td>46.6</td>
<td>$153.65</td>
<td>$49.46</td>
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<tr>
<td>Skilled Nursing</td>
<td>44.8</td>
<td>$140.56</td>
<td>$47.06</td>
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<td>Speech-Language Pathology</td>
<td>48.1</td>
<td>$167.00</td>
<td>$52.08</td>
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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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For Home Health Providers

**MM10341: Therapy Cap Values for Calendar Year (CY) 2018**

The Centers for Medicare & Medicaid Services (CMS) has issued the following Medicare LearningNetwork® (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/index.html

**MLN Matters Number:** MM10341  
**Related Change Request (CR) Number:** CR 10341  
**Related CR Release Date:** November 9, 2017  
**Effective Date:** January 1, 2018  
**Related CR Transmittal Number:** R3918CP  
**Implementation Date:** January 2, 2018

**Provider Types Affected**

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

**Provider Action Needed**

Change Request (CR) 10341 provides the amounts for outpatient therapy caps for Calendar Year (CY) 2018. For physical therapy and speech-language pathology combined, the CY 2018 cap is $2,010. For occupational therapy, the CY 2018 cap is $2,010. Make sure that your billing staffs are aware of these therapy cap value updates.

**Background**

The Balanced Budget Act of 1997, P.L. 105-33, Section 4541(c) applies, per beneficiary, annual financial limitations on expenses considered incurred for outpatient therapy services.
under Medicare Part B, commonly referred to as “therapy caps.” The therapy caps are updated each year based on the Medicare Economic Index.

Section 5107 of the Deficit Reduction Act of 2005 required an exceptions process to the therapy caps for reasonable and medically necessary services. The exceptions process for the therapy caps has been continuously extended several times through subsequent legislation. Most recently, Section 202 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) extended the therapy caps exceptions process through December 31, 2017.

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 of Change</th>
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<tr>
<td>November 13, 2017</td>
<td>Initial article released.</td>
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</table>

For Home Health Providers

**MM10374: Quarterly Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement**

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/index.html

**MLN Matters Number:** MM10374  
**Related CR Release Date:** November 17, 2017  
**Related CR Transmittal Number:** R3923CP  
**Related Change Request (CR) Number:** CR 10374  
**Effective Date:** April 1, 2018  
**Implementation Date:** April 2, 2018

**Provider Types Affected**
This MLN Matters Article is intended for Home Health Agencies (HHAs) and other providers submitting claims to Medicare Administrative Contractors (MACs) for home health services provided to Medicare beneficiaries

**Provider Action Needed**
This article is based on Change Request (CR) 10374, which provides the quarterly update of HCPCS codes used for HH consolidated billing effective April 1, 2018. Make sure that your billing staffs are aware of these changes.

**Background**
Section 1842(b)(6) of the Social Security Act requires that payment for home health services provided under a home health plan of care is made to the home health agency. This requirement is in Medicare regulations at 42 CFR 409.100 (https://www.ecfr.gov/cgi-bin/text-idx?SID=dade79f01c67f93604262bb8e8a95e7e&mc=true&node=pt42.2.409&rgn=div5#se42.2.409_1100) and in Medicare instructions provided in Chapter 10, Section 20 of the Medicare Claims Processing Manual.
The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of HCPCS codes that are subject to the consolidated billing provision of the Home Health Prospective Payment System (HH PPS). With the exception of therapies performed by physicians, supplies incidental to physician services and supplies used in institutional settings, services appearing on this list that are submitted on claims to your MAC will not be paid separately on dates when a beneficiary for whom such a service is being billed is in a home health episode (that is, under a home health plan of care administered by an HHA).

Medicare will only directly reimburse the primary HHAs that have opened such episodes during the episode periods. Therapies performed by physicians, supplies incidental to physician services, and supplies used in institutional settings are not subject to HH consolidated billing.

The HH consolidated billing code lists are updated annually to reflect changes to the HCPCS code set itself. Additional updates may occur as frequently as quarterly in order to reflect the creation of temporary HCPCS codes (for example, ‘K’ codes) throughout the calendar year. The new coding identified in each update describes the same services that were used to determine the applicable HH PPS payment rates. No additional services will be added by these updates; that is, new updates are required by changes to the coding system, not because the services subject to HH consolidated billing are being redefined.

Effective April 1, 2018, the following HCPCS code is added to the HH consolidated billing non-routine supply code list as a result of CR10374:

- A4575 Topical hyperbaric oxygen chamber, disposable (Hyperbaric o2 chamber disps)

No HCPCS codes are added to the HH consolidated billing therapy code list in this update.

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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For Home Health & 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 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 November CSE data
- The 2018 Customer Service Holiday/Training Schedule has been added to the Home Health & Hospice Customer Service Phone/Fax Web page at https://www.cgsmedicare.com/hhh/cs/cs_phone_fax.html. The Calendar icon on the Home Health & Hospice Contact Information Web page at https://www.cgsmedicare.com/hhh/cs/
index.html has been updated to direct you to the 2018 Customer Service Holiday/Training Schedule.

- The links to subscribe to the MLN Matters and MLN Educational Products electronic mailing lists were updated on the Centers for Medicare & Medicaid Services (CMS) Educational Resources Web page at https://www.cgsmedicare.com/hhh/education/CMS_Resources.html.

- The Instructions for completing the Pro-Forma for Provider Self-Determination of Aggregate Cap Limitation Web page at https://www.cgsmedicare.com/hhh/financial/instructions.html was updated by adding a service periods table for summary PS&R reports.

- The Resources for the Most Common Home Health and Hospice Medicare Questions Web page at https://www.cgsmedicare.com/hhh/education/materials/resources_most_common_hhh_questions.html was updated to revise the name of the files used to access home health and hospice telephone number and address information for assistance in resolving overlapping claim issues.

- The Billing Negative Pressure Wound Therapy (NPWT) Web page at https://www.cgsmedicare.com/hhh/education/materials/3118.html was updated to include the entry of “NPWT” in the REMARKS field. This entry is necessary to keep the 34X type of bill denying as a duplicate against the 329 type of bill.

- The Reopenings Web page at https://www.cgsmedicare.com/hhh/appeals/Reopenings.html was updated with additional instructions about including information in the REMARKS field when using Condition Code D9.

- The Medicare Secondary Payer (MSP) Overview Web page at https://www.cgsmedicare.com/hhh/education/materials/msp.html was updated to add a link to the CMS Medicare Secondary Payer Web page under the “MSP Resources from CMS” heading.

- The Medical Review Activity Log Web page at https://www.cgsmedicare.com/hhh/medreview/activitylog.html was updated to add 2 new hospice edits and 1 new edit for home health claims for targeted probe and education prepayment review.

- The Home Health Coverage Guidelines Web page at https://www.cgsmedicare.com/hhh/coverage/Home_Health_Coverage_Guidelines.html was updated to add a link to a new Web page, Incorporating Home Health Agency Documentation into the Physician’s Medical Record: Supporting Eligibility with Home Health Agency Clinician Notes.

- The Hospice Prescription Drug Reporting Table quick resource tool at https://www.cgsmedicare.com/hhh/education/materials/pdf/hospice_presdrugreportingtable.pdf was updated to add a link to the 2018 Table of Drugs document on the CMS website.

- Various website links on page 9 of the Hospice References quick resource tool at https://www.cgsmedicare.com/hhh/education/materials/pdf/hospice_tools.pdf were updated.

- The Hospice Medicare Billing Codes Sheet quick resource tool at https://www.cgsmedicare.com/hhh/education/materials/pdf/hospice_medicare_billing_codes_sheet.pdf was updated to include the D0 condition code and 56 occurrence codes used to correct notice of election (NOE) or notice of termination/revocation (NOTR) dates.

- The Claims Processing Issues Log Web page at https://www.cgsmedicare.com/hhh/claims/fiss_claims_processing_issues.html has been updated.
For Home Health & Hospice Providers

Change in Frequency of CGS Listserv Notifications

According to the most recent Medicare Satisfaction Indicator (MSI) Survey, feedback indicated a desire to reduce the amount of listserv notifications sent by CGS. We listened and effective immediately, CGS will share important information with you by sending listserv messages on Tuesdays and Thursdays. If necessary, urgent information will be sent on other days of the week.

As a Medicare provider, it is important that you stay informed of important Medicare news and ensure that your appropriate staff receives listserv notifications. To subscribe, go to the CGS ListServ Notification Service Web page at https://www.cgsmedicare.com/medicare_dynamic/ls/001.asp to sign up now.

For Home Health & Hospice Providers

Medicare Credit Balance Quarterly Reminder

This article is a reminder to submit the Quarterly Medicare Credit Balance Report. The next report is due in our office postmarked by January 30, 2018, for the quarter ending December 31, 2017. A Medicare credit balance is an amount determined to be refundable to the Medicare program for an improper or excess payment made to a provider because of patient billing or claims processing errors.


NOTE: Please do not submit duplicate Credit Balance Reports. To ensure CGS has received your report, consider using the website portal myCGS to submit your report. myCGS provides instant confirmation of receipt and allows you to check the status. Submitting your CBR using certified mail, or other methods that require a signature upon delivery is also an option.

The report must be postmarked by the date indicated above. If the report is received with a postmark date later than the date indicated above, we are required to withhold 100 percent of all payments being sent to your facility. This withholding will remain in effect until the reporting requirements are met. If no credit balance exists for your facility during a quarter, a signed Medicare Credit Balance Report certification is still required. Please include your Medicare provider number on the certification form.

Refer to the Medicare Credit Balance Report (CMS-838) form for complete instructions. However, for additional assistance in completing the form, refer to the “Tips on Completing a Credit Balance Report (Form CMS-838)” web page at https://www.cgsmedicare.com/hhh/financial/838_form_tips.html on the CGS website.

To ensure timely receipt and processing, send the CMS-838/Certification within 30 days of the quarter end date using one of the options below. Do not submit duplicate Credit Balance Reports.

<table>
<thead>
<tr>
<th>myCGS, secure Web Portal (preferred method):</th>
<th>myCGS provides instant confirmation of receipt. For details, refer to:</th>
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</table>
Please note that if you have or will be submitting an adjustment, please send the UB-04 along with the CMS-838 form.

If you are issuing a refund check for a credit balance:

- Send the CMS-838 and a copy of the refund check using one of the options listed above.
- Send the refund check with a copy of the CMS-838 or documentation that indicates the check is for a credit balance, the quarter end date, and provider number associated with the check to the following address:
  
  CGS - J15 Home Health and Hospice  
  PO Box 957124  
  St. Louis, MO 63195-7124

If you have general questions related to the Credit Balance report, refer to the CGS Credit Balance Report (Form CMS-838) website at http://www.cgsmedicare.com/hhh/financial/CMS-588.html or call the Provider Contact Center at 1.877.299.4500 (Option 1). If you have questions about withholding, call 1.877.299.4500 and select Option 4.

For Home Health & 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.

**For Home Health & Hospice Providers**

**MM9893 (Rescinded):** New Common Working File (CWF) Medicare Secondary Payer (MSP) Type for Liability Medicare Set-Aside Arrangements (LMSAs) and No-Fault Medicare Set-Aside Arrangements (NFMSAs)

The Centers for Medicare & Medicaid Services (CMS) has rescinded 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/index.html

**MLN Matters Number:** MM9893 Rescinded **Related Change Request (CR) Number:** CR 9893

**Related CR Release Date:** N/A **Effective Date:** October 1, 2017

**Related CR Transmittal Number:** N/A **Implementation Date:** October 2, 2017

This article was rescinded.

**For Home Health & Hospice Providers**

**MM9911 (Revised):** Qualified Medicare Beneficiary Indicator in the Medicare Fee-For-Service Claims Processing System

The Centers for Medicare & Medicaid Services (CMS) has revised 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/index.html

**MLN Matters Number:** MM9911 Revised **Effective Date:** for claims processed on or after October 2, 2017

**Related CR Release Date:** November 15, 2017 **Implementation Date:** October 2, 2017

**Related CR Transmittal Number:** R3920CP **Related Change Request (CR) Number:** CR 9911

**Note:** The article was revised on November 16, 2017, to reflect a revised CR9911 issued on November 15, 2017. In the article, the CR release date, transmittal number, and the Web address of CR9911 are revised. All other information remains the same.

**Provider Types Affected**

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

**Provider Action Needed**

Change Request (CR) 9911 modifies the Medicare claims processing systems to help providers more readily identify the Qualified Medicare Beneficiary (QMB) status of each patient and to support providers’ ability to follow QMB billing requirements. Beneficiaries enrolled in the QMB program are not liable to pay Medicare cost-sharing for all Medicare A/B claims. CR 9911 adds an indicator of QMB status to Medicare’s claims processing systems. This system enhancement will trigger notifications to providers (through the Provider Remittance Advice) and to beneficiaries (through the Medicare Summary Notice) to reflect
that the beneficiary is enrolled in the QMB program and has no Medicare cost-sharing liability. Make sure that your billing staffs are aware of these changes.

Background

QMB is a Medicaid program that assists low-income beneficiaries with Medicare premiums and cost-sharing. In 2015, 7.2 million persons (more than one out of every ten Medicare beneficiaries) were enrolled in the QMB program.

Federal law bars Medicare providers from billing a QMB individual for Medicare Part A and B deductibles, coinsurance, or copayments, under any circumstances. Sections 1902(n)(3)(B); 1902(n)(3)(C); 1905(p)(3); 1866(a)(1)(A); 1848(g)(3)(A) of the Social Security Act. State Medicaid programs may pay providers for Medicare deductibles, coinsurance, and copayments. However, as permitted by Federal law, states can limit provider payment for Medicare cost-sharing, under certain circumstances. Regardless, QMB individuals have no legal liability to pay Medicare providers for Medicare Part A or Part B cost-sharing. Providers may seek reimbursement for unpaid Medicare deductible and coinsurance amounts as a Medicare bad debt related to dual eligible beneficiaries under CMS Pub. 15-1, Chapter 3 of the “Provider Reimbursement Manual (PRM)”.

CR 9911 aims to support Medicare providers’ ability to meet these requirements by modifying the Medicare claims processing system to clearly identify the QMB status of all Medicare patients. Currently, neither the Medicare eligibility systems (the HIPAA Eligibility Transaction System (HETS)), nor the claims processing systems (the FFS Shared Systems), notify providers about their patient’s QMB status and lack of Medicare cost-sharing liability. Similarly, Medicare Summary Notices (MSNs) do not inform those enrolled in the QMB program that they do not owe Medicare cost-sharing for covered medical items and services.

CR 9911 includes modifications to the FFS claims processing systems and the “Medicare Claims Processing Manual” to generate notifications to Medicare providers and beneficiaries regarding beneficiary QMB status and lack of liability for cost-sharing.

With the implementation of CR 9911, Medicare’s Common Working File (CWF) will obtain QMB indicators so the claims processing systems will have access to this information.

- CWF will provide the claims processing systems the QMB indicators if the dates of service coincide with a QMB coverage period (one of the occurrences) for the following claim types: Part B professional claims; Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) claims; and outpatient institutional Types of Bill (TOB) 012x, 013x, 014x, 022x, 023x, 034x, 071x, 072x, 074x, 075x, 076x, 077x, and 085x; home health claims (TOB 032x) only if the revenue code for the line item is 0274, 029x, or 060x; and Skilled Nursing Facility (SNF) claims (based on occurrence code 50 date for revenue code 0022 lines on TOBs 018x and 021x).
- CWF will provide the claims processing systems the QMB indicator if the “through date” falls within a QMB coverage period (one of the occurrences) for inpatient hospital claims (TOB 011x) and religious non-medical health care institution claims (TOB 041x).

The QMB indicators will initiate new messages on the Remittance Advice that reflect the beneficiary’s QMB status and lack of liability for Medicare cost-sharing with three new Remittance Advice Remark Codes (RARC) that are specific to those enrolled in QMB. As appropriate, one or more of the following new codes will be returned:

- N781 – No deductible may be collected as patient is a Medicaid/Qualified Medicare Beneficiary. Review your records for any wrongfully collected coinsurance, deductible or co-payments.
• N782 – No coinsurance may be collected as patient is a Medicaid/Qualified Medicare Beneficiary. Review your records for any wrongfully collected coinsurance, deductible or co-payments.
• N783 – No co-payment may be collected as patient is a Medicaid/Qualified Medicare Beneficiary. Review your records for any wrongfully collected coinsurance, deductible or co-payments.

In addition, the MACs will include a Claim Adjustment Reason Code of 209 (“Per regulatory or other agreement. The provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to patient if collected. (Use only with Group code OA (Other Adjustment)).

Finally, CR 9911 will modify the MSN to inform beneficiaries if they are enrolled in QMB and cannot be billed for Medicare cost-sharing for covered items and services.

Additional Information

For more information regarding billing rules applicable to individuals enrolled in the QMB Program, see the MLN Matters Article, SE1128, at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se1128.pdf.

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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<thead>
<tr>
<th>Date of Change</th>
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<tr>
<td>November 16, 2017</td>
<td>The article was revised to reflect a revised CR9911 issued on November 15, 2017. In the article, the CR release date, transmittal number, and the Web address of CR9911 are revised. All other information remains the same.</td>
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<tr>
<td>July 24, 2017</td>
<td>The article was revised to add links to related MLN Matters Articles. SE1128 (<a href="https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se1128.pdf">https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se1128.pdf</a>) reminds all Medicare providers that they may not bill beneficiaries enrolled in the QMB program for Medicare cost-sharing. MM9817 (<a href="https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM9817.pdf">https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM9817.pdf</a>) states that CR 9817 instructs MACs to issue a compliance letter instructing named providers and suppliers to refund any erroneous charges and recall any past or existing billing with regard to improper QMB billing</td>
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<tr>
<td>June 29, 2017</td>
<td>The article was revised to reflect a revised CR9911 issued on June 28, 2017. In the article, the CR release date, transmittal number, and the Web address of CR9911 are revised. Clarifications were also made to the second paragraph of the Background section.</td>
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<tr>
<td>May 1, 2017</td>
<td>The article was revised to reflect a revised CR9911 issued on April 28, 2017. In the article, the CR release date, transmittal number, and the Web address of CR9911 are revised.</td>
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<tr>
<td>February 3, 2017</td>
<td>Initial article released</td>
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</table>
For Home Health & Hospice Providers

MM10098 (Revised): Common Working File (CWF) to Modify CWF Provider Queries to Only Accept National Provider Identifier (NPI) as Valid Provider Number

The Centers for Medicare & Medicaid Services (CMS) has revised 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/index.html

MLN Matters Number: MM10098 Revised Related Change Request (CR) Number: CR 10098
Related CR Release Date: November 9, 2017 Effective Date: January 1, 2018
Related CR Transmittal Number: R1976OTN Implementation Date: January 2, 2018

Note: This article was revised on November 13, 2017, to reflect a revised CR10098 issued on November 9. In the article, the CR release date, transmittal number, and Web address of CR are revised. All other information remains the same.

Provider Types Affected

This MLN Matters® Article is intended for physicians, providers, and suppliers querying Medicare's Common Working File (CWF) for checking eligibility and entitlement status for Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 10098, which informs the MACs about modifications to the CWF Provider Queries, ELGA, ELGH, HIQA, HIQH, and HUQA, to only accept the National Provider Identifier (NPI) as a valid Provider Number. Make sure that your billing staffs are aware of these changes.

Background

Providers, clearinghouses, and/or third-party vendors, herein referred to as “Trading Partners,” verify an individual’s Medicare eligibility and entitlement status prior to and/or while the individual is receiving services before billing Medicare for services rendered to Medicare beneficiaries using HIPAA Eligibility Transaction System (HETS) and/or CWF.

Within CWF, Trading Partners use CWF Provider Queries, ELGA, ELGH, HIQA, HIQH, and HUQA. Currently, Trading Partners are allowed to use either legacy Provider Numbers (CMS Certification Number (CCN) or Unique Physician Identification Number (UPIN)) or NPI on CWF Provider Queries.

The Centers for Medicare & Medicaid Services (CMS) is requiring CWF to modify CWF Provider Queries to only accept NPI as a valid Provider Number.

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 & Hospice Providers

MM10124: Revision of PWK (Paperwork)
Fax/Mail Cover Sheets

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/index.html

Provider Types Affected
This MLN Matters® Article is intended for all physicians, providers, and suppliers who submit claims to Medicare Administrative Contractors (MACs), including Durable Medical Equipment (DME) MACs, and Home Health and Hospices (HH+H) MACs, for services provided to Medicare beneficiaries.

Provider Action Needed
Change Request (CR) 10124 alerts providers that their MAC will provide revised fax/mail cover sheets via hardcopy and/or electronic download. These revised documents are attached to CR10124. There are three paperwork (PWK) attachments to CR10124: (1) Medicare Part A Fax/Mail Cover Sheet (2) Medicare Part B Fax/Mail Cover Sheet and (3) Medicare DME MAC Fax/Mail Cover Sheet.

Background
CR10124 revises the three PWK Fax/Mail Cover Sheets to remove Health Insurance Claim Number (HICN) from the forms and replace it with Medicare ID. HICN is being removed from the forms as part of the Medicare Access and CHIP Re-authorization Act (MACRA) of 2015, which requires removal of the Social Security Number-based HICN from Medicare cards within 4 years of enactment. These Fax/Mail Cover sheets are used so that providers are able to continue to submit electronic claims, which require additional documentation.

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>July 28, 2017</td>
<td>Initial article released</td>
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</table>
MM10230 (Revised): October 2017 Integrated Outpatient Code Editor (I/OCE) Specifications Version 18.3

The Centers for Medicare & Medicaid Services (CMS) has revised 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/index.html

MLN Matters Number: MM10230 Revised Related Change Request (CR) Number: CR 10230
Related CR Release Date: November 3, 2017 Effective Date: October 1, 2017
Related CR Transmittal Number: R3907CP Implementation Date: October 2, 2017

Note: This article was revised on November 3, 2017, to reflect the revised CR10230 issued on that same date. In the article, the modification table was updated to include the revisions to several age and gender edits (row 1 of the table) and to add reference to the conditional bilateral list in row 10 of the table. Also, the CR release date, transmittal number and the Web address for accessing the CR are revised. All other information remains the same.

Provider Type Affected
This MLN Matters Article is intended for physicians, providers and suppliers billing Medicare Administrative Contractors (MACs), 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.
### Effective Date | Edits Affected | Modification
--- | --- | ---
10/1/2017 | 2, 3 | Revisions to several age and gender edits (details in Summary of Data Changes of CR10230).
10/1/2017 | 1, 2, 3, 5, 86 | 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).
10/1/2017 | 29 | Updated the mental health diagnosis list based on the FY 2018 ICD-10-CM code revisions.
10/1/2017 | 95 | Modify the effective date for edit 95 to 10/1/2017.
4/1/2017 | 30, 95 | 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).
7/1/2017 | 22 | Add ZC (Merck/Samsung Bioepis) to the list of valid modifiers.
7/1/2017 | 94 | Add modifier ZC as a biosimilar manufacturer modifier applicable for HCPCS Q5102.
10/1/2016 | 99 | 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).
7/1/2017 | 41, 65 | Add new revenue code 1006 to the list of valid revenue codes and to the list of revenue codes not recognized by Medicare.
10/1/2017 | | Update the following lists for the release (see quarterly data files):
- Conditional bilateral list (R1 – code added to list)
- Edit 99 exclusion list (add new codes to exception list)
- Comprehensive Ambulatory Payment Classification(APC) ranking
- Comprehensive APC Code Pairs (correction to two APC Pairs missing complexity-adjusted APC assignment retroactive for 2016 service dates)
- New data file report for Comprehensive APCs (includes list of procedures, rank and flag for eligibility of complexity-adjusted APC)
- Device-procedure list (edit 92)
- Terminated device-procedures for device credit (Device offset amount corrections; updated code list)
- Non-standard CT Scan (updated code list)
5/25/2017 | 68 | Implement NCD mid-quarter effective editing for procedure code 93668.
4/3/2017 | 68 | Implement NCD mid-quarter effective editing for HCPCS A4575 and E0446.
10/1/2017 | | Make all HCPCS/APC/SI changes as specified by CMS (quarterly data files).
10/1/2017 | 20, 40 | Implement version 23.3 of the NCCI (as modified for applicable outpatient institutional providers).

### 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
| Date of Change | Description |
--- | --- |
November 3, 2017 | This article was revised to reflect the revised CR10230 issued on that same date. In the article, the modification table was updated to include the revisions to several age and gender edits (row 1 of the table) and to add reference to the conditional bilateral list in row 10 of the table. Also, the CR release date, transmittal number and the Web address for accessing the CR are revised. All other information remains the same. |
For Home Health & Hospice Providers

**MM10268: Implement Operating Rules - Phase III Electronic Remittance Advice (ERA) Electronic Funds Transfer (EFT): CORE 360 Uniform Use of Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC), and Claim Adjustment Group Code (CAGC) Rule - Update from Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE)**

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/index.html](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html)

<table>
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<th>MLN Matters Number: MM10268</th>
<th>Related Change Request (CR) Number: CR 10268</th>
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<tr>
<td>Related CR Release Date: November 9, 2017</td>
<td>Effective Date: April 1, 2018</td>
</tr>
<tr>
<td>Related CR Transmittal Number: R3915CP</td>
<td>Implementation Date: April 2, 2018</td>
</tr>
</tbody>
</table>

**Provider Types Affected**

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

**Provider Action Needed**

Change Request (CR) 10268 instructs MACs and Shared System Maintainers (SSMs) to update systems based on the CORE 360 Uniform Use of Claims Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC), and Claim Adjustment Group Code (CAGC) Rule publication. These system updates are based on the Committee on Operating Rules for Information Exchange (CORE) Code Combination List to be published on or about February 1, 2018. Make sure that your billing staff is aware of these changes.

**Background**

The Department of Health and Human Services (DHHS) adopted the Phase III Council for Affordable Quality Healthcare (CAQH) CORE, EFT, and ERA Operating Rule Set that was implemented on January 1, 2014 under the Affordable Care Act.

The Health Insurance Portability and Accountability Act (HIPAA) amended the Social Security Act by adding Part C—Administrative Simplification—to Title XI, requiring the Secretary of DHHS to adopt standards for certain transactions to enable health information to be exchanged more efficiently and to achieve greater uniformity in the transmission of health information.

The Centers for Medicare & Medicaid Services (CMS) instructs MACs to conduct updates based on the code update schedule that results in publication three times per year – around March 1, July 1, and November 1. CR10268 deals with the regular update in CAQH
CORE defined code combinations per Operating Rule 360 - Uniform Use of CARC and RARC (835) Rule.

CAQH CORE will publish the next version of the Code Combination List on or about February 1, 2018. This update is based on the CARC and RARC updates as posted at the Washington Publishing Company (WPC) website on or about November 1, 2017. This will also include updates based on Market Based Review that CAQH CORE conducts once a year to accommodate code combinations that are currently being used by Health Plans including Medicare as the industry needs them. You can find CARC and RARC updates at http://www.wpc-edi.com/reference and CAQH CORE defined code combination updates at http://www.caqh.org/CORECodeCombinations.php.

A discrepancy between the dates may arise as the WPC website is only updated three times per year and may not match the CMS release schedule. For CR10268, the MACs and the SSMs must get the complete list for both CARCs and RARCs from the WPC website to obtain the comprehensive lists for both code sets and determine the changes included on the code list since the last code update CR (CR10140).

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

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 of Change</th>
<th>Description</th>
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<tr>
<td>November 13, 2017</td>
<td>Initial article released</td>
</tr>
</tbody>
</table>

For Home Health & Hospice Providers

**MM10270:** Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP), and PC Print 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/index.html

**MLN Matters Number:** MM10270
**Related Change Request (CR) Number:** CR 10270
**Related CR Release Date:** November 9, 2017
**Related CR Transmittal Number:** R3910CP
**Effective Date:** April 1, 2018
**Implementation Date:** April 2, 2018
Provider Types Affected
This MLN Matters Article is intended for physicians, providers, and suppliers billing Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

What You Need To Know
Change Request (CR) 10270 updates the Remittance Advice Remark Codes (RARC) and Claims Adjustment Reason Code (CARC) lists and instructs Medicare Shared System Maintainers (SSMs) to update Medicare Remit Easy Print (MREP) and PC Print. Be sure your staffs are aware of these changes and obtain the updated MREP and PC Print software if they use that software.

Background
The Health Insurance Portability and Accountability Act of 1986 (HIPAA) instructs health plans to be able to conduct standard electronic transactions adopted under HIPAA using valid standard codes. Medicare policy states that CARCs and RARCs, as appropriate, which provide either supplemental explanation for a monetary adjustment or policy information that generally applies to the monetary adjustment, are required in the remittance advice and coordination of benefits transactions.

The Centers for Medicare & Medicaid Services (CMS) instructs MACs to conduct updates based on the code update schedule that results in publication three times per year – around March 1, July 1, and November 1.

SSMs have the responsibility to implement code deactivation, making sure that any deactivated code is not used in original business messages and allowing the deactivated code in derivative messages. SSMs must make sure that Medicare does not report any deactivated code on or after the effective date for deactivation as posted on the Washington Publishing Company (WPC) website. If any new or modified code has an effective date later than the implementation date specified in CR10270, MACs must implement on the date specified on the WPC website, available at: http://wpc-edi.com/Reference/.

A discrepancy between the dates may arise as the WPC website is only updated three times per year and may not match the CMS release schedule.

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>November 13, 2017</td>
<td>Initial Article Released</td>
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</table>
MM10271: Claim Status Category Codes and Claim Status Codes 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/index.html

MLN Matters Number: MM10271
Related Change Request (CR) Number: CR 10271
Related CR Release Date: November 9, 2017
Effective Date: April 1, 2018
Related CR Transmittal Number: R3916CP
Implementation Date: April 2, 2018

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

Provider Action Needed
Change Request (CR) 10271 informs MACs about system changes to update, as needed, the Claim Status Codes and Claim Status Category Codes used for the Accredited Standards Committee (ASC) X12 276/277 Health Care Claim Status Request and Response and ASC X12 277 Health Care Claim Acknowledgment transactions. Make sure your billing staffs are aware of these changes.

Background
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires all covered entities to use only Claim Status Category Codes and Claim Status Codes approved by the National Code Maintenance Committee in the ASC X12 276/277 Health Care Claim Status Request and Response and ASC X12 277 Health Care Claim Acknowledgment transactions. These codes explain the status of submitted claim(s). Proprietary codes may not be used in the ASC X12 276/277 transactions to report claim status.

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


Included in the code lists are specific details, including the date when a code was added, changed, or deleted. All code changes approved during the January 2018 committee meeting will be posted on these sites on or about February 1, 2018.

The Centers for Medicare & Medicaid Services (CMS) will issue notifications regarding the need for future updates to these codes. When instructed, MACs must update their claims systems to ensure that the current version of these codes is used in their claim status responses. MAC and shared systems changes will be made as necessary as part of a routine release to reflect applicable changes such as retirement of previously used codes or newly created codes.
These code changes are to be used in editing of all ASC X12 276 transactions processed on or after the date of implementation and to be reflected in the ASC X12 277 transactions issued on and after the date of implementation of Change Request (CR) 10271.

**Note:** References in CR 10271 to “277 responses” and “claim status responses” encompass both the ASC X12 277 Health Care Claim Status Response and the ASC X12 277 Healthcare Claim Acknowledgment transactions.

### Additional Information


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>November 13, 2017</td>
<td>Initial Article Released</td>
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### For Home Health & Hospice Providers

**New Medicare Card: New Web Page Information**


View new content on the Provider Web page ([https://www.cms.gov/Medicare/New-Medicare-Card/Providers/Providers.html](https://www.cms.gov/Medicare/New-Medicare-Card/Providers/Providers.html)) to be ready for the transition to the new Medicare card beginning April 1. We identify new and updated content as “New”. Learn more:

- Prepare for April 2018 – Sign up for your Medicare Administrative Contractor’s portal now - [https://www.cms.gov/Medicare/New-Medicare-Card/Providers/MACs-Provider-Portals-by-State.pdf](https://www.cms.gov/Medicare/New-Medicare-Card/Providers/MACs-Provider-Portals-by-State.pdf)
- How we are aligning eligibility search criteria among CMS systems
- Identify Railroad Retirement Board (RRB) Medicare patients – view the RRB card - [https://www.rrb.gov/sites/default/files/2017-10/New%20Medicare%20Card%20Sample_0.pdf](https://www.rrb.gov/sites/default/files/2017-10/New%20Medicare%20Card%20Sample_0.pdf)

### For Home Health & 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.
Date | PCC Training/Closures
---|---
Monday, January 1, 2018, New Year’s Day | Office Closed
Thursday, January 11, 2018 | PCC Closed 8:00 a.m. – 10:00 a.m. Central Time
Monday, January 15, 2018, Martin Luther King, Jr.’s Birthday | Office Closed
Thursday, January 25, 2018 | PCC Closed 8:00 a.m. – 10:00 a.m. Central Time

The Interactive Voice Response (IVR) (1.877.220.6289) is available for assistance in obtaining patient eligibility information, claim and deductible information, and general information. For information about the IVR, access the IVR User Guide at [https://www.cgsmedicare.com/hhh/help/pdf/IVR_User_Guide.pdf](https://www.cgsmedicare.com/hhh/help/pdf/IVR_User_Guide.pdf) on the CGS website. In addition, CGS’ 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 Home Health & Hospice Providers

Quarterly Provider Update

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

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

To receive notification when regulations and program instructions are added throughout the quarter, go to [https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/CMS-Quarterly-Provider-Updates-Email-Updates.html](https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/CMS-Quarterly-Provider-Updates-Email-Updates.html) to sign up for the Quarterly Provider Update (electronic mailing list).

SE1128 (Revised): Prohibition on Billing Dually Eligible Individuals Enrolled in the Qualified Medicare Beneficiary (QMB) Program

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/index.html

MLN Matters Number: SE1128 Revised
Related CR Release Date: November 3, 2017
Related CR Transmittal Number: N/A

Note: The article was revised to show the HETS QMB release will be in November 2017. Previously, the article was revised on October 18, 2017, to indicate that the Provider Remittance Advice and the Medicare Summary Notice for beneficiaries identifies the QMB status of beneficiaries and exemption from cost-sharing for Part A and B claims processed on or after October 2, 2017, and to recommend how providers can use these and other upcoming system changes to promote compliance with QMB billing requirements. All other information remains the same.

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

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

Look for new information and messages in CMS’ HIPAA Eligibility Transaction System (HETS) (effective November 2017) and the Provider Remittance Advice (RA) (effective October 2, 2017), to identify patients’ QMB status and exemption from cost-sharing prior to billing. If you are an MA provider, contact the MA plan for more information about verifying the QMB status of plan members.

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

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

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

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


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

Inappropriate Billing of QMB Individuals Persists

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

Ways to Promote Compliance with QMB Billing Rules

Take the following steps to ensure compliance with QMB billing prohibitions:

1. Establish processes to routinely identify the QMB status of your Medicare patients prior to billing for items and services.
   - Beginning in November 2017, providers and suppliers can use Medicare eligibility data provided to Medicare providers, suppliers, and their authorized billing agents (including clearinghouses and third party vendors) by CMS’ HETS to verify a patient’s QMB status and exemption from cost-sharing charges. For more information on HETS, visit https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/index.html.
   - Original Medicare providers and suppliers can readily identify the QMB status of patients and billing prohibitions on the Medicare Provider RA, which will contain new notifications and information about a patient’s QMB status for Part A and B claims processed on or after October 2, 2017. Refer to Qualified Medicare Beneficiary Indicator in the Medicare Fee-For-Service Claims Processing System at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/
- MA providers and suppliers should also contact the MA plan to learn the best way to identify the QMB status of plan members.

2. Providers and suppliers may also verify patient’s QMB status through State online Medicaid eligibility systems or by asking patients for other proof such as their Medicaid identification card or a copy of their Medicare Summary Notice, the quarterly summary of claims sent to Original Medicare beneficiaries that reflects, among other things, the patients’ QMB status for Part A and B claims processed on or after October 2, 2017. Ensure that billing procedures and third-party vendors exempt individuals enrolled in the QMB program from Medicare charges and that you remedy billing problems should they occur. If you have erroneously billed individuals enrolled in the QMB program, recall the charges (including referrals to collection agencies) and refund the invalid charges they paid.

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

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

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

Important Reminders Concerning QMB Billing Requirements

Be aware of the following policy clarifications on QMB billing requirements:

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

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

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

### QMB Eligibility and Benefits

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

<table>
<thead>
<tr>
<th>Program</th>
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<th>Benefits</th>
</tr>
</thead>
</table>
| QMB Plus    | ≤100% of FPL     | Determined by State | Part A***                            | Meets financial and other criteria for full Medicaid benefits | • Full Medicaid coverage  
• Medicaid pays for Part A (if any) and Part B premiums, and may pay for deductibles, coinsurance, and copayments to the extent consistent with the Medicaid State Plan (even if payment is not available under the State plan for these charges, QMBs are not liable for them) |

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

*** To qualify as a QMB or a QMB plus, individuals must be enrolled in Part A (or if uninsured for Part A, have filed for premium-Part A on a “conditional basis”). For more information on this process, refer to Section HI 00801.140 of the Social Security Administration Program Operations Manual System (https://secure.ssa.gov/apps10/poms.nsf/lnx/0600801140).

Additional Information


Document History

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<tr>
<td>November 3, 2017</td>
<td>Article revised to show the HETS QMB release will be in November 2017. All other information remains the same.</td>
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<tr>
<td>October 18, 2017</td>
<td>The article was revised to indicate that the Provider Remittance Advice and the Medicare Summary Notice for beneficiaries identifies the QMB status of beneficiaries and exemption from cost-sharing for Part A and B claims processed on or after October 2, 2017, and to recommend how providers can use these and other upcoming system changes to promote compliance with QMB billing requirements. All other information remains the same.</td>
</tr>
<tr>
<td>August 23, 2017</td>
<td>The article was revised to highlight upcoming system changes that identify the QMB status of beneficiaries and exemption from Medicare cost-sharing, recommend key ways to promote compliance with QMB billing rules, and remind certain types of providers that they may seek reimbursement for unpaid deductible and coinsurance amounts as a Medicare bad debt.</td>
</tr>
<tr>
<td>May 12, 2017</td>
<td>This article was revised on May 12, 2017, to modify language pertaining to billing beneficiaries enrolled in the QMB program. All other information is the same.</td>
</tr>
<tr>
<td>January 12, 2017</td>
<td>This article was revised to add a reference to MLN Matters article MM9817 (<a href="https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9817.pdf">https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9817.pdf</a>), which instructs Medicare Administrative Contractors to issue a compliance letter instructing named providers to refund any erroneous charges and recall any existing billing to QMBs for Medicare cost sharing.</td>
</tr>
<tr>
<td>February 4, 2016</td>
<td>The article was revised on February 4, 2016, to include updated information for 2016 and a correction to the second sentence in paragraph 2 under Important Clarifications Concerning QMB Balance Billing Law on page 3.</td>
</tr>
<tr>
<td>February 1, 2016</td>
<td>The article was revised to include updated information for 2016 and a clarifying note regarding eligibility criteria in the table on page 4.</td>
</tr>
<tr>
<td>March 28, 2014</td>
<td>The article was revised on to change the name of the Coordination of Benefits Contractor (COBC) to BCRC.</td>
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</table>
SE17019 (Reissued): Accepting Payment from Patients with a Medicare Set-Aside Arrangement

The Centers for Medicare & Medicaid Services (CMS) has reissued 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/index.html

MLN Matters Number: SE17019 Reissued Related Change Request (CR) Number: N/A
Related CR Release Date: November 8, 2017 Effective Date: N/A
Related CR Transmittal Number: N/A Implementation Date: N/A

Note: This article was reissued on November 8, 2017, to clarify information. The title of the article was also changed to better reflect the information.

Provider Type Affected
This MLN Matters® Article is intended for providers, physicians, and other suppliers who are told by patients that they must pay the bill themselves because they have a Medicare Set-Aside Arrangement (MSA).

What You Need to Know
This article is based on information received from Medicare beneficiaries, their legal counsel, and other entities that assist these individuals, indicating that physicians, providers, and other suppliers are often reluctant to accept payment directly from Medicare beneficiaries who state they have a MSA and must pay for their services themselves. This article explains what a MSA is and explains why it is appropriate to accept payment from a patient that has a funded MSA.

Please review your billing practices to be sure they are in line with the information provided.

Background
Medicare is always a secondary payer to liability insurance (including self-insurance), no-fault insurance, and workers’ compensation benefits. The law precludes Medicare payment for services to the extent that payment has been made, or can reasonably be expected to be made promptly. When future medical care is claimed, or a settlement, judgment, award, or other payment releases (or has the effect of releasing) claims for future medical care, it can reasonably be expected that the monies from the settlement, judgment, award, or other payment are available to pay for future medical items and services which are otherwise covered and reimbursable by Medicare.

Medicare should not be billed for future medical services until those funds are exhausted by payments to providers for services that would otherwise be covered and reimbursable by Medicare.

A MSA is a financial arrangement that allocates a portion of a settlement, judgment, award, or other payment to pay for future medical services. The law mandates protection of the Medicare trust funds but does not mandate a MSA as the vehicle used for that purpose. MSAs are the most frequently used formal method of preserving those funds for the Medicare beneficiary to pay for future items or services which are otherwise covered and reimbursable by Medicare and which are related to what was claimed or the settlement, judgment, award, or other payment had the effect of releasing. These funds must be exhausted before Medicare will pay for treatment related to the claimed injury, illness, or disease.
Medicare beneficiaries are advised that before receiving treatment for services to be paid by their MSA, they should advise their health care provider about the existence of the MSA. They are also notified that their health care providers should bill them directly, and that they should pay those charges out of the MSA if:

- The treatment or prescription is related to what was claimed or the settlement, judgment, award, or other payment had the effect of releasing AND
- The treatment or prescription is something Medicare would cover.

The obligation to protect the Medicare trust funds exists regardless of whether or not there is a formal CMS approved MSA amount. A Medicare beneficiary may or may not have documentation they can provide the physician, provider, or supplier from Medicare approving a Medicare Set-Aside amount.

Provider Action Needed

Where a patient who is a Medicare beneficiary states that he/she is required to use funds from the settlement, judgment, award, or other payment to pay for the items or services related to what was claimed or which the settlement, judgment, award, or other payment, it is appropriate for you to document your records with that information and accept payment directly from the patient for such services.

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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<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
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<tbody>
<tr>
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For Home Health & Hospice Providers

SE17035 (Revised): Medicare Fee-for-Service (FFS) Response to the 2017 California Wildfires

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/index.html

MLN Matters Number: SE17035 Revised  Related Change Request (CR) Number: N/A
Related CR Release Date: November 1, 2017  Effective Date: N/A
Related CR Transmittal Number: N/A  Implementation Date: N/A

Note: This article was revised on November 1, 2017, to add information regarding the exceptions granted for certain Medicare quality reporting and value-based purchasing programs. All other information is unchanged.

Provider Types Affected

This MLN Matters® Special Edition Article is intended for providers and suppliers who submit claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries, who were affected by the 2017 wildfires in the State of California.
Provider Information Available

Pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act, President Trump declared that, as a result of the effects of the 2017 Wildfires, a major disaster exists in the State of California. On October 15, 2017, Acting Secretary Hargan of the Department of Health & Human Services declared that a public health emergency exists in the State of California retroactive to October 8, 2017, and authorized waivers and modifications under §1135 of the Social Security Act.

On October 17, 2017, the Administrator of the Centers for Medicare & Medicaid Services (CMS) authorized waivers under §1812(f) of the Social Security Act for the State of California retroactive to October 8, 2017 for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of wildfires. Providers can request an individual Section 1135 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.

Background

Section 1135 and Section 1812(f) Waivers

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

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 California retroactive to October 8, 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.

The most current information can be found at https://www.cms.gov/About-CMS/Agency-Information/Emergency/Wildfires.html.

Also referenced below are Q&As that are applicable for items and services furnished to Medicare beneficiaries within the State of California. 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.
- 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 individual 1135 waivers requested by providers for California.

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.

- 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.
- 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.
Waiver for California

Under the authority of Section 1135 (or, as noted below, Section 1812(f)), CMS has issued the following waiver in the affected areas of California. Individual facilities do not need to apply for the following approved waiver.

Skilled Nursing Facilities

- 1812(f): This waiver of the requirement for a 3-day prior hospitalization for coverage of a Skilled Nursing Facility stay provides temporary emergency coverage of Skilled Nursing Facility (SNF) services without a qualifying hospital stay, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of the wildfires. 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).

- In addition, the waiver provides temporary emergency coverage of SNF services that are not post-hospital SNF services under the authority in §1812(f) of the Social Security Act (the Act), for those people who are evacuated, transferred, or otherwise dislocated as a result of the effects in the State of California, in October 2017. In addition, this waiver provides authority under §1812(f) of the Act to provide coverage for extended care services which will not require a new spell of illness in order to renew provision of services by a SNF. These temporary emergency policies would apply to the timeframes specified in the waiver(s) issued under §1135 of the Act in connection with the effects of the wildfires in the State of California in October 2017. Accordingly, both the effective date and expiration date for these temporary emergency policies are the same as those specified pursuant to the §1135 waivers. Further, unlike the policies authorized directly under the §1135 waiver authority itself, the two policies described above would not be limited to beneficiaries who have been relocated within areas that have been designated as emergency areas. Instead, the policies would apply to all beneficiaries who were evacuated from an emergency area as a result of the effects of the wildfires in California in October 2017, regardless of where the “host” SNF providing post-disaster care is located.

Administrative Relief

Appeal Administrative Relief for Areas Affected by California Wildfires

If you were affected by the California wildfires 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.

Requesting an 1135 Waiver


More information is available in the 1135 Waiver Letter, which is posted in the Downloads section at https://www.cms.gov/About-CMS/Agency-Information/Emergency/Wildfires.html.

Medicare Quality Reporting and Value-based Purchasing Programs

CMS is granting exceptions under certain Medicare quality reporting and value-based purchasing programs to acute care hospitals, inpatient psychiatric facilities, skilled nursing facilities, home health agencies, hospices, inpatient rehabilitation facilities, long-term care hospitals, renal dialysis facilities, and ambulatory surgical centers located in areas affected by the devastating impacts of the Northern California wildfires since October 8, 2017, in

### Additional Information

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<table>
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<tr>
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### For Home Health & Hospice Providers

#### Stay Informed and Join the CGS ListServ Notification Service

The CGS Listserv Notification Service is the primary means used by CGS to communicate with Kentucky and Ohio Medicare Part B providers. The Listserv is a free email notification service that provides you with prompt notification of Medicare news including policy, benefits, claims submission, claims processing and educational events. Subscribing for this service means that you will receive information as soon as it is available, and plays a critical role in ensuring you are up-to-date on all Medicare information.

Consider the following benefits to joining the CGS ListServ Notification Service:

- It’s free! There is no cost to subscribe or to receive information.
- You only need a valid e-mail address to subscribe.
- Multiple people/e-mail addresses from your facility can subscribe. We recommend that all staff (clinical, billing, and administrative) who interacts with Medicare topics register individually. This will help to facilitate the internal distribution of critical information and eliminates delay in getting the necessary information to the proper staff members.

To subscribe to the CGS ListServ Notification Service, go to [http://www.cgsmedicare.com/medicare_dynamic/ls/001.asp](http://www.cgsmedicare.com/medicare_dynamic/ls/001.asp) and complete the required information.

### For Home Health & 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](https://www.cgsmedicare.com/hhh/education/Education.html). CGS suggests that you bookmark this page and visit it often for the latest educational opportunities.
For Home Health & Hospice Providers

Unsolicited/Voluntary Refunds

Providers need to be aware that the acceptance of a voluntary refund as repayment for the claims specified in no way affects or limits the rights of the Federal Government, or any of its agencies or agents, to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims.

Medicare administrative contractors (MACs) receive unsolicited/voluntary refunds from providers. These voluntary refunds are not related to any open accounts receivable. Providers billing MACs typically make these refunds by submitting adjustment bills, but they occasionally submit refunds via check. Providers billing carriers usually send these voluntary refunds by check.

Related CR 3274 is intended mainly to provide a detailed set of instructions for MACs regarding the handling and reporting of such refunds. The implementation and effective dates of that CR apply to the carriers and intermediaries. But, the important message for providers is that the submission of such a refund related to Medicare claims in no way limits the rights of the Federal Government, or any of its agencies or agents, to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to those or any other claims.


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

For Home Health & Hospice Providers

Updated 2018 Amount in Controversy (AIC) for Administrative Law Judge Hearings or Federal District Court Appeals

The Centers for Medicare & Medicaid Services (CMS) has notified Medicare contractors of the update to the Amount in Controversy (AIC) required to sustain Administrative Law Judge (ALJ) or Federal District Court appeal rights beginning January 1, 2018.

- The amount remaining in controversy requirement for ALJ hearing requests made on or before December 31, 2017, is $160. **This amount will remain at $160 for ALJ hearing requests filed on or after January 1, 2018.**

- The amount that must remain in controversy for reviews in Federal District Court requested on or before December 31, 2017 is $1,560. **This amount will increase to $1,600 for appeals to Federal District Court filed on or after January 1, 2018.**

Please share this with your appropriate staff.

For additional information about appeals, refer to the Medicare Appeals Process factsheet, which provides an overview of the Medicare Part A and Part B administrative appeals process available to providers, physicians and other suppliers who provide services and supplies to Medicare beneficiaries, as well as details on where to obtain more information about this appeals process. The factsheet is available on the CMS Web site at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedicareAppealsProcess.pdf.