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FROM THE MEDICAL DIRECTOR

Exciting New Program Soon in Jurisdiction C – Targeted Probe and Educate

You may have heard this term “Targeted Probe & Educate” used in recent years in the Medicare program. In 2014 & 2015 the MAC Probe & Educate medical review strategy for hospital inpatient cases produced favorable outcomes with respect to educating providers and reducing improper payments. The Probe & Educate strategy is also being employed for Home Health, which has received similar appreciation from providers and MACs. Finally, CMS has seen very positive results from a currently running DME pilot for this program as well as modifications to existing programs as a result of lessons learned. CMS believes that this strategy will continue to demonstrate measurable reductions in the number of claims denied and the number and merit of appeals.

The key element of TPE is that each selected supplier will have up to three rounds of a pre-payment Targeted Probe & Educate process. How will this work?

- Suppliers, selected for the TPE process based on data analysis of claims submitted in Jurisdiction C, will receive a letter explaining that they’ve been selected for TPE. It will describe the process, the reason for selection and the HCPCS code or codes under review.

- Prepayment review of 20 to 40 claims will be developed for additional documentation and evaluated by a CGS Medical Review clinician. Depending on the number and type of errors found, the supplier will receive 1-on-1 education from the Medical Review clinician, including helpful material to reduce or eliminate the errors noted in the review. If the error rate is low, no further action is taken and the supplier is excluded from further MAC TPE review for at least 12 months.

- For suppliers with higher error rates on the probe review, 1-on-1 education will be provided and at least 45 days will be given to implement any necessary changes to the supplier’s processes. At that point another probe review will take place, again with 20 to 40 prepayment claims. Similar to the first round of TPE, a Medical Review clinician will conduct 1-on-1 education, based on the errors observed.

- If high denial rates continue after three rounds of TPE, CGS will consult with CMS for additional action, which may include extrapolation, referral to the ZPIC/UPIC, referral to the RAC, 100% pre-pay review, etcetera.

This new TPE strategy is designed to efficiently utilize medical review processes and incorporate comprehensive education, with the option for potential elevated action; all designed to reduce or prevent improper payments and reduce appeals.

This program is scheduled to begin in October 2017. If you are selected for TPE, you’ll have all of the information you need in the letter received. Read it carefully and follow the directions closely. It is critically important that you respond to the request for records promptly.

Robert D. Hoover, Jr., MD, MPH, FACP
Senior Medical Director
CGS DME MAC Jurisdiction C
CGS Wizard (formerly, MR WIZARD) contains processed claim details for all claims submitted to Jurisdiction B and C, PLUS you can access ADR status, medical review decisions and resources directly from our website! Just enter a 14-digit CCN (claim control number) and CGS Wizard will give you the claim and/or medical review details you need to resubmit your claim! If your CCN is also tied to an additional documentation request, the CGS Wizard will let you know the status. The CGS Wizard also links you directly to education that is specific to your individual needs.

CGS Wizard does not require special access to get information. Just click the link on our website and you’re ready to go! Processed claim information, education and instruction are available 24/7!

When you use CGS Wizard, there is no need to call and verify that the information is correct or complete because CGS Wizard gives you exactly the same, word-for-word processed claim information and education resources you’ll get from any CGS customer service advocate and, the information is exactly the same whether you use our other CGS self-service tools including CGS GO Mobile and myCGS! If you do call, our friendly customer service advocates will educate you on the CGS Wizard tool so you can get the information you need when you need it!

For those that use our popular CGS GO Mobile app to access CGS Wizard, watch for our new menu icon! (You may need to download our most recent update to see the new menu icon).

Thousands of Jurisdiction B and C customers use CGS Wizard every day because they know they can trust that the information provided is detailed, accurate and thorough – AND, they don’t have to call CGS customer service to get the information!

Try CGS Wizard today!
COMING SOON—myCGS Version 4.0 with Built-in ID Management

myCGS version 4 is coming soon!

myCGS v4 will introduce an all new user ID management and registration system built directly into myCGS (https://www.cgsmedicare.com/jc/mycgs/index.html). Currently myCGS utilizes the CMS Enterprise Identity Management website (EIDM) for user ID management and registration. With the release of myCGS v4, EIDM will no longer be used by myCGS. All existing/current myCGS (EIDM) user IDs will be transitioned into myCGS, while all new user registration will take place directly within myCGS once v4 is released.

Existing Users
If you are an existing myCGS user, your current EIDM user ID will be transferred to the new myCGS user ID system. When you first log in to myCGS v4, you will use your current EIDM ID and password. You will immediately be asked to change your password, and a temporary password will be sent to you via email. After changing your password, you will need to set up your Multi-Factor Authentication (MFA) preferences and your security challenge questions and answers. Note that your MFA and security challenge questions will not be transferred from EIDM.

Once you have successfully changed your password, set up your MFA, and set your security challenge Q&A, you will be able to use myCGS just as you do today. You will have the same level of access as you had at the time of myCGS v4 implementation.

New Users
If you are not currently a myCGS user but want to register for myCGS v4, we will be providing complete instructions in a new/revised version of the myCGS Registration Guide (https://www.cgsmedicare.com/jc/mycgs/pdf/mycgs_registrationguide.pdf). The registration process will be similar to the current myCGS registration process, but will take place entirely within myCGS (instead of utilizing EIDM) and will no longer require Remote Identity Proofing (RIDP). Stay tuned for details.

MFA
With myCGS v4, we are simplifying the way MFA works in myCGS. When you first log in to myCGS v4, you will need to set up your MFA preferences. You will have two choices for how you authenticate using MFA—text message or email (or both). Other forms of MFA will no longer be accepted.

In addition to the new ID management and registration process, myCGS v4 will include several "under the hood" improvements to help make myCGS faster and more stable.

myCGS v4 will be released in mid-to-late October, 2017. We will be publishing additional information and all the details you need to know as we get closer to the v4 release. Be sure to stay tuned to our ListServ (https://www.cgsmedicare.com/medicare_dynamic/ls/001.asp) and the Important News page (https://www.cgsmedicare.com/jc/pubs/news/index.html) on our website to keep up with all of our exciting myCGS news.
Medicare provides coverage for therapeutic shoes and related inserts for beneficiaries with diabetes. Custom molded inserts are billed using HCPCS code A5513 [FOR DIABETICS ONLY, MULTIPLE DENSITY INSERT, CUSTOM MOLED FROM MODEL OF PATIENT’S FOOT, TOTAL CONTACT WITH PATIENT’S FOOT, INCLUDING ARCH, BASE LAYER MINIMUM OF 3/16 INCH MATERIAL OF SHORE A 35 DUROMETER OR HIGHER), INCLUDES ARCH FILLER AND OTHER SHAPING MATERIAL, CUSTOM FABRICATED, EACH]. Inserts billed with A5513 must be made in compliance with criteria specified in the code narrative described above, the coding guidelines section of the LCD related Policy Article, and the DMEPOS Quality Standards. Suppliers of these inserts must assure themselves that the products provided meet the requirements for classification as A5513 before billing this HCPCS code.

The HCPCS code narrative passage, "...CUSTOM MOLED FROM MODEL OF PATIENT’S FOOT...", requires that a physical model of the beneficiary’s foot must be produced and that the insert be individually molded to the physical model. Some manufacturers do not produce an actual physical model of the individual beneficiary’s foot. Instead, a CAD-CAM system creates an electronic positive model derived from specific patient measurements, i.e. a “virtual model”, or use a library of generic models to fabricate an insert. Inserts produced using these or similar techniques must not be coded as A5513 for Medicare billing.

The Medicare Benefit Policy Manual (Internet Only Manual 100-2) chapter 15, §140 describes the benefit requirements associated with therapeutic shoes. It describes a covered insert. The section says, in relevant part:

3. Inserts

   Inserts are total contact, multiple density, removable inlays that are directly molded to the patient’s foot or a model of the patient’s foot and that are made of a suitable material with regard to the patient’s condition.

   [Emphasis added]

The Therapeutic Shoes for Persons with Diabetes LCD related Policy Article coding guidelines section says:

   Code A5513 describes a total contact, custom fabricated, multiple density, removable inlay that is molded to a model of the beneficiary’s foot so that it conforms to the plantar surface and makes total contact with the foot, including the arch. A custom fabricated device is made from materials that do not have predefined trim lines for heel cup height, arch height and length, or toe shape.

   [Emphasis added]

The DMEPOS Quality Standards Appendix C (42 CFR 424.57) defines custom fabrication for these items and requires that custom fabricated inserts be made to a physical model of the individual beneficiary’s foot. Appendix C says, in relevant part:

1. Custom Fabricated: A custom fabricated item is one that is individually made for a
specific Patient. No other patient would be able to use this item...

a. Molded-to-Patient-Model: A particular type of custom fabricated device in which either:

ii. An impression (usually by means of a plaster or fiberglass cast) of the specific body part is made directly on the patient, and **this impression is then used to make a positive model of the body part from which the final product is crafted**; or

iii. A digital image of the patient’s body part is made using Computer-Aided Design-Computer-Aided Manufacturing (CAD-CAM) software. This technology includes specialized probes/digitizers and scanners that **create a computerized positive model, and then direct milling equipment to carve a positive model**. The device is then individually fabricated and molded over the positive model of the patient. [Emphasis added]

These standards are not met by:

1. Electronic (virtual) beneficiary models created within CAD-CAM systems which in turn are used to directly fabricate the insert; or,

2. Generic models which are used to create a nonspecific insert for later modification to individual beneficiary specifications.

Therapeutic shoe inserts produced from virtual or generic models must be billed to Medicare using HCPCS code A9270 [NON-COVERED ITEM OR SERVICE].


For questions about correct coding, contact the Pricing, Data Analysis, and Coding (PDAC) contractor at (877) 735-1326 during the hours of 8:30 a.m. to 4:00 p.m. CT, Monday through Friday, or e-mail the PDAC by completing the DME PDAC Contact Form at https://www.dmepdac.com/.
Correct Coding – Bariatric Pressure Reducing Support Surfaces

- DME MAC Joint Publication

The DME MAC Pressure Reducing Support Surfaces LCDs (PRSS Groups 1-3) and related Policy Articles include a variety of products including mattress pads/overlays, mattresses, and complete beds. Questions occasionally arise about how to code bariatric versions of PRSS mattresses and mattress pads.

Most of the mattress pad/overlay and mattress PRSS codes are covered when used on a covered hospital bed frame and when the applicable reasonable and necessary (R&N) criteria described in the relevant PRSS Group 1 – 3 LCDs are met.

Per the Hospital Bed LCD, bed frames are grouped based upon three weight categories:

- Up to 350 pounds
- From 350 to 600 pounds (heavy duty)
- Greater than 600 pounds (extra heavy duty)

The mattress and mattress pad/overlay PRSS HCPCS code descriptors and PRSS LCD related Policy Article Coding Guidelines do not make distinctions based upon beneficiary weight. For Medicare billing purposes, the PRSS HCPCS codes are considered all-inclusive i.e., applicable to all beneficiary weights. The provided PRSS item must be appropriate for the beneficiary’s weight (avoids “bottoming out”), provide comparable weight capacity to match that of the provided hospitable bed frame, and must be appropriately sized to correctly fit on the provided bed frame or underlying mattress for pads/overlays. For example; a powered pressure reducing air mattress provided for a 250 lb., 400lb., or 650 lb. beneficiary all would be correctly coded as E0277 (POWERED PRESSURE REDUCING AIR MATTRESS) despite the individual products being of differing sizes, differing construction, etc.

Refer to the applicable Pressure Reducing Support Surface (Groups 1-3) LCDs and the related Policy Articles for additional information about coverage, coding and documentation.

For questions about correct coding, contact the Pricing, Data Analysis, and Coding (PDAC) contractor at (877) 735-1326 during the hours of 8:30 a.m. to 4:00 p.m. CT, Monday through Friday, or e-mail the PDAC by completing the DME PDAC Contact Form at https://www.dmepdac.com/.
Correct Coding - Center Mount Elevating Leg Rest - Revised

- DME MAC Joint Publication


Originally Posted on June 22, 2017
Revised August 10, 2017

This article is revised to correct an error in the billing information for codes E1012 and K0040.

HCPCS code E1012 (WHEELCHAIR ACCESSORY, ADDITION TO POWER SEATING SYSTEM, CENTER MOUNT POWER ELEVATING LEG REST/PLATFORM, COMPLETE SYSTEM, ANY TYPE, EACH) describes a center mount leg rest system that comprises all components of the leg rest, including fixed angle footplates and foot platforms.

Adjustable angle footplates coded K0040 (ADJUSTABLE ANGLE FOOTPLATE, EACH) are separately payable when provided initially with leg rests coded as E1012. The original article published June 22, 2017 incorrectly stated code K0040 could not be billed separately.

Note that reimbursement for code E1012 does include fixed angle footplates and foot platforms. The Wheelchair Options and Accessories LCD-related Policy Article (https://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=52504&ContrID=140) Coding Guidelines state:

There is no separate billing/payment if fixed, swingaway, or detachable footrests or a foot platform without angle adjustment are provided. There is no separate billing for angle adjustable footplates with Group 1 or 2 PWCs. Angle adjustable footplates may be billed separately with Group 3, 4 and 5 PWCs.

Medicare claims for K0108 (WHEELCHAIR COMPONENT OR ACCESSORY, NOT OTHERWISE SPECIFIED) for fixed angle foot platforms or footplates billed in conjunction with code E1012 will be denied as unbundling.


For questions about correct coding, contact the Pricing, Data Analysis, and Coding (PDAC) contractor at (877) 735-1326 during the hours of 8:30 a.m. to 4:00 p.m. CT, Monday through Friday, or e-mail the PDAC by completing the DME PDAC Contact Form at https://www.dmepdac.com/.

Revision History

| Publication Date: August 10, 2017
| Revised: Corrects an error in the billing information for codes E1012 and K0040. |
Correct Coding – A5513 Product Coding Redetermination Project

- DME MAC Joint Publication


Posted on August 10, 2017

Background
In July 2017, the DME MACs published an article titled Correct Coding – A5513 Custom Molding Requirements DME MAC Joint Publication. The article advised suppliers and manufacturers that the DMEPOS Quality Standards, Appendix C require that custom fabricated inserts (HCPCS Code A5513 - FOR DIABETICS ONLY, MULTIPLE DENSITY INSERT, CUSTOM MOLDED FROM MODEL OF PATIENT’S FOOT, TOTAL CONTACT WITH PATIENT’S FOOT, INCLUDING ARCH, BASE LAYER MINIMUM OF 3/16 INCH MATERIAL OF SHORE A 35 DUROMETER OR HIGHER INCLUDES ARCH FILLER AND OTHER SHAPING MATERIAL, CUSTOM FABRICATED, EACH) be manufactured on a beneficiary-specific, physical, positive model. Direct carving (milling) using a CAD-CAM or similar system, without the creation of the required physical, positive model does not meet this requirement. Therefore, the PDAC will begin a project to re-evaluate all the products currently listed in DMECS for code A5513 to assure that inserts billed to Medicare with HCPCS code A5513 are correctly coded.

New Coding Verification Review - Required
Per the Coding Guidelines section of the Therapeutic Shoes for Persons with Diabetes LCD-Related Policy Article (https://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=52501&ContrID=140), manufacturers wishing to use A5513 for their product(s) are required to submit a coding verification application to the PDAC. Therefore, all products must be submitted for this review. There is no carryover or “grandfathering” of prior coding determinations.

All products currently listed in the DMECS Product Classification List on the PDAC web site as assigned to HCPCS code A5513 will be end-dated effective May 31, 2018. After this end-date only products that have completed this current review and that have been verified as meeting all A5513 code requirements will be listed. Effective for claims with dates of service on or after June 1, 2018, the only products which may be billed to Medicare using code A5513 are the products that are listed in the Product Classification List in DMECS maintained on the PDAC website: https://www.dmepdac.com/dmecsapp/do/search.

For claims with dates of service on or before May 31, 2018, products that are presently listed in the Product Classification List in DMECS may continue to use code A5513 for Medicare billing.

Products which have not received coding verification review from the PDAC must be billed to Medicare with code A9270 (NONCOVERED ITEM OR SERVICE).

Coding Verification Review Process
PDAC coding reviews can take up to 90 days to complete. PDAC strongly encourages applicants to submit coding verification applications well in advance of the May 31, 2018 end-date to avoid disruption to the billing of their products. Manufacturers are also encouraged to be sure that coding applications clearly and unambiguously show that all applicable coding requirements are met. The PDAC coding verification application required for these products is the Therapeutic Shoes and Inserts for Diabetics. This application is located on
Correct Coding - Submitting Diabetic Shoe Inserts for HCPCS Coding - PDAC Coding Application Instruction - Revised

-DME MAC Joint Publication


Posted on August 10, 2017

This revision adds information about the DMEPOS Quality Standards, Appendix C requirements for custom fabrication of A5513.

Inserts used with therapeutic shoes for persons with diabetes coded as A5512 and A5513 must meet certain specifications outlined in the Therapeutic Shoes for Persons with Diabetes Local Coverage Determination and related Policy Articles as well as the requirements for custom fabrication set out in the DMEPOS Quality Standards, Appendix C for A5513. This article provides guidance regarding the information necessary to be included with a HCPCS coding application submitted to the Pricing, Data Analysis, and Coding (PDAC) contractor.

A5512

[FOR DIABETICS, ONLY, MULTIPLE DENSITY INSERT, DIRECT FORMED, MOLDED TO FOOT AFTER EXTERNAL HEAT SOURCE OF 230 DEGREES FAHRENHEIT OR HIGHER, TOTAL CONTACT WITH PATIENT’S FOOT, INCLUDING ARCH, BASE LAYER MINIMUM OF 1/4 INCH MATERIAL OF SHORE A 35 DUROMETER OR 3/16 INCH MATERIAL OF SHORE A 40 DUROMETER (OR HIGHER), PREFabricATED, EACH]

The current Coding Guidelines for A5512 say:

Code A5512 describes a total contact, multiple density, prefabricated removable inlay that is directly molded to the beneficiary’s foot. Direct molded means it has been conformed by molding directly to match the plantar surface of the individual beneficiary’s foot. Total contact means it makes and retains actual and continuous
physical contact with the weight-bearing portions of the foot, including the arch throughout the standing and walking phases of gait.

The insert must retain its shape during use for the life of the insert. The layer responsible for shape retention is called the “base layer” in the code descriptor. This material usually constitutes the bottom layer of the device and must be of a sufficient thickness and durometer to maintain its shape during use (i.e., at least ¼ inch of 35 Shore A or higher or at least 3/16 inch of 40 Shore A or higher). The material responsible for maintaining the shape of the device must be heat moldable. The specified thickness of the base layer must extend from the heel through the distal metatarsals and may be absent at the toes.

For an insert to be coded as A5512, the criteria listed in the code narrative and in the coding guideline must be met. A PDAC coding application must include sufficient and clear detail to demonstrate that all criteria are met. To assist applicants PDAC has reformatted the requirements into a list to aid manufacturer and practitioners in verifying that each criterion has been addressed in their coding application. To be assigned to HCPCS code A5512 information must be included showing that the product:

- Is a prefabricated, multiple density insert
- Is direct formed by being molded to the beneficiary’s foot with an external heat source of 230 degrees Fahrenheit or higher
- Has total contact with beneficiary’s foot, including the arch
- Has a base layer that has a minimum
  - 1/4-inch material of Shore A 35 durometer or
  - 3/16-inch material of Shore A 40 durometer (or higher),
- Has the specified thickness of the base layer extend from the heel through the distal metatarsals. (May be absent at the toes)
- Retains its shape during use for the life of the insert

A sample pair of inserts must be submitted with the Coding Verification Application. Applications are available on the PDAC website at www.dmepdac.com.

A5513

FOR DIABETICS ONLY, MULTIPLE DENSITY INSERT, CUSTOM MOLDED FROM MODEL OF PATIENT’S FOOT, TOTAL CONTACT WITH PATIENT’S FOOT, INCLUDING ARCH, BASE LAYER MINIMUM OF 3/16 INCH MATERIAL OF SHORE A 35 DUROMETER OR HIGHER, INCLUDES ARCH FILLER AND OTHER SHAPING MATERIAL, CUSTOM FABRICATED, EACH

The current Coding Guidelines for A5513 say:

Code A5513 describes a total contact, custom fabricated, multiple density, removable inlay that is molded to a model of the beneficiary’s foot so that it conforms to the plantar surface and makes total contact with the foot, including the arch. A custom fabricated device is made from materials that do not have predefined trim lines for heel cup height, arch height and length, or toe shape.

The insert must retain its shape during use for the life of the insert. The base layer of the device must be at least 3/16 inch of 35 Shore A or higher material. The base layer is allowed to be thinner in the custom fabricated device because appropriate arch fill or other additional material will be layered up individually to maintain shape and achieve total contact and accommodate each beneficiary’s specific needs. The central portion of the base layer of the heel may be thinner (but at least 1/16 inch) to allow for greater pressure reduction. The specified thickness of the lateral portions of the base
layer must extend from the heel through the distal metatarsals and may be absent at
the toes. The top layer of the device may be of a lower durometer and must also be
heat moldable. The materials used should be suitable with regards to the beneficiary’s
condition.

For an insert to be coded as A5513, the criteria listed in the code narrative and in the coding
guideline must be met. In addition, the custom fabrication set out in the DMEPOS Quality
Standards, Appendix C must be met. A PDAC coding application must include sufficient and
clear detail to demonstrate that all criteria are met. To assist applicants PDAC has reformatted
the requirements into a list to aid manufacturer and practitioners in verifying that each criterion
has been addressed in their coding application. To be assigned to HCPCS code A5513
information must be included showing that the product:

• Is a custom fabricated, multiple density insert
• Is molded to a beneficiary-specific, physical model and made from basic materials
• Has total contact with beneficiary’s foot, including the arch
• Has a base layer that has a minimum 3/16-inch material of Shore A 35 durometer (The
central portion of the heel may be not be less than 1/16 inch thick)
• Has the specified thickness of the base layer extend from the heel through the distal
metatarsals. (May be absent at the toes)
• Has a heat-moldable top layer
• Retains its shape during use for the life of the insert

Manufacturers/central fabrication facilities must submit: (1) a 4 x 4 x ½ inch sample of base layer
material(s), (2) a sample pair of inserts, and (3) a narrative description and photographs and/or
videos of the manufacturing process with the Coding Verification Application. Applications are
available on the PDAC website at https://www.dmepdac.com/

A copy of the PDAC Coding Verification Letter to the manufacturer / central fabrication facility,
approving the product as A5513, must be kept on file and be available to distributors, suppliers,
and CMS contractors upon request.

Practitioners who create custom fabricated inserts from raw materials for dispensing directly to
the end user (the beneficiary) are not required to have their insert listed on the PDAC website
to bill using code A5513. However, a coding verification request may be submitted to the
PDAC to ensure accuracy of the code for the item provided. If a Coding Verification Review is
requested, the information described above for manufacturers/ central fabrication facilities must
be provided.

Refer to the Therapeutic Shoes for Persons with Diabetes LCD (https://www.cms.gov/
medicare-coverage-database/details/lcd-details.aspx?LCDId=33369&ContrID=140) and
asp?articleId=52501&ContrID=140) for information about coverage, documentation, and coding
for these items

Suppliers are reminded to access the PDACs Durable Medical Equipment Coding System
(DMECS) https://www.dmepdac.com/dmecs/index.html for any questions regarding the
correct coding of products or call the PDAC Contact Center at 877-735-1326 between the hours
of 8:30 a.m. and 4:00 p.m. CT.

<table>
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<tr>
<th>Publication History</th>
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<tbody>
<tr>
<td>Publication Date: August 10, 2017</td>
</tr>
<tr>
<td>Revised: Adds information about the DMEPOS Quality Standards, Appendix C requirements for custom fabrication of A5513.</td>
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<tr>
<td>Originally Published September 2010</td>
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Intermittent urinary catheters are eligible for Medicare payment when the requirements described in the Urological Supplies Local Coverage Determination (LCD L33803 and related Policy Article (A52521) are met. Intermittent catheters are classified as "straight" or "coudé" catheters. Straight catheters are flexible and able to bend or adjust to the path of a urethra as it is used. In some clinical scenarios, the urethra is tortuous, constricted or twisted to a degree that makes it difficult to pass a typical straight catheter. In these situations, a coudé catheter is often used. A coudé catheter has a fixed, curved tip that allows it to more easily be moved through a tortuous urethra.

Recently, Coloplast introduced the SpeediCath® Flex Coudé Catheter. Although the term "coudé" is part of the product name, this item is a straight catheter without the characteristic permanent, curved tip that distinguishes a coudé catheter. The SpeediCath® Flex Coudé Catheter has a tip that is thinner and more flexible than the typical straight catheter. Despite the use of the term "coudé" as part of the product name, the SpeediCath® Flex Coudé Catheter is classified as a straight catheter. For Medicare billing purposes, the correct HCPCS code for this product is:

A4351 - INTERMITTENT URINARY CATHETER; STRAIGHT TIP, WITH OR WITHOUT COATING (TEFLON, SILICONE, SILICONE ELASTOMER, OR HYDROPHILIC, ETC.), EACH.

Claims for this item must not be submitted using HCPCS code A4352 [INTERMITTENT URINARY CATHETER; COUDÉ (CURVED) TIP, WITH OR WITHOUT COATING (TEFLON, SILICONE, SILICONE ELASTOMERIC, OR HYDROPHILIC, ETC.), EACH]. Billing Medicare for this item using A4352 or other HCPCS codes is incorrect coding.


Suppliers are reminded to access the PDACs Durable Medical Equipment Coding System (DMECS) https://www.dmedpac.com/dmecs/index.html for any questions regarding the correct coding of products or call the PDAC Contact Center at 877-735-1326 between the hours of 8:30 a.m. and 4:00 p.m. CT.
Dear Physician,

For certain specified items of durable medical equipment (listed on CMS's website, https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/FacetoFaceEncounterRequirementforCertainDurableMedicalEquipment.html), the Affordable Care Act requires:

1. An in-person, face-to-face examination with the treating practitioner (Medical Doctor (MD), Doctor of Osteopathic Medicine (DO) or Doctor of Podiatric Medicine (DPM), physician assistant (PA), nurse practitioner (NP) or clinical nurse specialist (CNS)) and,
2. The treating practitioner must document that the beneficiary was evaluated and/or treated for a condition that supports the need for the item(s) of DME ordered; and,
3. The face-to-face examination must have occurred sometime during the six (6) months prior to the date of the order for the item.

* The Medicare Access and SCHIP Reauthorization Act of 2015 eliminated the ACA requirement that the NP, PA, or CNS face-to-face examination documentation be co-signed by an MD or DO.

The purpose of this letter is to provide additional details of these requirements.

Medicare rules stipulate that a face-to-face examination meeting the requirements discussed below be performed each time a new prescription (i.e., written order) for one of the specified items is written. A new prescription is required by Medicare:

- For all claims for purchases or initial rentals
- If there is a change in the order for the accessory, supply, drug, etc.
- On a regular basis (even if there is no change in the order) only if it is so specified in the documentation section of a particular medical policy
- When an item is replaced
- When there is a change in the supplier, and the new supplier is unable to obtain a copy of a valid order and documentation from the original supplier.

These requirements are effective for all new Medicare orders for the specified items created on or after July 1, 2013.

**Prescription (order) Requirements**

ACA 6407 requires a specific written order prior to delivery for the specified items. This ACA 6407-required prescription has five (5) mandatory elements. The ACA 6407-required order is referred to as a 5-element order (5EO). The 5EO must meet all of the requirements below:

- The 5EO must include all of the following elements:
- Beneficiary’s name
- Item of DME ordered - this may be general – e.g., "hospital bed"– or may be more specific
- Signature of the prescribing practitioner
- Prescribing practitioner's National Practitioner Identifier (NPI)
- The date of the order
  - The 5EO must be completed within six (6) months after the required ACA 6047 face-to-face examination; and,
  - The date of the written order shall be on or before the date of delivery or date shipped if the shipping date is used as the date of service.

Note that a 5EO for these specified DME items require the National Provider Identifier to be included on the prescription. Prescriptions for other DME items do not have this NPI requirement.

**Face-to-face Examination Requirements**

For Medicare beneficiaries, the treating practitioner must have a face-to-face examination with the beneficiary in the six (6) months prior to the date of the written order for the specified items of DME.

This face-to-face requirement includes examinations conducted via the Centers for Medicare & Medicaid Services (CMS)-approved use of telehealth examinations (as described in Chapter 15 of the Medicare Benefit Policy Manual and Chapter 12 of the Medicare Claims Processing Manual - CMS Internet-Only Manuals, Publ. 100-02 and 100-04, respectively).

For the treating practitioner prescribing a specified DME item:

- The face-to-face examination with the beneficiary must be conducted within the six (6) months prior to the date of the prescription.
- The face-to-face examination must document that the beneficiary was evaluated and/or treated for a condition that supports the need for the item(s) of DME ordered.
- Remember that all Medicare coverage and documentation requirements for DMEPOS also apply. There must be sufficient medical information included in the medical record to demonstrate that the applicable coverage criteria are met. Refer to the applicable Local Coverage Determination for information about the medical necessity criteria for the item(s) being ordered.

The treating practitioner that conducted the face-to-face examination does not need to be the prescriber for the DME item; however, the prescriber must:

- Verify that the in-person visit occurred within the six (6) months prior to the date of their prescription; and,
- Have documentation of the face-to-face examination that was conducted.

**Date and Timing Requirements**

There are specific date and timing issues:

- The date of the face-to-face examination must be on or before the date of the 5EO and maybe no older than 6 months prior to the 5EO date.
- The date of the face-to-face examination must be on or before the date of delivery for the item(s) prescribed.
- The date of the 5EO (prescription) must be on or before the date of delivery or Date of Service (DOS).
- ALL DMEPOS suppliers must have the completed 5EO in their file BEFORE the delivery of these items.
All other date and timing requirements specified in the CMS Program Integrity Manual regarding specific items or services remain unchanged.

Upon request by the contractor, all DMEPOS suppliers must provide documentation from the qualifying face-to-face examination and the completed 5EO.

This letter is intended to be a general summary. It is not intended to take the place of the law, regulations, or national and local coverage determinations. Detailed information about these requirements can be found on the CMS website http://www.cms.gov or on the DME contractors’ website.

Sincerely,

Wilfred Mamuya, MD, PhD
Medical Director, DME MAC, Jurisdiction A
Noridian Healthcare Solutions

Robert D. Hoover, Jr., MD, MPH, FACP
Medical Director, DME MAC, Jurisdiction C
CGS Administrators, LLC

Stacey V. Brennan, MD, FAAFP
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Noridian Healthcare Solutions

PUBLICATION HISTORY

Publication Date: August 2017
Revised: Clarifies Date and Timing Requirements for documentation associated with 42 CFR 410.38(g)
Added: Link to CMS website in place of Table for items specified per 42 CFR 410.38(g)

Publication Date: April 2016
Update the criteria associated with the written order prior to delivery and face-to-face examination.

Original Publication Date: February and May 2014
Extension of the Transition to the Fully Adjusted Durable Medical Equipment Prosthetics, Orthotics, and Supplies Payment Rates Under Section 16007 of the 21st Century Cures Act


MLN Matters® Number: MM9968 Revised
Related CR Release Date: June 28, 2017
Related CR Transmittal #: R3801CP
Related Change Request (CR) #: CR 9968
Effective Date: July 1, 2016
Implementation Date: October 2, 2017

Note: This article was revised on June 29, 2017, to reflect the revised CR 9968 issued on June 28. As a result, the implementation date, CR release date, transmittal number, and the Web address of the CR in the article were revised. In addition, a RARC code for adjusted claims has been added. All other information remains the same.

Provider Types Affected
This MLN Matters® Article is intended for providers who bill Medicare Administrative Contractors (MACs) for Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) and services provided to Medicare beneficiaries.

Provider Action Needed
Change Request (CR) 9968 provides instructions regarding the implementation of revised 2016 DMEPOS fee schedule amounts based on changes mandated by Section 16007 of the 21st Century Cures Act. These changes relate to the new Chapter 20, Section 20.6 (Phase-In for Competitive Bidding Rates in Areas Not in a Competitive Bid Area) of the “Medicare Claims Processing Manual,” which is part of CR9968. Please make sure your billing staff is aware of these instructions.

Background
Effective January 1, 2017, legislation requires changes to the July and October 2016 fee schedule amounts for certain items. Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for certain DME items furnished on or after January 1, 2016, in areas that are not competitive bid areas, based on information from competitive bidding programs for DME.

Regulations at Section 414.210(g)(9) phased in these adjusted fees so that from January 1, 2016, through June 30, 2016, the fee schedule amount in non-bid areas was based on 50 percent of the adjusted payment amount established using competitive bidding information and 50 percent of the unadjusted fee schedule amount (the 2015 fee schedule amount updated by the 2016 covered item update). Beginning July 1, 2016, the fee schedule amounts for non-bid areas reverted to 100 percent of the adjusted payment amounts determined using competitive bidding information.

Section 16007 of the 21st Century Cures Act changes the 2016 fee schedule transition period so that payment based on 50 percent of the adjusted payment amount established using competitive bidding information and 50 percent of the unadjusted fee schedule amount extends from June 30, 2016, to December 31, 2016. Section 16007 also changes from July 1, 2016, to January 1, 2017, the date that payment based on 100 percent of the adjusted payment amounts in non-bid areas is effective.
To supplement Section 16007 for dates of service July 1, 2016, through December 31, 2016, the 50/50 blend fee schedules have been recalculated so that the adjusted portion of the payment blend utilizes July 1, 2016, adjusted fees. Also, the KE modifier fee schedules for items bid in the initial Round 1 Competitive Bidding Program (CBP) have been added back to the fee schedule file for this extended phase-in period. The KE modifier was added to the DMEPOS fee schedule file as part of the January 2009 fee schedule update and described items that were bid under the initial Round 1 CBP but were used with non-competitive bid base equipment. Suppliers should submit a request for reopening if their claim for dates of service between July 1, 2016, and December 31, 2016, should have been processed with the KE modifier.

The revised July 1, 2016, through December 31, 2016, DMEPOS and parenteral and enteral nutrition (PEN) fee schedule files will be made available to the DME MACs. The previously posted July 2016 and October 2016 DMEPOS and PEN public use files will be revised to reflect the new fee schedule amounts associated with the extension of the transition period. MACs will accept the KE modifier on the adjusted claims. In addition, for claims that the KE modifier would have been applicable to, the supplier may adjust the claim or notify MACs to adjust the claims after the mass adjustments for the 50/50 fee blend have been completed.

Your MAC will reprocess affected claims and adjust claims that were previously paid. The MACs will begin this claim adjustment process once the revised fee schedule files are available. MACs will use a Remittance Advice Remark Code (RARC) on the Cures Act claim adjustments for the dates of service that are being repriced in order to identify these claims. The RARC code for each of these claims is N689 - Alert: This reversal is due to a retroactive rate change.

Additional Information


If you have any questions, please contact your MAC at their toll-free number. That number is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/.

Document History

• February 17, 2017 – Initial article released.

• June 29, 2017 – Article revised to reflect the revised CR 9968 issued on June 28. As a result, the implementation date, CR release date, transmittal number, and the Web address of the CR in the article were revised. In addition, a RARC code for adjusted claims has been added. All other information remains the same.

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<td>Initial article released</td>
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<tr>
<td>June 29, 2017</td>
<td>Article revised to reflect the revised CR 9968 issued on June 28. As a result, the implementation date, CR release date, transmittal number, and the Web address of the CR in the article were revised. In addition, a RARC code for adjusted claims has been added. All other information remains the same.</td>
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Prohibition on Billing Dually Eligible Individuals Enrolled in the Qualified Medicare Beneficiary (QMB) Program

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


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

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

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

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

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

Implement key measures to ensure compliance with QMB billing requirements. Ensure that billing procedures and third-party vendors exempt individuals enrolled in the QMB program from Medicare charges. If you have erroneously billed an individual enrolled in the QMB program, recall the charges (including referrals to collection agencies) and refund the invalid charges he or she paid. For information about obtaining payment for Medicare cost-sharing, contact the Medicaid agency in the States in which you practice. Refer to the Background and Additional Information Sections below for further details and important steps to promote compliance.
Background
All original Medicare and MA providers and suppliers—not only those that accept Medicaid—must refrain from charging individuals enrolled in the QMB program for Medicare cost-sharing. Providers who inappropriately bill individuals enrolled in QMB are subject to sanctions. Providers and suppliers may bill State Medicaid programs for these costs, but States can limit Medicare cost-sharing payments under certain circumstances.

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

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

Note that certain types of providers may seek reimbursement for unpaid Medicare deductible and coinsurance amounts as a Medicare bad debt discussed in Chapter 3 of the Provider Reimbursement Manual (Pub.15-1).

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.

Ways to Promote Compliance with QMB Billing Rules
Take the following steps to ensure compliance with QMB billing prohibitions:

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

- MA providers and suppliers should also contact the MA plan to learn the best way to identify the QMB status of plan members.
- Providers and suppliers may also verify a patient’s QMB status through State online Medicaid eligibility systems or other documentation, including Medicaid identification cards and documents issued by the State proving the patient is enrolled in the QMB program.

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

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

   - If a claim is automatically crossed over to another payer, such as Medicaid, it is customarily noted on the Medicare RA.
   
   - Understand the processes you need to follow to request payment for Medicare cost-sharing amounts if they are owed by your State. You may need to complete a State Provider Registration Process and be entered into the State payment system.

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.
<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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<tr>
<td>QMB Plus</td>
<td>≤100% of FPL</td>
<td>Determined by State</td>
<td>Part A***</td>
<td>Meets financial and other criteria for full Medicaid benefits</td>
<td>• Full Medicaid coverage</td>
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<td>• 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)</td>
</tr>
</tbody>
</table>

* States can effectively raise these Federal income and resources criteria under Section 1902(r)(2) of the Act.

*** 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.

Additional Information

Document History

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<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>
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<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>
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Scheduled End of the Intravenous Immune Globulin (IVIG) Demonstration


**Provider Types Affected**
This MLN Matters Article is intended for suppliers submitting claims to Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for Intravenous Immune Globulin (IVIG) drugs and services provided to beneficiaries under the Medicare IVIG Demonstration. The article is also intended for physicians who may treat patients with primary immune deficiency syndrome that use IVIG.

**Provider Action Needed**

**STOP – Impact to You:**
This article is a reminder of the scheduled end date for the IVIG Demonstration.

**CAUTION – What You Need to Know:**
The IVIG Demonstration is a three-year demonstration that is scheduled to end September 30, 2017. **Since the demonstration ends on September 30, 2017, no payment will be made for the demonstration services** (Q2052- IVIG demonstration, services/supplies) **rendered after that date.** Claims submitted after that date for dates of service on/before September 30, 2017, will continue to be processed in accordance with the IVIG Demonstration guidelines. Please note that traditional Medicare fee for service will continue to pay for IVIG in the home but, once
the demonstration ends, will no longer pay for the services and supplies to administer the drug unless the beneficiary is receiving covered Medicare home health services. Medicare will be notifying beneficiaries enrolled in the demonstration about the ending of payment for Q2052 as the ending of the demonstration may result in beneficiaries making alternative arrangements to receive their IVIG.

Since the demonstration ends on September 30, the last date that beneficiaries can submit an application for enrollment in the demonstration is August 15, 2017. This application must be received by the IVIG Demonstration Support Contractor, Noridian, by this date either via fax or mail. Approved enrollments will be effective 9/1/17 allowing for IVIG services to be provided in the last month of the demonstration. Submission of an application does not guarantee that a beneficiary will be accepted to participate in the demonstration.

GO – What You Need to Do:

Make sure your billing staffs are aware of the end of the demonstration.

Background

The Medicare IVIG Access and Strengthening Medicare and Repaying Taxpayers Act of 2012 authorized a three-year demonstration under Part B of Title XVIII of the Social Security Act to evaluate the benefits of providing payment for items and services needed for the in-home administration of IVIG for the treatment of Primary Immune Deficiency Disease (PIDD).

Additional Information

For more information about the Medicare Intravenous Immune Globulin (IVIG) Demonstration, go to https://innovation.cms.gov/initiatives/ivig/. Additional information is also available on the Noridian IVIG website at https://med.noridianmedicare.com/web/ivig.

You may also want to review MLN Matters Article MM9746, which specifies the IVIG Demonstration payment rate of $354.60 for services rendered on or after January 1, 2017, through September 30, 2017, for code Q2052 (services, supplies, and accessories used in the home under the Medicare IVIG Demonstration).

If you have any questions, please contact your MAC at their toll-free number. That number is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/. For questions specific to the IVIG demonstration, you may want to contact Noridian at 1-844-625-6284, Monday-Friday 8:30 a.m. – 4 p.m. CT.

Document History

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<td>May 30, 2017</td>
<td>Initial article released</td>
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Disclaimer This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2016 American Medical Association. All rights reserved.
Hurricane Harvey and Medicare Disaster Related Texas Claims


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

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

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

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

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

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

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

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

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

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

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

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

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

### Blanket Waivers Issued by CMS

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

**Skilled Nursing Facilities**

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

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

**Home Health Agencies**

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


**Critical Access Hospitals**

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

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

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

**Emergency Durable Medical Equipment, Prosthetics, Orthotics, and Supplies for Medicare Beneficiaries Impacted by Hurricane Harvey**

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


**Application Deadline Extended for Reclassifications Submission to MGCRB**

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

**Deadline Extended for IPPS Wage Index Requests**

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

**Facilities Quality Reporting**

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

**Medicare-dependent small, rural hospitals (MDHs)**

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

**Low-volume hospital**

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

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

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

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

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

**Moratoria on Part B Non-emergency Ambulance Suppliers**

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

**Requesting an 1135 Waiver**

Information for requesting an 1135 waiver, when a blanket waiver hasn’t been approved, can

**Additional Information**

If you have any questions, please contact your MAC at their toll-free number. That number is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/.

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


**Document History**

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**Disclaimer:** This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2016 American Medical Association. All rights reserved.
Tropical Storm Harvey and Medicare Disaster Related Louisiana Claims


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

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

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

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

Background

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

1. Change Request (CR) 6451 (Transmittal 1784, Publication 100-04) issued on July 31, 2009, applies to items and services furnished to Medicare beneficiaries within the State of Louisiana from August 27, 2017, for the duration of the emergency. In accordance with CR6451, use of the "DR" condition code and the "CR" modifier are mandatory on claims for items and services for which Medicare payment is conditioned on the presence of a "formal waiver" including, but not necessarily limited to, waivers granted under either Section 1135 or Section 1812(f) of the Act.
2. The most current information can be found at [https://www.cms.gov/emergency](https://www.cms.gov/emergency). Medicare FFS Questions & Answers (Q&As) posted in the downloads section at the bottom of the Emergency Response and Recovery webpage and also referenced below are applicable for items and services furnished to Medicare beneficiaries within the State of Louisiana. These Q&As are displayed in two files:

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

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

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

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

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

**Blanket Waivers Issued by CMS**

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

**Skilled Nursing Facilities**

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

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

**Home Health Agencies**

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


**Critical Access Hospitals**

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

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

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

**Emergency Durable Medical Equipment, Prosthetics, Orthotics, and Supplies for Medicare Beneficiaries Impacted by Hurricane Harvey**

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


**Application Deadline Extended for Reclassifications Submission to MGCRB**

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

**Deadline Extended for IPPS Wage Index Requests**

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

**Facilities Quality Reporting**

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

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

Low-volume hospital

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

Appeal Administrative Relief for Areas Affected by Tropical Storm Harvey

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

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

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

Requesting an 1135 Waiver

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

Additional Information

If you have any questions, please contact your MAC at their toll-free number. That number is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/.

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

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Disclaimer: This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2016 American Medical Association. All rights reserved.

Hurricane Irma and Medicare Disaster Related United States Virgin Islands, Commonwealth of Puerto Rico and State of Florida Claims


MLN Matters® Number: SE17022 Revised
Article Release Date: September 19, 2017
Related CR Transmittal Number: N/A
Related Change Request (CR) Number: N/A
Effective Date: N/A
Implementation Date: N/A

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

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


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

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

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

Background

Section 1135 and Section 1812(f) Waivers

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

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

2. The most current information can be found at https://www.cms.gov/emergency. Medicare FFS Questions & Answers (Q&As) posted in the downloads section at the bottom of the Emergency Response and Recovery webpage and also referenced below are applicable for items and services furnished to Medicare beneficiaries within the United States Virgin Islands, Commonwealth of Puerto Rico and State of Florida. These Q&As are displayed in two files:
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The second file addresses policies and procedures that are applicable only with approved Section 1135 waivers or, when applicable, approved Section 1812(f) waivers. These Q&As are applicable for approved Section 1135 blanket waivers and approved individual 1135 waivers requested by providers and are effective September 5, 2017, for the United States Virgin Islands and Commonwealth of Puerto Rico and September 4, 2017, for the State of Florida.

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

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

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

Blanket Waivers Issued by CMS

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

Skilled Nursing Facilities

- Section 1812(f): Waiver of the requirement for a 3-day prior hospitalization for coverage of a skilled nursing facility (SNF) stay provides temporary emergency coverage of SNF services without a qualifying hospital stay, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of Hurricane Irma in the United States Virgin Islands, Commonwealth of Puerto Rico and State of Florida in 2017. In addition, for certain beneficiaries who recently exhausted their SNF benefits, it authorizes renewed SNF coverage without first having to start a new benefit period. (Blanket waiver for all impacted facilities)
- 42 CFR 483.20: Waiver provides relief to Skilled Nursing Facilities on the timeframe requirements for Minimum Data Set assessments and transmission. (Blanket waiver for all impacted facilities)

Home Health Agencies

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

Critical Access Hospitals

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

Housing Acute Care Patients In Excluded Distinct Part Units

CMS has determined it is appropriate to issue a blanket waiver to IPPS hospitals that, as a result of Hurricane Irma, need to house acute care inpatients in excluded distinct part units, where the distinct part unit’s beds are appropriate for acute care inpatient. The IPPS hospital should bill for the care and annotate the patient’s medical record to indicate the patient is an acute care inpatient being housed in the excluded unit because a result of Hurricane Irma, need to house acute care inpatients in excluded distinct part units, where the distinct part unit’s beds are appropriate for acute care inpatient. The IPPS hospital should bill for the care and annotate the patient’s medical record to indicate the patient is an acute care inpatient being housed in the excluded unit because of capacity issues related to Hurricane Irma. (Blanket waiver for all IPPS hospitals located in the affected areas that need to use distinct part beds for acute care patients as a result of the hurricane.)
Care for Excluded Inpatient Psychiatric Unit Patients in the Acute Care Unit of a Hospital – This information added on September 19, 2017.

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

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

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

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

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


Facilities Quality Reporting – This information added on September 19, 2017.

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

Appeal Administrative Relief for Areas Affected by Hurricane Irma

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

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

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

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

Additional Information
If you have any questions, please contact your MAC at their toll-free number. That number is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/.

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


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Hurricane Irma and Medicare Disaster Related South Carolina and Georgia Claims

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

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

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

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

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

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

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

Blanket Waivers Issued by CMS

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

Skilled Nursing Facilities
- Section 1812(f): Waiver of the requirement for a 3-day prior hospitalization for coverage of a skilled nursing facility (SNF) stay provides temporary emergency coverage of SNF services without a qualifying hospital stay, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of Hurricane Irma in the States of South Carolina and Georgia in 2017. In addition, for certain beneficiaries who recently exhausted their SNF benefits, it authorizes renewed SNF coverage without first having to start a new benefit period. (Blanket waiver for all impacted facilities)
- 42 CFR 483.20: Waiver provides relief to Skilled Nursing Facilities on the timeframe requirements for Minimum Data Set assessments and transmission. (Blanket waiver for all impacted facilities)

Home Health Agencies
- 42 CFR 484.20(c)(1): This waiver provides relief to Home Health Agencies on the timeframes related to OASIS Transmission. (Blanket waiver for all impacted agencies)
Critical Access Hospitals
This action waives the requirements that Critical Access Hospitals limit the number of beds to 25, and that the length of stay be limited to 96 hours. (Blanket waiver for all impacted hospitals)

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

Care for Excluded Inpatient Psychiatric Unit Patients in the Acute Care Unit of a Hospital – This information added on September 19, 2017.
CMS has determined it is appropriate to issue a blanket waiver to IPPS and other acute care hospitals with excluded distinct part inpatient psychiatric units that, as a result of Hurricane Irma, need to relocate inpatients from the excluded distinct part psychiatric unit to an acute care bed and unit. The hospital should continue to bill for inpatient psychiatric services under the inpatient psychiatric facility prospective payment system for such patients and annotate the medical record to indicate the patient is a psychiatric inpatient being cared for in an acute care bed because of capacity or other exigent circumstances related to the hurricane. This waiver may be utilized where the hospital’s acute care beds are appropriate for psychiatric patients and the staff and environment are conducive to safe care. For psychiatric patients, this includes assessment of the acute care bed and unit location to ensure those patients at risk of harm to self and others are safely cared for.

Care for Excluded Inpatient Rehabilitation Unit Patients in the Acute Care Unit of a Hospital – This information added on September 19, 2017.
CMS has determined it is appropriate to issue a blanket waiver to IPPS and other acute care hospitals with excluded distinct part inpatient Rehabilitation units that, as a result of Hurricane Irma, need to relocate inpatients from the excluded distinct part Rehabilitation unit to an acute care bed and unit. The hospital should continue to bill for inpatient rehabilitation services under the inpatient rehabilitation facility prospective payment system for such patients and annotate the medical record to indicate the patient is a rehabilitation inpatient being cared for in an acute care bed because of capacity or other exigent circumstances related to the hurricane. This waiver may be utilized where the hospital’s acute care beds are appropriate for providing care to rehabilitation patients and such patients continue to receive intensive rehabilitation services.

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

Appeal Administrative Relief for Areas Affected by Hurricane Irma

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

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

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

Requesting an 1135 Waiver

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

Additional Information

If you have any questions, please contact your MAC at their toll-free number. That number is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/.

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


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Hurricane Maria and Medicare Disaster Related United States Virgin Islands and Commonwealth of Puerto Rico Claims


MLN Matters® Number: SE17028  Related Change Request (CR) Number: N/A
Article Release Date: September 21, 2017  Effective Date: N/A
Related CR Transmittal Number: N/A  Implementation Date: N/A

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

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

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

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

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

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

from September 17, 2017, for the duration of the emergency. In accordance with CR6451, use of the “DR” condition code and the “CR” modifier are mandatory on claims for items and services for which Medicare payment is conditioned on the presence of a “formal waiver” including, but not necessarily limited to, waivers granted under either Section 1135 or Section 1812(f) of the Act.

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

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

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

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

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

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Blanket Waivers Issued by CMS

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

Skilled Nursing Facilities

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

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

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

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

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

Appeal Administrative Relief for Areas Affected by Hurricane Maria

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MEDICAL POLICY

Policy Article Revisions Summary for June 1, 2017


Posted on June 1, 2017

Outlined below are the principal changes to the DME MAC Policy Article (PA), Standard Documentation Requirements for All Claims Submitted to the DME MACs, that has been revised and posted. Please review the entire PA for complete information.

Standard Documentation Requirements for All Claims Submitted to DME MACs


Revision Effective Date: 06/01/2017

PROOF OF DELIVERY:
• Revised: Corrects clerical error introduced with 01/01/2017 version. Language reverts to original three methods of delivery found in 04/28/16 version of SDL article.

Note: The information contained in this article is only a summary of revisions to the LCDs and Policy Articles. For complete information on any topic, you must review the LCDs and/or Policy Articles.

Policy Article Revision Summary for June 8, 2017

Link to current version on the CGS website: https://www.cgsmedicare.com/articles/cope3418.html

Posted on June 8, 2017

Outlined below are the principal changes to the DME MAC Policy Article (PA), Standard Documentation Requirements for All Claims Submitted to the DME MACs, that has been revised and posted. Please review the entire PA for complete information.

Standard Documentation Requirements for All Claims Submitted to DME MACs


Revision Effective Date: 06/01/2017

REFILL REQUIREMENTS:
• Revised: Deleted refill requirements that are policy specific and are currently located in the applicable LCDs

Note: The information contained in this article is only a summary of revisions to the LCDs and Policy Articles. For complete information on any topic, you must review the LCDs and/or Policy Articles.
LCD and Policy Article Summary for June 8, 2017 – Drafts Released to Final


Draft Surgical Dressings Local Coverage Determination and Policy Article have been finalized.

The medical policy will be effective for claims with dates of service on or after July 24, 2017. The notice period start date is June 8, 2017 and the notice period end date is July 23, 2017.

Surgical Dressings

LCD

Revision Effective Date: 07/24/2017

COVERAGE INDICATIONS, INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

• Removed: Standard Documentation Language
• Added: New reference language and directions to Standard Documentation Requirements
• Added: General Requirements
• Revised: Refill Requirements

DOCUMENTATION REQUIREMENTS:

• Removed: Standard Documentation Language
• Added: General Documentation Requirements
• Added: New reference language and directions to Standard Documentation Requirements

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:

• Removed: Standard Documentation Language
• Added: Direction to Standard Documentation Requirements
• Removed: Supplier Manual reference from Miscellaneous section
• Removed: PIM reference under Appendices
• Revised: Pressure ulcer staging criteria per NPUAP 2016 Staging Consensus Conference

SOURCES OF INFORMATION AND BASIS FOR DECISION:

• Revised: Updated bibliography

RELATED LOCAL COVERAGE DOCUMENTS:

• Added: LCD-related Standard Documentation Requirements article

Policy Article


Revision Effective Date: 07/24/2017

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:

• Added: Order and Modifier requirements

RELATED LOCAL COVERAGE DOCUMENTS:

• Added: LCD-related Standard Documentation Requirements Language Article

Review the entire LCD, the related Policy Article, and the Standard Documentation Requirements Article for coverage, coding and documentation requirements.

The Response to Comments Summary is attached to the LCD.
Surgical Dressings Comments and Response
Summary – Revised

- DME MAC Joint Publication


2015 Draft LCD Released for Comment August 2015
Originally Published: June 8, 2017
Revised: September 7, 2017

Removal of the Phrase “Usual” with Respect to Frequency of Dressing Changes
Multiple comments noted that removal of the term “usual” with respect to frequency of wound dressings is ambiguous, lacks clarity, and removes a clinician’s ability to use their clinical judgement to provide appropriate wound care - leading to a restriction of coverage. The recommendation was to continue the prior LCD language, specifically by reinstating usage of the term “usual” regarding the frequency of dressing changes.

Response: The statutorily-based coverage requirements regarding the specific types of wounds and sites that are eligible for reimbursement are unchanged in the posted draft policy. Likewise, none of the policy-based criteria pertaining to the choice of dressing were changed in this draft. Removal of the term “usual” does not remove or restrict the use of clinical judgment, but rather serves to clarify utilization parameters by removing ambiguous terminology.

Honey, Silver, Copper and Iodine Dressings are Safe and Efficacious
Multiple comments that there is sufficient evidence that honey, silver, copper and iodine dressings are safe and efficacious, and that the assignment of A4649 to these products ignores FDA approval of these dressings.

Response: The primary action of these substances is widely perceived to be antimicrobial agents. Claims by the manufacturer for direct antimicrobial effect in the wound would require these substances to receive FDA clearance as a drug rather than as a substance included in a surgical dressing. In the 510(k) process the FDA does not directly assess safety and efficacy of individual surgical dressing materials.

Longstanding statutory requirements exclude antiseptics, antimicrobials and numerous other substances from Medicare coverage as surgical dressings. This LCD revision separates dressings that are primarily composed of these non-covered materials from dressings primarily composed of covered material(s) to allow for more precise HCPCS coding and for correct claim processing.

Use of Clinically Predominant Component of a Dressing Instead of the 50% by Weight Classification in the Coding Guidelines Section of the Related Policy Article
Multiple comments were received that the assignment of A4649 to products containing honey should not be based on the weight-based standard, but rather on the clinically predominant component of the product.

Response: The DME MACs appreciate the comments on the coding guideline for multi-
component dressings. Coding Guidelines, documentation requirements and non-medical necessity coverage and payment rules contained in the LCD-related Policy Articles are not subject to LCD notice and comment requirements. This information was included in the published draft policy to provide relevant contextual information necessary for complete understanding of the reasonable and necessary provisions in the draft LCD.

**Inpatient Facilities Will not be Able to Provide Care to Prevent Pressure Ulcers**

Multiple comments were received that skilled nursing facilities (SNFs) and Long Term Care Facilities (LTCs) will not be able to provide needed care to prevent pressure ulcers, thus becoming non-compliant with relevant Surveyor Guidelines to prevent pressure ulcers.

**Response:** Medicare is a defined benefit program. For any item to be eligible for payment, the item must first be eligible for inclusion into one of the statutorily-established benefit categories. The Medicare Surgical Dressings Benefit provides the definition of covered dressings that are eligible for dressing reimbursement (see CMS Internet Only Manual (IOM), Publication 100-02, *Benefit Policy Manual*, Chapter 15, Section 100). The Surgical Dressings Benefit does not provide coverage of surgical dressings once a wound is healed or for the prevention of pressure ulcers.

In addition, prevention of pressure ulcers involves a multi-factorial approach which includes bedside care such as ensuring adequate nutrition and hydration, frequent repositioning, use of specialized pressure-reducing mattresses, and addressing moisture and continence. These care measures are not impacted by the Surgical Dressing Draft LCD.

**The Bibliography was Incomplete and Should be Exhaustive**

Several comments were received that stated the bibliography was inadequate since it was not an exhaustive listing of references. Several commenters included references to published articles.

**Response:** CMS provides guidance to contractors on the development of LCDs in the *Program Integrity Manual* (see CMS IOM 100-08, Chapter 13). CMS does not require that a bibliography be exhaustive, but rather should reflect the relevant articles, clinical guidelines, and other scientific publications which inform the authors when writing LCDs. The revised bibliography section in the final LCD incorporates references cited by commenters, together with an updated literature review.

**Mugard® Mucoadhesive Oral Wound Rinse Should be Covered in the Surgical Dressings LCD Because of its Clinical Effectiveness in Treating Oral Mucositis**

Multiple comments and testimonial letters were received supporting this was effective in treating oral mucositis and that it should be covered in the surgical dressings LCD.

**Response:** Oral mucositis is not considered to be a “qualifying wound” under the Medicare Surgical Dressings Benefit. The DME MACs published a Correct Coding and Coverage article entitled "Oral Suspensions Used in The Treatment of Oral Mucosal Injuries" on July 20, 2016 which explains the coverage requirements in more detail. The article can be found on the DME MACs web sites.

**Coverage of Dressings Should be Based on the Clinical Stage of the Wound**

Multiple comments that coverage of surgical dressings should be based on the clinical staging of the wound
Response: Wound staging as a clinical classification tool only applies to pressure ulcers. The Medicare Surgical Dressings Benefit includes surgically-created wounds, surgically-modified wounds, as well as any wound that requires debridement as qualifying wounds. Although pressure ulcers are among the most commonly debrided wounds, there are other wound types such as venous stasis ulcers and arterial insufficiency ulcers that may require surgical intervention and/or debridement. Describing coverage only in terms of pressure ulcer staging would not include these other eligible wound types.

Restricting Usage of Dressings to Stage 3 and 4 Ulcers

Several comments were made that the language regarding foam, collagen, and hydrogel dressings restricted their use to stage 3 and 4 ulcers.

Response: Each dressing type is separately addressed.

- Coverage criteria related to wound staging for foam dressings have not changed from the draft LCD, and remain covered for stage III and IV full thickness wounds,
- Collagen dressings are a new addition to this LCD and thus have no prior coverage statement in the previous version of the policy. The current wound depth criterion reflects generally recommended standards.
- The hydrogel dressing coverage requirements in the previous version indicated that these dressings were, “...not usually medically necessary for stage II ulcers.” Additional documentation was required for consideration of coverage on a case-by-case basis. When this language was included in the policy, these determinations were made at initial claim submission. Individual consideration i.e., a case-by-case consideration for coverage when an item is considered to be not medically necessary is still available. CMS now requires this exception assessment process to occur at the Redetermination level of the appeals process not with the initial claim submission, as was the previous procedure. Thus, although the language indicating the availability of exceptions for this specific product has been removed, the available alternative via the appeals process results in no real change in coverage for hydrogel dressings used on stage II ulcers.

Clarify Language on Recommended Frequency of Dressing Change

One comment was made that the change frequencies of recommended dressing changes should be modified from “the change frequencies of the individual products should be considered and ideally help to extend the wear of the individual dressings.” to instead read “the change frequencies of the individual products should be considered and ideally help to extend the wear-time of the individual products.”

Response: Language in the draft LCD, which is unchanged from the current active LCD, does take into consideration the variance of change frequency among different products. Specifically, the draft LCD states:

“When combinations of primary dressings, secondary dressings, and wound filler are used, the change frequencies of the individual products should be similar. For purposes of this policy, the product in contact with the wound determines the change frequency. It is not reasonable and necessary to use a combination of products with differing change intervals.” [Emphasis added]"
Weekly coverage of wounds using zinc paste-impregnated bandages reflects general frequency changes as per usual clinical practice and manufacturers’ recommendations. For those situations where a greater frequency of dressing changes is necessary, an individual consideration process is available.

The LCD Increases the Administrative Burden on Providers.
Several comments were received that the documentation requirements in the LCD would increase the administrative burden on providers.

Response: Documentation requirements, as described in Section 1833(e) of the Social Security Act, precludes payment to any provider of services unless “there has been furnished such information as may be necessary to determine the amounts due such provider.” The draft LCD does not introduce new requirements nor change any of the long-standing documentation requirements present in the current active LCD.

Use of Compression Bandages and Stockings for Venous Ulcers
Several comments were received that coverage of elastic bandages and compression stockings be available for venous ulcers to prevent recurrence and therapy for lymphedema.

Response: Compression dressings are covered for use on qualified wounds. A venous ulcer that meets the statutory benefit requirements to be classified as a qualifying wound would be eligible for dressing coverage. Compression items used for the treatment of edema often associated with venous ulcers are outside of the scope of the Medicare Surgical Dressings Benefit.

Choice of Secondary Dressing
One comment that the LCD provides no coverage for secondary dressings for minimally draining wounds other than gauze and thin films, which does not follow NPUAP Practice Guidelines

Response: The draft LCD does not introduce new requirements nor change any of the long-standing coverage requirements present in the current active LCD.

Use of HCPCS Codes to Determine Coverage
One comment that the existence or absence of HCPCS codes identify specific products or ingredients in their descriptions is not determinative of coverage and should not be used as such.

Response: We agree. HCPCS codes, by themselves, do not determine coverage. HCPCS codes describe products. These codes are used by payors for billing. Medicare, and other payors, assign their own payment rules and pricing to HCPCS codes to allow for automation during claim processing. When a product is assigned to an existing HCPCS code, it inherits the payor’s payment rules associated with the code.

Documentation Requirements do not Comply with Medicare Program Instructions
One comment that neither the Program Integrity Manual nor all four DME MACs’ Supplier Manuals address the need for the order (both detailed and preliminary) or the provider’s medical record to specify the size of the dressing. Hence, we request the language requiring “the size of the dressing” under Policy Specific Documentation be removed.

Response: Medicare requires that all items billed must have a prescription before delivery and a detailed order that specifies the item or HCPCS code for the item before billing. Many of the surgical dressing HCPCS codes include long descriptors that specify specific dressing size. Consequently, it is expected the provider’s medical record justifies the dressing quantity and sizes, based on the clinical characteristics of the wound.
Alternate Methods to Determine the “Clinically Predominant” Component for Multi-Component Products

One comment that there are recognized standardized tests which can be performed to evaluate the clinically predominant component for coding decisions. Offer is given to share their expertise.

Response: The DME MACs are always willing to entertain alternatives to existing policy requirements. Refer to the DME MAC web sites for information about how to request changes.

Note

Since the posting of the Draft LCD, the Open Public Meeting and the Notice-and-Comment period in 2015, a major format change has been made to all DME MAC LCDs. This change involves removing standard documentation language from the LCD and moving the Policy Specific Documentation language to the related Policy Article. The standard documentation information has been moved to a stand-alone article (A55426), which is attached to each LCD. The final version of the Surgical Dressings LCD incorporates these changes to be consistent with other DME MAC LCDs for all 4 DME jurisdictions.

Publication History

Publication Date: September 7, 2017
Correspondence was received that indicated that in the “Response to Comments and Response Summary” erroneously stated that there was no change in coverage requirements for hydrogel dressings. The response to the section “Restricting Usage of Dressings to Stage 3 and 4 Ulcers” has been revised to better explain the non-coverage statement of hydrogel for stage II wounds in this version of the LCD.

Publication Date: June 8, 2017
Originally Published

LCD and Policy Article Revisions Summary for June 29, 2017


Posted on June 29, 2017

Outlined below are the principal changes to the DME MAC Local Coverage Determinations (LCDs) and Policy Articles (PAs) that have been revised and posted. The policy included is External Infusion Pumps. Please review the entire LCD and related PA for complete information.

External Infusion Pumps

LCD

Revision Effective Date: 01/01/2017

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
• Revised: Typographical error K0522 to correct code of K0552
• Added: Coverage for Cuvitru (J7799) - effective 9/13/2016

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
• Revised: verbiage “prior to” to “to justify” Medicare reimbursement
Policy Article

Revision Effective Date: 01/01/2017
CODING GUIDELINES:
• Revised: A4221 descriptor to include subcutaneous infusion catheter
• Revised: Typographical error K0522 to correct code of K0552
• Added: Coding guidelines for Cuvitru (J7799) - effective 9/13/2016

Note: The information contained in this article is only a summary of revisions to the LCDs and Policy Articles. For complete information on any topic, you must review the LCDs and/or Policy Articles.

LCD and Policy Article Revisions Summary for August 24, 2017


Outlined below are the principal changes to the DME MAC Local Coverage Determination (LCD) and Policy Article (PA) for Wheelchair Seating that has been revised and posted. Please review the entire LCD and related PA for complete information.

Wheelchair Seating

LCD

Revision Effective Date: 01/01/2017
ICD-10 CODES THAT SUPPORT MEDICAL NECESSITY:
• Added: Z codes for acquired absence of limb to Group 3 and Group 4 Diagnosis Codes

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
• Clarified: Verbiage in Policy Specific Documentation Requirements

08/24/2017: At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.

Policy Article

Revision Effective Date: 01/01/2017
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
• Added: 42 CFR 410.38(g) language, previously in Policy Specific Documentation Requirements section

Note: The information contained in this article is only a summary of revisions to the LCDs and Policy Articles. For complete information on any topic, you must review the LCDs and/or Policy Articles.
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)

MLN Matters® Number: MM9893 Revised
Related CR Release Date: June 6, 2017
Related CR Transmittal #: R1857OTN
Related Change Request (CR) #: CR 9893
Effective Date: October 1, 2017
Implementation Date: October 2, 2017

Note: This article was revised on June 9, 2017, due to the release of an updated Change Request (CR). The CR date, transmittal number and the link to the transmittal changed. All other information remains the same.

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

What You Need to Know
This article is based on CR 9893. To comply with the Government Accountability Office (GAO) final report entitled Medicare Secondary Payer (MSP): Additional Steps Are Needed to Improve Program Effectiveness for Non-Group Health Plans (GAO 12-333), the Centers for Medicare & Medicaid Services (CMS) will establish two (2) new set-aside processes: a Liability Insurance Medicare Set-Aside Arrangement (LMSA), and a No-Fault Insurance Medicare Set-Aside Arrangement (NFMSA). An LMSA or an NFMSA is an allocation of funds from a liability or an auto/no-fault related settlement, judgment, award, or other payment that is used to pay for an individual's future medical and/or future prescription drug treatment expenses that would otherwise be reimbursable by Medicare.

Please be sure your billing staffs are aware of these changes.

Background
CMS will establish two (2) new set-aside processes: a Liability Medicare Set-aside Arrangement (LMSA), and a No-Fault Medicare Set-aside Arrangement (NFMSA).

CR 9893 addresses (1) the policies, procedures, and system updates required to create and utilize an LMSA and an NFMSA MSP record, similar to a Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) MSP record, and (2) instructs the MACs and shared systems when to deny payment for items or services that should be paid from an LMSA or an NFMSA fund.

Pursuant to 42 U.S.C. Sections 1395y(b)(2) and 1862(b)(2)(A)(ii) of the Social Security Act, Medicare is precluded from making payment when payment “has been made or can reasonably be expected to be made under a workers’ compensation plan, an automobile or liability insurance policy or plan (including a self-insured plan), or under no-fault insurance.” Medicare
does not make claims payment for future medical expenses associated with a settlement, judgment, award, or other payment because payment “has been made” for such items or services through use of LMSA or NFMSA funds. However, Liability and No-Fault MSP claims that do not have a Medicare Set-Aside Arrangement (MSA) will continue to be processed under current MSP claims processing instructions.

**Key Points of CR9893**

Medicare will not pay for those services related to the diagnosis code (or related within the family of diagnosis codes) associated with the open LMSA or NFMSA MSP record when the claim’s date of service is on or after the MSP effective date and on or before the MSP termination date. Your MAC will deny such claims using Claim Adjustment Reason Code (CARC) 201 and Group Code “PR” will be used when denying claims based on the open LMSA or NFMSA MSP auxiliary record.

In addition to CARC 201 and Group Code PR, when denying a claim based upon the existence of an open LMSA or NFMSA MSP record, your MAC will include the following Remittance Advice Remark Codes (RARCs) as appropriate to the situation:

- N723—Patient must use Liability Set Aside (LSA) funds to pay for the medical service or item.
- N724—Patient must use No-Fault Set-Aside (NFSA) funds to pay for the medical service or item.

Where appropriate, MACs may override and make payment for claim lines or claims on which:

- Auto/no-fault insurance set-asides diagnosis codes do not apply, or
- Liability insurance set-asides diagnosis codes do not apply, or are not related, or
- When the LMSA and NFMSA benefits are exhausted/terminated per CARC or RARC and payment information found on the incoming claim as cited in CR9009.

On institutional claims, if the MAC is attempting to allow payment on the claim, the MAC will include an “N” on the ‘001’ Total revenue charge line of the claim.

**Additional Information**


If you have any questions, please contact your MAC at their toll-free number. That number is available at [https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/](https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/).

**Document History**

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<td>February 17, 2017</td>
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Guidance on Implementing System Edits for Certain Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)


MLN Matters® Number: MM9904 Revised
Related CR Release Date: November 6, 2013
Related CR Transmittal #: R1910OTN

Related Change Request (CR) #: CR 9904
Effective Date: July 1, 2017
Implementation Date: October 2, 2017

**Note:** This article was revised on August 18, 2017, to reflect an updated Change Request (CR). The CR changed the July analysis implementation date and revised the codes used for denied claims. The CR release date, transmittal number and link to the CR also changed. All other information remains the same.

**Provider Types Affected**

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

**Provider Action Needed**

CR9904 updates CR7333 and CR9371 and informs MACs about changes related to Section 302 of the Medicare Modernization Act of 2003 (MMA). Section 302 added a new paragraph to the Social Security Act (the Act), Section 1834(a)(20) requiring the Secretary to establish and implement quality standards for suppliers of DMEPOS.

All DMEPOS suppliers that furnish such items or services required in the new paragraph, as the Secretary determines appropriate, must comply with the quality standards in order to receive Medicare Part B payments and to retain a supplier billing number. The covered items and services are defined in the Act.

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) added a new subparagraph for implementing quality standards which state the Secretary shall require suppliers furnishing items and services on or after October 1, 2009, directly or as a subcontractor for another entity, to have submitted evidence of accreditation by an accreditation organization designated by the Secretary. Make sure that your billing staffs are aware of these changes.

**Background**

Pursuant to subparagraph 1834(a)(20)(D) of the Act, the covered items and services are defined in Section 1834(a)(13), Section 1834(h)(4), and Section 1842(s)(2) of the Act. The covered items include:

- DME
• Medical supplies
• Home dialysis supplies and equipment
• Therapeutic shoes
• Parenteral and enteral nutrient, equipment and supplies
• Transfusion medicine
• Devices, prosthetics, and orthotics

Section 154(b) of MIPPA added a new subparagraph (F) to Section 1834(a)(20) of the Act. In implementing quality standards under this paragraph, the Secretary shall require suppliers furnishing items and services on or after October 1, 2009, directly or as a subcontractor for another entity, to have submitted evidence of accreditation by an accreditation organization designated by the Secretary. This subparagraph states that eligible professionals and other persons (defined below) are exempt from meeting the September 30, 2009, accreditation deadline unless the Centers for Medicare & Medicaid Services (CMS) determines that the quality standards are specifically designed to apply to such professionals and persons. The eligible professionals who are exempt from meeting the September 30, 2009, accreditation deadline (as defined in Section 1848(k)(3)(B)) include the following practitioners:

• Physicians (as defined in Section 1861(r) of the Act)
• Physical Therapists
• Occupational Therapists
• Qualified Speech-Language Pathologists
• Physician Assistants
• Clinical Nurse Specialists
• Certified Registered Nurse Anesthetists
• Certified Nurse-Midwives
• Clinical Social Workers
• Clinical Psychologists
• Registered Dietitians
• Nutritional professionals

Section 154(b) of MIPPA allows the Secretary to specify “other persons” that are exempt from meeting the accreditation deadline unless CMS determines that the quality standards are specifically designed to apply to such other persons. At this time, “such other persons” are specifically defined as the following practitioners:

• Orthotists
• Prosthetists
• Opticians
• Audiologists

All supplier types (except those listed above) who furnish items and services requiring accreditation, directly or as a subcontractor for another entity, must have submitted evidence of accreditation by an accreditation organization designated by the Secretary on or after October 1, 2009.

Medicare systems will have edits to check for accreditation on claims with HCPCS codes in the product categories designated by MIPPA as requiring accreditation. The edits will deny claims for these codes unless the DMEPOS supplier has been identified as accredited and verified on their CMS-855S or the DMEPOS supplier is currently exempt from meeting the accreditation requirements.
Denied Claims
MACs will use Claim Adjustment Reason Code (CARC) B7 and Remittance Advice Remark Code (RARC) N211 and RARC N790 for denial:

- **CARC B7** - This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- **RARC N211** - Alert: You may not appeal this decision.
- **RARC N790** - Provider/supplier not accredited for product/service
- **Group Code**: CO - Contractual Obligation

Additional Information

If you have any questions, please contact your MAC at their toll-free number. That number is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/.

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Qualified Medicare Beneficiary Indicator in the Medicare Fee-For-Service Claims Processing System


MLN Matters® Number: MM9911 Revised
Related CR Release Date: June 28, 2017
Related CR Transmittal #: R3802CP
Related Change Request (CR) #: CR 9911
Effective Date: for claims processed on or after October 2, 2017
Implementation Date: October 2, 2017

Note: This article was revised on July 24, 2017, to add links to related MLN Matters Articles. SE1128 reminds all Medicare providers that they may not bill beneficiaries enrolled in the QMB program for Medicare cost-sharing. MM9817 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. 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.


If you have any questions, please contact your MAC at their toll-free number. That number is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/.
Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP), and PC Print Update

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MLN Matters® Number: MM10040
Related Change Request (CR) Number: 10040
Related CR Release Date: May 26, 2017
Effective Date: October 1, 2017
Related CR Transmittal #: R3780CP
Implementation Date: October 2, 2017

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

Provider Action Needed
Change Request (CR) 100040 updates the remittance advice remark code (RARC) and claims adjustment reason code (CARC) lists and also instruct ViPS Medicare System (VMS) and Fiscal Intermediary Shared System (FISS) maintainers to update Medicare Remit Easy Print (MREP) and PC Print. Make sure that your billing 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 (HIPAA) of 1996 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.

CMS provides a CR as a code update notification indicating when updates to CARC and RARC lists are made available on the Washington Publishing Company (WPC) website. Shared System Maintainers (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 WPC website. If any new or modified code has an effective date past the implementation date specified in the CR, MACs must implement those updates on the date specified on the WPC website, which is 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. For CR10040, 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 (CR 9878).

Additional Information


If you have any questions, please contact your MAC at their toll-free number. That number is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/.

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


MLN Matters® Number: MM10041
Related CR Release Date: May 26, 2017
Related CR Transmittal Number: R3781CP
Related Change Request (CR) Number: 10041
Effective Date: October 1, 2017
Implementation Date: October 2, 2017

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

Provider Action Needed
This article is based on Change Request (CR) 10041 which instructs MACs and Medicare’s Shared System Maintainers (SSMs) to update systems based on the CORE 360 Uniform Use of Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC) and Claim Adjustment Group Code (CAGC) Rule publication. These system updates reflect the Committee on Operating Rules for Information Exchange (CORE) Code Combination List for June 2017. Make sure that your billing staff is aware of these changes.

In addition, if you use the PC Print or Medicare Remit Easy Print (MREP) software supplied by your MAC, be sure to obtain the updated version of that software when it is available.

Background
The Department of Health and Human Services (DHHS) adopted the Phase III CAQH CORE, EFT and ERA Operating Rule Set that was implemented on January 1, 2014, under the Patient Protection and Affordable Care Act (ACA) of 2010.

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

Through the ACA, Congress sought to promote implementation of electronic transactions and achieve cost reduction and efficiency improvements by creating more uniformity in the implementation of standard transactions. This was done by mandating the adoption of a set
of operating rules for each of the HIPAA transactions. The ACA defines operating rules and specifies the role of operating rules in relation to the standards.

Change Request (CR) 10041 deals with the regular update in CAQH CORE defined code combinations per Operating Rule 360 - Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule.

CAQH CORE will publish the next version of the Code Combination List on or about June 10, 2017. This update is based on the CARC and RARC updates as posted at the Washington Publishing Company (WPC) website on or about March 1, 2017. This will also include updates based on Market Based Review (MBR) 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 [CARC/RARC News](#) and CAQH CORE defined code combination updates at [CAQH/CORE News](#).

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

**Additional Information**


If you have any questions, please contact your MAC at their toll-free number. That number is available at [https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/](https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/).

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Claim Status Category and Claim Status Codes
Update


MLN Matters® Number: MM10043
Related CR Release Date: May 26, 2017
Related CR Transmittal Number: R3782CP
Related Change Request (CR) #: 10043
Effective Date: October 1, 2017
Implementation Date: October 2, 2017

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

Provider Action Needed
Change Request (CR) 10043 informs MACs about system changes to update, as needed, the Claim Status and Claim Status Category Codes used for the Accredited Standards Committee (ASC) X12 276/277 Health Care Claim Status Request and Response and ASC X12 277 Health Care Claim Acknowledgment transactions. Make sure that 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 transaction standards adopted under HIPAA for electronically submitting health care claims status requests and responses. These codes explain the status of submitted claim(s). Proprietary codes may not be used in the ASC X12 276/277 transactions to report claim status. This Recurring Update Notification (RUN) can be found in Chapter 31, Section 20.7. 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 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 June 2017 committee meeting will be posted on these sites on or about July 1, 2017. MACs must complete entry of all applicable code text changes and new codes, and terminate use of deactivated codes by the implementation date of CR 10043.

The Centers for Medicare & Medicaid Services (CMS) will issue RUNs regarding the need for future updates to these codes. When instructed, Medicare contractors must update their claims systems to ensure that the current version of these codes is used in their claim status responses. Contractor 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 this CR 10043.
Additional Information


If you have any questions, please contact your MAC at their toll-free number. That number is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/.

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Claim Status Category and Claim Status Codes Update


MLN Matters® Number: MM10132  
Related CR Release Date: August 18, 2017  
Related CR Transmittal Number: R3839CP  
Related Change Request (CR) Number: 10132  
Effective Date: January 1, 2018  
Implementation Date: January 2, 2018

Provider Types Affected

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

Provider Action Needed

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

Background

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

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

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

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

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

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

**Additional Information**


If you have any questions, please contact your MAC at their toll-free number. That number is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/.

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


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

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

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

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

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

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

**Additional Information**


If you have any questions, please contact your MAC at their toll-free number. That number is available at [https://www.cms.gov/Research-Statistics-Data-and-Systems/ Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/](https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/).

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Healthcare Provider Taxonomy Codes (HPTCs)
October 2017 Code Set Update


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

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

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

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

You should note that:

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

The HPTC set is maintained by the NUCC for standardized classification of health care providers. The NUCC updates the code set twice a year with changes effective April 1 and October 1. The HPTC list is available for view from the Washington Publishing Company (WPC) website at www.wpc-edi.com/codes and can be downloaded from the NUCC’s website http://www.nucc.org/index.php/code-sets-mainmenu-41/provider-taxonomy-mainmenu-40.

Although the NUCC generally posts their updates on the WPC webpage 3 months prior to the effective date, changes are not effective until April 1 or October 1 as indicated in each update. The changes to the code set include the addition of a new code and addition of definitions to existing codes. When reviewing the Health Care Provider Taxonomy code set online, you can identify revisions made since the last release by color code:
Suppression of the Standard Paper Remittance Advice (SPR) in 45 days if also Receiving Electronic Remittance Advice (ERA)


MLN Matters® Number: MM10151
Related CR Release Date: August 4, 2017
Related CR Transmittal Number: R1305OTN
Related Change Request (CR) Number: 10151
Effective Date: January 1, 2018
Implementation Date: January 2, 2018

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

Provider Action Needed
Change Request (CR) 10151 provides notice that beginning January 2, 2018, Medicare’s Shared System Maintainers (SSMs) must eliminate issuance of Standard Paper Remittance Advice (SPRs) to those providers/suppliers (or a billing agent, clearinghouse, or other entity representing those providers/suppliers) who also have been receiving Electronic Remittance Advice (ERA) transactions for 45 days or more. The shared system changes to suppress the distribution of SPRs were implemented in January 2006 per CR3991 (issued August 12, 2005, Transmittal 645). Make sure your billing staffs are aware of the suppression of the SPR.
Background
The SPR is the hard copy version of an ERA. MACs, including Durable Medical Equipment (DME) MACs must be capable of producing SPRs for providers/suppliers who are unable or choose not to receive an ERA. The MACs and the DME MACs suppress distribution of SPRs if an Electronic Data Interchange (EDI) enrolled provider/supplier is also receiving ERAs for more than 31 days for Institutional Health Care Claims (837I) and 45 days for DME and Professional Health Care Claims (837P). Internet-Only-Manuals (IOMs), MLN Matters Article MM4376 provided information to the MACs regarding the receipt of SPR and ERA distribution time lines.

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


Additional Information

If you have any questions, please contact your MAC at their toll-free number. That number is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/.

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Modernized National Plan and Provider Enumeration System


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

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

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

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

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


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

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

New NPPES Impact on Type 2 Providers

In the past, the sharing of login credentials between Type 2 providers and surrogates posed great security risks including fraud and provider identity theft. The new unified login and surrogacy helps lessen these risks and increase account security. Type 2 provider users will need I&A authentication credentials to access the modernized NPPES. Users may obtain these in the I&A system by going to https://nppes.cms.hhs.gov/IAWeb/login.do. The Authorized Officials (AO) and Delegated Officials (DO) in I&A of Type 2 providers will be able to access all NPIs under the Employer Identification Number (EIN) on the type 2 provider with an organization EIN. Users can claim NPIs using their legacy Type 2 usernames and passwords after they login with an I&A account. As an additional convenience, large organizations can contact the enumerator to get access to their NPIs. More information on the types of possible user roles is available at https://nppes.cms.hhs.gov/IAWebContent/Quick_Reference_Guide.pdf.

Key Features of the Modernized NPPES

Some of the key features of the modernized and more responsive UI include:

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

Electronic File Interchange (EFI) Features

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

Data Dissemination File (DDS) Enhancements

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

New Optional Fields in NPPES 3.0

The following new fields will allow the user to give more information about the provider and the practice location:
Frequently Asked Questions
Feel free to visit the NPPES web help guide to see solutions to frequently asked questions. That guide is available at https://nppes.cms.hhs.gov/webhelp/nppeshelp/NPPES%20FAQS.html.

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

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

If you have any questions, please contact the NPI enumerator by phone at 1-800-465-3203 (NPI Toll-Free) or 1-800-692-2326 (NPI TTY), by email at customerservice@npienumerator.com or by regular mail at:

NPI Enumerator
PO Box 6059
Fargo, ND 58108-6059

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FEES & PRICING

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


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

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

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

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

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


Also, payment on a fee schedule basis is a regulatory requirement at 42 Code of Federal Regulations (CFR) §414.102 for parenteral and enteral nutrition (PEN), splints and casts and intraocular lenses (IOLs) inserted in a physician’s office.

Additionally, Section 1834 of the Act mandates adjustments to the fee schedule amounts for certain items furnished on or after January 1, 2016, in areas that are not competitive bid areas (CBAs), based on information from competitive bidding programs (CBPs) for DME. The Social Security Act (§1842(s)(3)(B)) provides authority for making adjustments to the fee schedule amount for enteral nutrients, equipment and supplies (enteral nutrition) based on information from CBPs. Also, the adjusted fees apply a rural payment rule. The DMEPOS and PEN fee
schedule files contain HCPCS codes that are subject to the adjustments as well as codes that are not subject to the fee schedule adjustments. Additional information on adjustments to the fee schedule amounts based on information from CBPs is available in CR 9642 (Transmittal 3551, dated June 23, 2016).

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

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

**KU Modifier for Complex Rehabilitative Power Wheelchair Accessories & Seat and Back Cushions**

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

**Therapeutic Continuous Glucose Monitor (CGM)**

As part of this update, the fee schedule amounts for the following therapeutic CGM HCPCS codes are added to the DMEPOS fee schedule file effective for dates of service on or after July 1, 2017:

- K0553 - Supply allowance for therapeutic continuous glucose monitor (CGM), includes all supplies and accessories, 1 unit of service = 1 month’s supply
- K0554 - Receiver (monitor), dedicated, for use with therapeutic continuous glucose monitor system


**Additional Information**


If you have any questions, please contact your MAC at their toll-free number. That number is available at [https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/](https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/).
Quarterly Update for the Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program (CBP) - October 2017


MLN Matters® Number: MM10128
Related CR Release Date: June 16, 2017
Related CR Transmittal Number: R3798CP
Related Change Request (CR) Number: CR10128
Effective Date: October 1, 2017
Implementation Date: October 2, 2017

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

Provider Action Needed
Change Request (CR) 10128 provides the October 2017 quarterly update for the Medicare DMEPOS fee schedule. The instructions include information, when necessary, to implement fee schedule amounts for new codes and correct any fee schedule amounts for existing codes. The Centers for Medicare & Medicaid Services (CMS) issued CR 10128 to provide the DMEPOS Competitive Bidding Program (CBP) October 2017 quarterly update.

CR 10128 provides specific instructions to your DME MAC for implementing updates to the DMEPOS CBP Healthcare Common Procedure Coding System (HCPCS), Zip code, and Single Payment Amount files. Note that quarterly updates are available at http://dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/home. To review the updates, select (click) on the quarterly updates link on the left of the page.

Background
The DMEPOS CBP was mandated by Congress through the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). The statute requires that Medicare replace the current fee schedule payment methodology for selected DMEPOS items with a competitive
bid process. The intent is to improve the effectiveness of the Medicare methodology for setting DMEPOS payment amounts, which will reduce beneficiary out-of-pocket expenses and save the Medicare program money while ensuring beneficiary access to quality items and services.

Under the program, a competition among suppliers who operate in a particular competitive bidding area is conducted. Suppliers are required to submit a bid for selected products. Not all products or items are subject to competitive bidding. Bids are submitted electronically through a web-based application process and required documents are mailed. Bids are evaluated based on the supplier's eligibility, its financial stability, and the bid price. Contracts are awarded to the Medicare suppliers who offer the best price and meet applicable quality and financial standards. Contract suppliers must agree to accept assignment on all claims for bid items and will be paid the bid price amount. The amount is derived from the median of all winning bids for an item.

Additional Information

If you have any questions, please contact your MAC at their toll-free number. That number is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/.

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October 2017 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions To Prior Quarterly Pricing Files


MLN Matters® Number: MM10187
Related CR Release Date: July 21, 2017
Related CR Transmittal Number: R3809CP

Related Change Request (CR) Number: 10187
Effective Date: October 1, 2017
Implementation Date: October 2, 2017

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

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

**Background**

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

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

For any drug or biological not listed in the ASP or NOC drug-pricing files, MACs will determine the payment allowance limits in accordance with the policy described in the “Medicare Claims Processing Manual,” Chapter 17, Section 20.1.3, which is available at [https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c17.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c17.pdf). For any drug or biological not listed in the ASP or NOC drug-pricing files that is billed with the KD modifier, contractors shall determine the payment allowance limits in accordance with instructions for pricing and payment changes for infusion drugs furnished through an item of Durable Medical Equipment (DME) on or after January 1, 2017, associated with the passage of the 21st Century Cures Act.

**Additional Information**


If you have any questions, please contact your MAC at their toll-free number. That number is available at [https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/](https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/).

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## Archived MLN Connects®
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E-mail:  ngs.CEDIHelpdesk@anthem.com  
Jurisdiction C  
CEDI (toll-free):  1.866.311.9184  
Mon - Fri, 8:00 a.m. - 6:00 p.m. CT   |
| Paper Claim Submission               | Address: CGS - Jurisdiction C  
PO Box 20010  
Nashville, TN 37202  
IVR (Interactive Voice Response):  1.866.238.9650  
Mon - Fri, 6:00 a.m. - 8:00 p.m. CT;  
Sat, 6:00 a.m. - 4:00 p.m. CT  
Customer Service: 1.866.270.4909  
Mon - Fri, 7:00 a.m. - 5:00 p.m. CT  
Hearing Impaired: 1.888.204.3771  
Mon - Fri, 7:00 a.m. - 5:00 p.m. CT  |
| Provider Customer Service Calls      | Jurisdiction C  
CEDI (toll-free):  1.866.311.9184  
Mon - Fri, 8:00 a.m. - 6:00 p.m. CT   |
| Beneficiary Customer Service Calls   | Phone: 1.800.Medicare  
Written Inquiries  
E-mail:  CGS.Medicare.OPID@cgsadmin.com  
Telephone requests for Reopenings: 1.866.813.7878  
Mon - Fri, 7:00 a.m. - 5:00 p.m. CT  
Fax: 1.615.782.4630  |
| Claim Reopenings (Adjustments)       | Address: CGS - Jurisdiction C  
PO Box 20010  
Nashville, TN 37202  
Fax (for underpayments): 1.615.782.4649  
Fax (for overpayments): 1.615.782.4477  
Claim Status Inquiry Security Access Issues/Password Reset,  
E-mail:  CGS.Medicare.OPID@cgsadmin.com  
Enrollment Status: 1.866.270.4909  |
| Appeals – Redetermination Requests   | Address: CGS - Jurisdiction C  
PO Box 20009  
Nashville, TN 37202  
Fax: 1.615.782.4630  |
| Electronic Funds Transfer            | Address: CGS  
Attn: EFT-DME  
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Nashville, TN 37202  
Refunds  
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DME MAC Jurisdiction C  
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Nashville, TN 37228  
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Website: [http://www.cgsmedicare.com/jc/index.html](http://www.cgsmedicare.com/jc/index.html)  
Advance Determination of Medicare Coverage (ADMC) - Requests  
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