Attention myCGS Web Portal Users: Multi-Factor Authentication (MFA) is Mandatory

Due to increased security requirements mandated by the Centers for Medicare & Medicaid (CMS), all myCGS portal Users MUST sign up for Multi-Factor Authentication (MFA) by July 1, 2017. Go to http://www.cgsmedicare.com/articles/cope2540.html for important information about the MFA timeline and instructions for activating MFA.

Articles contained in this edition are current as of April 29, 2017.

Bold, italicized material is excerpted from the American Medical Association Current Procedural Terminology CPT codes. Descriptions and other data only are copyrighted 2017 American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Kentucky & Ohio

New and Retired Local Policies – Update V2

CGS Administrators, LLC (CGS) has ten new policies that will take effect in March 2017 and two policies retiring in March 2017. L33951 - Circulating Tumor Cell Marker Assays and L34086 - Polysomnography and Sleep Studies will be retiring March 5, 2017. They will be replaced with new policies L36973 - Circulating Tumor Cell Marker Assays and L36902 - Polysomnography and Other Sleep Studies, effective March 6, 2017. The other eight policies will be effective as indicated below:

Note from CGS: CGS has decided not to move forward with implementing draft policies, L36910-MolDX: APC and MUYTH Gene Testing, and L36908- MolDX-CDD: Percepta® Bronchial Genomic Classifier as anticipated. We plan to bring these two policies back to draft for review and anticipate including at the next scheduled Carrier Advisory Committee (CAC) meeting in the summer. Policy L36975 Bladder/Urothelial Tumor Markers was added in error to the original note as not being promoted as intended. We apologize for any confusion.

- L36975-Bladder/Urothelial Tumor Markers-effective 03/06/2017
- L36906-GlycoMark testing for Glycemic Control-effective 03/06/2017
- L36979-MolDX: 4K Score Assay-effective 03/13/2017
- L36910-MolDX: APC and MUYTH Gene Testing-03/13/2017
- L36485-MolDX: HLA-DQB1*06:02 Testing for Narcolepsy-effective 03/06/2017
- L36951-MolDX-CDD: Oncotype DX® Breast Cancer for DCIS (Genomic Health™)-effective 03/06/2017
- L36908-MolDX-CDD: Percepta® Bronchial Genomic Classifier-03/13/2017
- L35897-Nerve Conduction Studies and Electromyography-effective 03/06/2017

All comments received were reviewed before the finalization of the policies and if needed updates were made accordingly. There were no comments received during open comment period for the following policies:

- L36973-Circulating Tumor Cell Marker Assays
- L36902-Polysomnography and Other Sleep Studies
- L36485-MolDX: HLA-DQB1*06:02 Testing for Narcolepsy
- L36951-MolDX - CDD: Oncotype DX® Breast Cancer for DCIS (Genomic Health™)
Please see additional articles for the comments received (http://www.cgsmedicare.com/partb/medicalpolicy/draft.html) by CGS during the open comment period for each policy. The response to comments article for each policy will be attached to the policy when it becomes effective.

Kentucky & Ohio

Frequency of General Modalities for Outpatient Physical and Occupational Therapy

CGS performed data analysis for CPT codes 97012, 97016, 97018, 97022, 97024, 97032, 97033, 97035, 97036, 97039, and G0283. Our analysis revealed that these services are being billed in excess of the frequency edits stipulated in LCD L34049: Outpatient Physical and Occupational Therapy. Therefore, CGS will be implementing frequency edits for the above codes in KY and OH effective May 25, 2017.

For guidance regarding documentation, please refer to the LCD in the supportive documentation recommendations section for each of the codes above (http://www.cgsmedicare.com/partb/medicalpolicy/index.html).

Kentucky & Ohio

Attention myCGS Web Portal Users: Multi-Factor Authentication (MFA) is Mandatory

Due to increased security requirements mandated by the Centers for Medicare & Medicaid (CMS), all myCGS portal Users MUST sign up for Multi-Factor Authentication (MFA) by July 1, 2017. This article explains what MFA is, the timeline and instructions for activating MFA.

What is MFA?

MFA is an extra layer of security that will help ensure your myCGS account and your patient’s Medicare information is protected. Each time you access myCGS, you will receive an eight-digit verification code via the option you selected (text, or e-mail). Once the verification code is entered, you will have access to the myCGS website portal. Refer to the “How It Works” information below.

Important Timelines

Note from CGS: CGS encourages Users to sign up early! It only takes a few more seconds to complete.

• May 1, 2017 to June 30, 2017: myCGS Users will be required to sign up for MFA at enrollment, password reset and account update.

• July 1, 2017: myCGS Users not signed up for MFA will automatically be set to MFA with the e-mail address associated with the user ID.

How It Works

To activate MFA, enter your password as usual and access the ‘My Account’ tab. MFA information is located toward the bottom of the page. Instructions are also available in the myCGS User Manual, Chapter 1: Overview of myCGS (http://www.cgsmedicare.com/pdf/mycgs/chapter1.pdf).
1. **Multi-factor Authentication**: Select “Yes”

2. **MFA E-mail Address**: Verify your e-mail address of your active e-mail account in myCGS

3. **MFA Mobile Opt-in**: Select “Yes” to receive your verification code via text message. Select “No” to receive your verification code via e-mail.

4. **Mobile Phone**: If you selected “Yes” for the MFA Mobile Opt-in, enter your mobile phone number.

5. **Carrier**: If you selected “Yes” for the MFA Mobile Opt-in, enter the name of your mobile phone carrier.

6. Click the Submit button.
Once activated, signing in to your myCGS account will work a little differently: Each time you will be logging in to the myCGS portal, you will be provided with a verification code via the selected method. Once you receive your verification code, you will enter it in the verification box and you’re in. It may seem cumbersome at first, but once you get used to it, this added security will allow you to enjoy peace of mind that will make this extra step more than worth it!

**Kentucky & Ohio**

**MM9876 Revised: Implementation of New Influenza Virus Vaccine Code**

The Centers for Medicare & Medicaid Services (CMS) has revised the following Medicare Learning Network® (MLN) Matters article. This MLN Matters article and other CMS articles can be found on the CMS website at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2016-MLN-Matters-Articles.html

MLN Matters® Number: MM9876 Revised Related Change Request (CR) #: CR 9876
Related CR Release Date: April 21, 2017 Effective Date: July 1, 2017
Related CR Transmittal #: R3754CP Implementation Date: July 3, 2017

**Provider Types Affected**

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

**What You Need to Know**

Change Request (CR) 9876 provides instructions for payment and edits for the common working file (CWF) to include influenza virus vaccine code 90682 (Influenza virus vaccine, quadrivalent (RIV4), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use) for claims with dates of service on or after July 1, 2017. Make sure that your billing staffs are aware of these instructions.

**Background**

Effective for dates of service on and after July 1, 2017, influenza virus code 90682 will be payable by Medicare. Annual Part B deductible and coinsurance amounts do not apply to this code. MACs will:

- Effective for dates of service on or after August 1, 2017, MACs will pay for code 90682 using the Centers for Medicare & Medicaid Services (CMS) Seasonal Influenza Vaccines Pricing at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html) to determine the payment rate for influenza virus vaccine code 90682.
- Pay for vaccine code 90682 on institutional claims as follows:
  - Hospitals – Types of Bill (TOB) 12X and 13X, Skilled Nursing Facilities (SNFs) – TOB 22X and 23X, Home Health Agencies (HHAs) – TOB 34X, hospital-based Renal Dialysis Facilities (RDFs) – TOB 72X, and Critical Access Hospitals (CAHs) – TOB 85X, based on reasonable cost
  - Indian Health Service (IHS) Hospitals – TOB 12X, and 13X, IHS CAHs – TOB 85X, and hospices (81X and 82X) based on the lower of the actual charge or 95 percent of the Average Wholesale Price (AWP)
Comprehensive Outpatient Rehabilitation Facility (CORF) – TOB 75X, and independent RDFs – TOB 72X, based on the lower of actual charge or 95 percent of the AWP

MACs will pay at discretion claims for code 90682 with dates of service July 1, 2017, through July 31, 2017.

MACs will return to the provider (RTP) institutional claims if submitted with code 90682 for dates of service January 1, 2017, through June 30, 2017.

MACs will deny Part B claims submitted with code 90682 for dates of service January 1, 2017, through June 30, 2017, using the following messages:

- Claim Adjustment Reason Code: 181 – “Procedure code was invalid on the date of service.”
- Remittance Advice Remark Code: N56 – “Procedure code billed is not correct/valid for the services billed or the date of service billed.”
- Group Code: CO (Contractual Obligation)

In addition, effective for claims with dates of service on or after October 1, 2016, MACs will pay vaccines (Influenza, PPV, and HepB) to hospices based on the lower of the actual charge or 95% of AWP. Coinsurance and deductibles do not apply. Further, MACs will adjust previously processed hospice claims (TOB 81x or 82x) for these vaccines with dates of service on or after October 1, 2016.

**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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**Kentucky & Ohio**

**MM9956 Revised: New Waived Tests**

The Centers for Medicare & Medicaid Services (CMS) has revised the following Medicare Learning Network® (MLN) Matters article. This MLN Matters article and other CMS articles can be found on the CMS website at: [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2016-MLN-Matters-Articles.html](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2016-MLN-Matters-Articles.html)

**MLN Matters® Number:** MM9956 Revised  
**Related Change Request (CR) #:** CR 9956  
**Related CR Release Date:** March 30, 2017  
**Effective Date:** April 1, 2017  
**Implementation Date:** April 3, 2017  

**Note:** This article was revised on April 3, 2017, to reflect the revised CR9956 issued on March 30, 2017. In the article, the CR release date, transmittal number, and the Web address for accessing the CR are revised. All other information remains the same. The CR was revised to correct CPT drug test code from 80305 to 80305QW in the attachment to CR9956.
Provider Types Affected
This MLN Matters® Article is intended for clinical diagnostic laboratories submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed
Change Request (CR) 9956 informs MACs of new Clinical Laboratory Improvement Amendments of 1988 (CLIA) waived tests approved by the Food and Drug Administration (FDA). Since these tests are marketed immediately after approval, the Centers for Medicare & Medicaid Services (CMS) must notify MACs of the new tests so that they can accurately process claims. Make sure that your billing staffs are aware of these CLIA-related changes.

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

Listed below are the latest tests approved by the FDA as waived tests under CLIA. The Current Procedural Terminology (CPT) codes for the following new tests must have the modifier QW to be recognized as a waived test. However, the tests mentioned on the first page of the list attached to CR9956 (CPT codes: 81002, 81025, 82272, 82962, 83026, 84830, 85013, and 85651) do not require a QW modifier to be recognized as a waived test.

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

- G0477QW [from July 7, 2016, to December 31, 2016], 80305QW [on and after January 1, 2017], July 7, 2016, TransMed Company, CLIA Screen In-Vitro Multi-Drug Urine Test Dip Card
- G0477QW [from July 7, 2016, to December 31, 2016], 80305QW [on and after January 1, 2017], July 7, 2016, TransMed Company, CLIA Screen In-Vitro Multi-Drug Urine Test Dip Cup
- G0477QW [from August 11, 2016, to December 31, 2016], 80305QW [on and after January 1, 2017], August 11, 2016, Nobel Medical Inc., AEON Multi-Drug Urine Test Cup
- G0477QW [from August 11, 2016, to December 31, 2016], 80305QW [on and after January 1, 2017], Nobel Medical Inc., August 11, 2016, AEON Multi-Drug Urine Test Dip Card
- G0477QW [from August 11, 2016, to December 31, 2016], 80305QW [on and after January 1, 2017], August 11, 2016, Nobel Medical Inc., INSTA-SCREEN Multi-Drug Urine Test Dip Card
- 82274QW, G0328QW, September 6, 2016, ProAdvantage Immunochemical Fecal Occult Blood Test
- 87880QW, September 16, 2016, Cardinal Health Strep A Cassette Rapid Test
- G0477QW [from September 16, 2016, to December 31, 2016], 80305QW [on and after January 1, 2017], September 16, 2016, Premier Biotech, Inc., MDETOX Multi-Drug Urine Test Cup
- 81003QW, October 7, 2016, Moore Medical LLC mooremedical U120 Urine Analyzer
The HCPCS code G0477 [Drug tests(s), presumptive, any number of drug classes; any number of devices or procedures, (eg, immunoassay) capable of being read by direct optical observation only (eg, dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service] was discontinued on 12/31/2016. The new HCPCS code 80305 [Drug test(s), presumptive, any number of drug classes, any number of devices or procedures (eg, immunoassay); capable of being read by direct optical observation only (eg, dipsticks, cups, cards, cartridges) includes sample validation when performed, per date of service] was effective 1/1/2017. HCPCS code 80305QW describes the waived testing previously assigned the code G0477QW. All tests in the attachment that previously had HCPCS G0477QW are now assigned 80305QW.

The new waived complexity code 87633QW [Infectious agent detection by nucleic acid (DNA or RNA); respiratory virus (eg, adenovirus, influenza virus, coronavirus, metapneumovirus, parainfluenza virus, respiratory syncytial virus, rhinovirus), multiplex reverse transcription and amplified probe technique, multiple types or subtypes, 12-25 targets] was assigned for the testing performed by BioFire Diagnostics, FilmArray 2.0 EZ Configuration Instrument (Viral and Bacterial Nucleic Acids) (Nasopharyngeal Swabs).

The attachment to CR9956 has been re-organized. HCPCS codes with more than 20 test systems listed in previous transmittal attachments will now not mention the specific waived complexity test system. Instead, there will be a generic test system name and a statement to refer to the FDA waived analytes internet site (http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfClia/analyteswaived.cfm) for the specific test system name. The HCPCS codes mentioned on the attachment that will now only be mentioned in a generic manner are G0477QW (80305QW effective 1/1/2017), 81003QW, 82274QW, G0328QW, 86308QW, 86318QW, and 87880QW. For these codes, future New Waived Test transmittals will only mention the specific name of the latest FDA test system in the transmittal and not be included in the attachment.
MACs will not search their files to either retract payment or retroactively pay claims based on these changes. However, MACs should adjust claims that you bring to their attention.

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

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Kentucky & Ohio

**MM10001: Payment for Moderate Sedation Services**

The Centers for Medicare & Medicaid Services (CMS) has issued the following Medicare Learning Network® (MLN) Matters article. This MLN Matters article and other CMS articles can be found on the CMS website at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2016-MLN-Matters-Articles.html

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**MLN Matters® Number:** MM10001

**Related Change Request (CR) #:** CR 10001

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

**Effective Date:** January 1, 2017

**Related CR Transmittal #:** R3747CP

**Implementation Date:** May 15, 2017

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**Note:** This article was revised on April 3, 2017, to reflect the revised CR9956 issued on March 30, 2017. In the article, the CR release date, transmittal number, and the Web address for CR9956 are revised. All other information remains the same. The CR was revised to correct CPT drug test code from 80305 to 80305QW in the attachment to CR9956.

**Provider Types Affected**

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

**What You Need to Know**

Change Request (CR) 10001 revises existing Medicare Claims Processing Manual language to bring the manual in line with current payment policy for moderate sedation and anesthesia services. Providers should refer to the revised Medicare Claims Processing Manual, Chapter 12 (Physicians/Nonphysician Practitioners), Sections 50 and 140 for information regarding the reporting of moderate sedation and anesthesia services. The revision is attached to CR10001. Make sure your billing staff is aware of these revisions.

**Key Manual Changes**

**General Payment Rule**

The fee schedule amount for physician anesthesia services furnished is, with the exceptions noted, based on allowable base and time units multiplied by an anesthesia conversion factor...
specific to that locality. The base unit for each anesthesia procedure is communicated to the MACs by means of the Healthcare Common Procedure Coding System (HCPCS) file released annually. The Centers for Medicare & Medicaid Services (CMS) releases the conversion factor annually. The base units and conversion factor are available at [https://www.cms.gov/Center/Provider-Type/Anesthesiologists-Center.html](https://www.cms.gov/Center/Provider-Type/Anesthesiologists-Center.html).

**Moderate Sedation Services Furnished in Conjunction with and in Support of Procedural Services**

Anesthesia services range in complexity. The continuum of anesthesia services, from least intense to most intense in complexity is as follows: local or topical anesthesia, moderate (conscious) sedation, regional anesthesia and general anesthesia. Moderate sedation is a drug induced depression of consciousness during which the patient responds purposefully to verbal commands, either alone or accompanied by light tactile stimulation. Moderate sedation does not include minimal sedation, deep sedation or monitored anesthesia care.

Practitioners will report the appropriate CPT and/or HCPCS code that accurately describes the moderate sedation services performed during a patient encounter, which are performed in conjunction with and in support of a procedural service, consistent with CPT guidance.

**Other Manual Revisions to Sections 50 and 140**

There are other minor revisions to these manual sections and those revised manual sections are attached to CR10001.

**Additional Information**

Your MAC will not search their files to either retract payment for claims already paid or to retroactively pay claims. They will adjust impacted claims that you bring to their attention.


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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**Kentucky & Ohio**

**MM10016: July 2017 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revision to Prior Quarterly Pricing Files**

The Centers for Medicare & Medicaid Services (CMS) has issued the following **Medicare Learning Network® (MLN) Matters** article. This MLN Matters article and other CMS articles can be found on the CMS website at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2016-MLN-Matters-Articles.html](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2016-MLN-Matters-Articles.html).

**MLN Matters® Number:** MM10016  
**Related CR Release Date:** April 7, 2017  
**Related CR Transmittal #:** 3746CP  
**Related Change Request (CR) #:** CR 10016  
**Effective Date:** July 1, 2017  
**Implementation Date:** July 3, 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) 10016 provides the July 2017 quarterly update and instructs MACs to download and implement the July 2017 ASP drug pricing files and, if released by the Centers for Medicare & Medicaid Services (CMS), the revised April 2017, January 2017, October 2016, and July 2016 Average Sales Price (ASP) drug pricing files for Medicare Part B drugs. 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 July 3, 2017, with dates of service July 1, 2017, through September 30, 2017. MACs will not search and adjust claims previously processed unless brought to their attention.

Background
The ASP methodology is based on quarterly data submitted to 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 OPPS are incorporated into the Outpatient Code Editor (OCE) through separate instructions.

The following files are related to this most recent update:
- July 2017 ASP and ASP NOC – Effective Dates of Service: July 1, 2017, through September 30, 2017
- April 2017 ASP and ASP NOC – Effective Dates of Service: April 1, 2017, through June 30, 2017
- January 2017 ASP and ASP NOC – Effective Dates of Service: January 1, 2017, through March 31, 2017
- October 2016 ASP and ASP NOC – Effective Dates of Services: October 1, 2016, through December 31, 2016
- July 2016 ASP and ASP NOC – Effective Dates of Service: July 1, 2016, through September 30, 2016

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

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<td>April 7, 2017</td>
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This newsletter should be shared with all health care practitioners and managerial members of the provider/supplier staff. Newsletters issued after January 1997 are available at no cost from our website at http://www.cgsmedicare.com. © 2017 Copyright, CGS Administrators, LLC.
**MM10082: Quarterly Update to the National Correct Coding Initiative (NCCI) Procedure to Procedure (PTP) Edits, Version 23.2, Effective July 1, 2017**

The Centers for Medicare & Medicaid Services (CMS) has issued the following Medicare Learning Network® (MLN) Matters article. This MLN Matters article and other CMS articles can be found on the CMS website at: [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2016-MLN-Matters-Articles.html](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2016-MLN-Matters-Articles.html)

**MLN Matters® Number:** MM10082  
**Related Change Request (CR) #:** CR10082  
**Related CR Release Date:** April 14, 2017  
**Effective Date:** July 1, 2017  
**Related CR Transmittal #:** R3748CP  
**Implementation Date:** July 3, 2017

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

**Provider Action Needed**  
Change Request (CR) 10082 informs Medicare Administrative Contractors (MACs) about the update to the National Correct Coding Initiative (NCCI) procedure to procedure edits (PTP). This notice applies to Chapter 23, Section 20.9 of the Medicare Claims Processing Manual. Make sure your billing staffs are aware of these changes.

**Background**  
The Centers for Medicare & Medicaid Services (CMS) developed the NCCI to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment in Part B claims.

Version 23.2 will include all previous versions and updates from January 1, 1996, to the present. In the past, CCI was organized in two tables: Column 1/Column 2 Correct Coding Edits and Mutually Exclusive Code (MEC) Edits. In order to simplify the use of NCCI edit files (two tables), on April 1, 2012, CMS consolidated these two edit files into the Column One/Column Two Correct Coding edit file. Separate consolidations have occurred for the two practitioner NCCI edit files and the two NCCI edit files used for the Outpatient Code Editor (OCE). It will only be necessary to search the Column One/Column Two Correct Coding edit file for active or previously deleted edits. CMS no longer publishes a Mutually Exclusive edit file on its website for either practitioner or outpatient hospital services, since all active and deleted edits will appear in the single Column One/Column Two Correct Coding edit file on each website. The edits previously contained in the Mutually Exclusive edit file are NOT being deleted but are being moved to the Column One/Column Two Correct Coding edit file. Refer to the CMS NCCI Web page for additional information at [http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html](http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html).

The coding policies developed are based on coding conventions defined in the American Medical Association’s Current Procedural Terminology manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practice, and review of current coding practice.

**Additional Information**  
Kentucky & Ohio

SE1603 Revised: Educational Resources to Assist Chiropractors with Medicare Billing

The Centers for Medicare & Medicaid Services (CMS) has issued the following Medicare Learning Network® (MLN) Matters article. This MLN Matters article and other CMS articles can be found on the CMS website at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2016-MLN-Matters-Articles.html

MLN Matters® Number: SE1603 Revised
Related CR Release Date: N/A
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 April 7, 2017, to correct a statement under the “Coverage, Documentation and Billing Section” on page 2. That section included a reference to “220.1.3: Certification and Recertification of Need for Treatment and Therapy Plans of Care.” However, chiropractic treatment is not included in that section. All other information is unchanged.

Provider Types Affected

This Special Edition (SE) MLN Matters® article is intended for Chiropractors submitting claims to Medicare Administrative Contractors (MACs) for chiropractic services provided to Medicare beneficiaries.

This article is part of a series of SE articles prepared for Chiropractors by CMS in response to the request for educational materials at the September 24, 2015 Special Open Door Forum titled: Improving Documentation of Chiropractic Services.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) is providing this article in order to provide education for chiropractic billers on accessing the correct resources for proper billing. This article is intended to be a comprehensive resource for chiropractic documentation and billing.

Be aware of these policies along with any local coverage determinations (LCDs) for these services in your area that might limit circumstances under which active/corrective chiropractic services are paid.

Background

In 2014, the Comprehensive Error Testing Program (CERT) that measures improper payments in the Medicare Fee-for-Service program reported a 54 percent error rate for Chiropractic services. The majority of those errors were due to insufficient documentation/documentation errors. This article provides a detailed list of informational/educational resources that can help chiropractors avoid these errors. Those resources are as follows:

Enrollment Information

This section outlines the definition of a chiropractor, licensure and authorization to practice, and minimum standards.

The "Medicare Benefit Policy Manual," Chapter 15, “Covered Medical and Other Health Services,” includes Section 40.4 (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf), "Definition of Physician/Practitioner." This section explains that the opt out law does not define physician to include a chiropractor; therefore, a chiropractor may not opt out of Medicare and provide services under a private contract.

The "Medicare Program Integrity Manual," Chapter 15 "Medicare Enrollment," includes Section 15.4.4.11 (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c15.pdf), "Physicians." This section explains that a physician must be legally authorized to practice medicine by the State in which he/she performs such services in order to enroll in the Medicare Program and to retain Medicare billing privileges. A chiropractor who meets Medicare qualifications may enroll in the Medicare Program.

Coverage, Documentation, and Billing

The other articles in this series of articles on chiropractic services are SE1601 (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1601.pdf), which discusses Medicare’s medical record documentation requirements for chiropractic services, and SE1602 (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1602.pdf), which discusses the importance of using the AT modifier on claims for chiropractic services.


- 30.5: Chiropractor’s Services;
- 240: Chiropractic Services – General; This section establishes that payment for chiropractic services is based on the Medicare Physician Fee Schedule (MPFS) and that payment is made to the beneficiary or, on assignment, to the chiropractor.
- 240.1.1: Manual Manipulation;
- 240.1.2: Subluxation May Be Demonstrated by X-Ray or Physician’s Exam;
- 240.1.3: Necessity for Treatment;
- 240.1.4: Location of Subluxation; and
- 240.1.5: Treatment Parameters.

The Chiropractic Local Coverage Determinations (LCDs) for MACs include ICD-10 Coding Information for ICD-10 Codes that support the medical necessity for Chiropractor services. Each contractor has an LCD for Chiropractors. There may be additional documentation information in your LCD. There are links to the chiropractic LCDs in the additional information section of this article. Some of those LCDs are as follows:

- National Government Services (LCD L33613);
- First Coast Options, Inc (LCD L33840);
- CGS Administrators, LLC (LCD L33982);
- Noridian Healthcare Solutions, LLC (Jurisdiction F) (LCD L34009);
- Noridian Healthcare Solutions, LLC (Jurisdiction E) (LCD 34242);
• Wisconsin Physicians Service Insurance Corporation (LCD L34585); and
• Novitas Solutions, Inc (LCD L35424).

The Fact Sheet “Misinformation on Chiropractic Services” (http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Chiropractors_fact_sheet.pdf) is designed to provide education on Medicare regulations and policies on chiropractic services to Medicare providers. It includes information on the documentation needed to support a claim submitted to Medicare for medical services.


The “Medicare Claims Processing Manual,” Chapter 1 (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf) “General Billing Requirements” includes the following sections which apply to billing for a chiropractor’s services:

- 30.3.12: Carrier Annual Participation Program;
- 30.3.12.1: Annual Open Participation Enrollment Process;
- 30.3.12.1.2: Annual Medicare Physician Fee Schedule File Information; and
- 80.3.2.1.3: A/B MAC (B) Specific Requirements for Certain Specialties/Services.

The “Medicare Claims Processing Manual,” Chapter 12 “Physicians/Nonphysician Practitioners,” includes Section 220 (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf), “Chiropractic Services.” This section explains the documentation requirements when billing for a chiropractor’s services. Also the claims processing edits related to payment for a chiropractor’s services are explained.


More Resources: A chiropractor is eligible to receive incentive payments under the Physician Quality Reporting System (PQRS), Electronic Prescribing (eRx) Incentive Program, and Electronic Health Record (EHR) Incentive Program. Information on reporting these measures is available in the Physician and Other Enrolled Health Care Professionals pathway.

The “Medicare Claims Processing Manual, Chapter 23 “Fee Schedule Administration and Coding Requirements,” includes Section 30 (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf), “Services Paid Under the Medicare Physician’s Fee Schedule.” This section explains that a chiropractor is paid under the MPFS.
Advance Beneficiary Notice (ABN) Information


The “Medicare Claims Processing Manual,” Chapter 23 “Fee Schedule Administration and Coding Requirements,” includes Section 20.9.1.1 (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c23.pdf), “Instructions for Codes With Modifiers (Carriers Only).” This section outlines the modifiers that may be used when a chiropractor notifies a beneficiary the item or service may not be covered.


Information about the ABN, including downloadable forms is available at https://www.cms.gov/MEDICARE/medicare-general-information/bni/abn.html on the CMS website.

Additional Information

If you have any questions, please contact your MAC at their toll-free number. That number is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html under - How Does It Work.

You may want to review the educational video on Improving the Documentation of Chiropractic Services (https://www.youtube.com/watch?v=tMiw1X9KvDA) which gives a thorough presentation on medical necessity and proper documentation.

**Document History**

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<td>April 7, 2017</td>
<td>The article was revised to correct a statement under the “Coverage, Documentation and Billing Section” on page 2. That section included a reference to “220.1.3: Certification and Recertification of Need for Treatment and Therapy Plans of Care.” However, chiropractic treatment is not included in that section.</td>
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<tr>
<td>June 21, 2016</td>
<td>The article was revised to add a reference and link to an educational video on Improving the Documentation of Chiropractic Services that gives a thorough presentation on medical necessity and proper documentation.</td>
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<tr>
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<td>Initial article post.</td>
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**Kentucky & Ohio**

**SE1605 Revised: Provider Enrollment Revalidation – Cycle 2**

The Centers for Medicare & Medicaid Services (CMS) has revised the following *Special Edition Medicare Learning Network® (MLN) Matters* article. This MLN Matters article and other CMS articles can be found on the CMS website at: [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2016-MLN-Matters-Articles.html](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2016-MLN-Matters-Articles.html)

**MLN Matters® Number:** SE1605 Revised **Related Change Request (CR) #:** N/A
**Related CR Release Date:** N/A **Effective Date:** N/A
**Related CR Transmittal #:** N/A **Implementation Date:** N/A

**Note:** This article was revised on April 10, 2017, to correct the table on page 6. The last row should have stated the date as “November 29 – December 14, 2017.” All other information is unchanged.

**Provider Types Affected**
This Medicare Learning Network (MLN) Matters® Special Edition Article is intended for all providers and suppliers who are enrolled in Medicare and required to revalidate through their Medicare Administrative Contractors (MACs), including Home Health & Hospice MACs (HH&H MACs), Medicare Carriers, Fiscal Intermediaries, and the National Supplier Clearinghouse (NSC)). These contractors are collectively referred to as MACs in this article.

**Provider Action Needed**

**STOP – Impact to You**
Section 6401 (a) of the Affordable Care Act established a requirement for all enrolled providers/suppliers to revalidate their Medicare enrollment information under new enrollment screening criteria. The Centers for Medicare & Medicaid Services (CMS) has completed its initial round of revalidations and will be resuming regular revalidation cycles in accordance with 42 CFR §424.515. In an effort to streamline the revalidation process and reduce provider/supplier burden, CMS has implemented several revalidation processing improvements that are captured within this article.

**CAUTION – What You Need to Know**

**Special Note:** The Medicare provider enrollment revalidation effort does not change other aspects of the enrollment process. Providers/suppliers should continue to submit changes (for example, changes of ownership, change in practice location or reassignments, final adverse action, changes in authorized or delegated officials or, any other changes) as they always have. If you also receive a request for revalidation from the MAC, respond separately to that request.

**GO – What You Need to Do**

1. Check [http://go.cms.gov/MedicareRevalidation](http://go.cms.gov/MedicareRevalidation) for the provider/suppliers due for revalidation;

2. If the provider/supplier has a due date listed, CMS encourages you to submit your revalidation within six months of your due date or when you receive notification from your MAC to revalidate. When either of these occur:
   - Submit a revalidation application through Internet-based PECOS located at [https://pecos.cms.hhs.gov/pecos/login.do](https://pecos.cms.hhs.gov/pecos/login.do), the fastest and most efficient way to submit your revalidation information. Electronically sign the revalidation application and upload your supporting documentation or sign the paper certification statement and mail it along with your supporting documentation to your MAC; or
   - Complete the appropriate CMS-855 application available at [https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html](https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html);
Background
Section 6401 (a) of the Affordable Care Act established a requirement for all enrolled providers/suppliers to revalidate their Medicare enrollment information under new enrollment screening criteria. CMS has completed its initial round of revalidations and will be resuming regular revalidation cycles in accordance with 42 CFR §424.515. This cycle of revalidation applies to those providers/suppliers that are currently and actively enrolled.

What's ahead for your next Medicare enrollment revalidation?

Established Due Dates for Revalidation
CMS has established due dates by which the provider/supplier’s revalidation application must reach the MAC in order for them to remain in compliance with Medicare’s provider enrollment requirements. The due dates will generally be on the last day of a month (for example, June 30, July 31 or August 31). Submit your revalidation application to your MAC within 6 months of your due date to avoid a hold on your Medicare payments and possible deactivation of your Medicare billing privileges. Generally, this due date will remain with the provider/supplier throughout subsequent revalidation cycles.

- The list will be available at http://go.cms.gov/MedicareRevalidation and will include all enrolled providers/suppliers. Those due for revalidation will display a revalidation due date, all other providers/suppliers not up for revalidation will display a “TBD” (To Be Determined) in the due date field. In addition, a crosswalk to the organizations that the individual provider reassigns benefits will also be available at http://go.cms.gov/MedicareRevalidation on the CMS website.

  IMPORTANT: The list identifies billing providers/suppliers only that are required to revalidate. If you are enrolled solely to order, certify, and/or prescribe via the CMS-855O application or have opted out of Medicare, you will not be asked to revalidate and will not be reflected on the list.

- Due dates are established based on your last successful revalidation or initial enrollment (approximately 3 years for DME suppliers and 5 years for all other providers/suppliers).

- In addition, the MAC will send a revalidation notice within 2-3 months prior to your revalidation due date either by e-mail (to e-mail addresses reported on your prior applications) or regular mail (at least two of your reported addresses: correspondence, special payments and/or your primary practice address) indicating the provider/supplier’s due date.

  Revalidation notices sent via e-mail will indicate “URGENT: Medicare Provider Enrollment Revalidation Request” in the subject line to differentiate from other e-mails. If all of the e-mails addresses on file are returned as undeliverable, your MAC will send a paper revalidation notice to at least two of your reported addresses: correspondence, special payments and/or your primary practice address.

  NOTE: Providers/suppliers who are within 2 months of their listed due dates on http://go.cms.gov/MedicareRevalidation but have not received a notice from their MAC to revalidate, are encouraged to submit their revalidation application.

- To assist with submitting complete revalidation applications, revalidation notices for individual group members, will list the identifying information of the organizations that the individual reassigns benefits.
Large Group Coordination

Large groups (200+ members) accepting reassigned benefits from providers/suppliers identified on the CMS list will receive a letter from their MACs listing the providers linked to their group that are required to revalidate for the upcoming 6 month period. A spreadsheet detailing the applicable provider’s Name, National Provider Identifier (NPI) and Specialty will also be provided. CMS encourages the groups to work with their practicing practitioners to ensure that the revalidation application is submitted prior to the due date. We encourage all groups to work together as only one application from each provider/supplier is required, but the provider must list all groups they are reassigning to on the revalidation application submitted for processing. MACs will have dedicated provider enrollment staff to assist in the large group revalidations.

Groups with less than 200 reassignments will not receive a letter or spreadsheet from their MAC, but can utilize PECOS or the CMS list available on http://go.cms.gov/MedicareRevalidation to determine their provider/supplier’s revalidation due dates.

Unsolicited Revalidation Submissions

All unsolicited revalidation applications submitted more than 6 months in advance of the provider/supplier’s due date will be returned.

- What is an unsolicited revalidation?
  - If you are not due for revalidation in the current 6 month period, your due date will be listed as “TBD” (To Be Determined). This means that you do not yet have a due date for revalidation. Please do not submit a revalidation application if there is NOT a listed due date.
  - Any off-cycle or ad hoc revalidations specifically requested by CMS or the MAC are not considered unsolicited revalidations.
  - If your intention is to submit a change to your provider enrollment record, you must submit a ‘change of information’ application using the appropriate CMS-855 form.

Submitting Your Revalidation Application

IMPORTANT: Each provider/supplier is required to revalidate their entire Medicare enrollment record.

A provider/supplier’s enrollment record includes information such as the provider’s individual practice locations and every group that benefits are reassigned (that is, the group submits claims and receives payments directly for services provided). This means the provider/supplier is recertifying and revalidating all of the information in the enrollment record, including all assigned NPIs and Provider Transaction Access Numbers (PTANs).

If you are an individual who reassigns benefits to more than one group or entity, you must include all organizations to which you reassign your benefits on one revalidation application. If you have someone else completing your revalidation application for you, encourage coordination with all entities to which you reassign benefits to ensure your reassignments remain intact.

The fastest and most efficient way to submit your revalidation information is by using the Internet-based PECOS.

To revalidate via the Internet-based PECOS, go to https://pecos.cms.hhs.gov/pecos/login.do. PECOS allows you to review information currently on file and update and submit your revalidation via the Internet. Once completed, YOU MUST electronically sign the revalidation application and upload any supporting documents or print, sign, date, and mail the paper certification statement along with all required supporting documentation to your appropriate MAC IMMEDIATELY.
PECOS ensures accurate and timelier processing of all types of enrollment applications, including revalidation applications. It provides a far superior alternative to the antiquated paper application process.

To locate the paper enrollment applications, refer to [https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html](https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html) on the CMS website.

**Getting Access to PECOS**

To use PECOS, you must get approved to access the system with the proper credentials which are obtained through the Identity and Access Management System, commonly referred to as “I&A.” The I&A system ensures you are properly set up to submit PECOS applications. Once you have established an I&A account you can then use PECOS to submit your revalidation application as well as other enrollment application submissions.


If you have questions regarding filling out your application via PECOS, please contact the MAC that sent you the revalidation notice. You may also find a list of MAC’s at [https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/contact_list.pdf](https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/contact_list.pdf).

For questions about accessing PECOS (such as login, forgot username/password) or I&A, contact the External User Services (EUS) help desk at 1.866.484.8049 or at EUSSupport@cgi.com.

**Deactivations Due to Non-Response to Revalidation or Development Requests**

It is important that you submit a complete revalidation application by your requested due date and you respond to all development requests from your MACs timely. Failure to submit a complete revalidation application or respond timely to development requests will result in possible deactivation of your Medicare enrollment.

If your application is received substantially after the due date, or if you provide additional requested information substantially after the due date (including an allotted time period for US or other mail receipt) your provider enrollment record may be deactivated. Providers/suppliers deactivated will be required to submit a new full and complete application in order to reestablish their provider enrollment record and related Medicare billing privileges. The provider/supplier will maintain their original PTAN; however, an interruption in billing will occur during the period of deactivation resulting in a gap in coverage.

**NOTE:** The reactivation date after a period of deactivation will be based on the receipt date of the new full and complete application. Retroactive billing privileges back to the period of deactivation will not be granted. Services provided to Medicare patients during the period between deactivation and reactivation are the provider’s liability.

**Revalidation Timeline and Example**

Providers/suppliers may use the following table/chart as a guide for the sequence of events through the revalidation progression.

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<thead>
<tr>
<th>Action</th>
<th>Timeframe</th>
<th>Example</th>
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<tr>
<td>Revalidation list posted</td>
<td>Approximately 6 months prior to due date</td>
<td>March 30, 2017</td>
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<tr>
<td>Issue large group notifications</td>
<td>Approximately 6 months prior to due date</td>
<td>March 30, 2017</td>
</tr>
<tr>
<td>MAC sends e-mail/letter notification</td>
<td>75 – 90 days prior to due date</td>
<td>July 2 - 17, 2017</td>
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**Deactivations Due to Non-Billing**

Providers/suppliers that have not billed Medicare for the previous 12 consecutive months will have their Medicare billing privileges deactivated in accordance with 42 CFR §424.540. The effective date of deactivation will be 5 days from the date of the corresponding deactivation letter issued by the MACs notifying the providers/suppliers of the deactivation action.

Providers/suppliers who Medicare billing privileges are deactivated will be required to submit a new full and complete application in order to reestablish their provider enrollment record and related Medicare billing privileges. The provider/supplier will maintain their original PTAN; however, an interruption in billing will occur during the period of deactivation resulting in a gap in coverage.

**Application Fees**

Institutional providers of medical or other items or services and suppliers are required to submit an application fee for revalidations. The application fee is $560.00 for Calendar Year (CY) 2017. CMS has defined “institutional provider” to mean any provider or supplier that submits an application via PECOS or a paper Medicare enrollment application using the CMS-855A, CMS-855B (except physician and non-physician practitioner organizations), or CMS-855S forms.

All institutional providers (that is, all providers except physicians, non-physicians practitioners, physician group practices and non-physician practitioner group practices) and suppliers who respond to a revalidation request must submit the 2017 enrollment fee (reference 42 CFR 424.514) with their revalidation application. You may submit your fee by ACH debit, or credit card. To pay your application fee, go to [https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do](https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do) and submit payment as directed. A confirmation screen will display indicating that payment was successfully made. This confirmation screen is your receipt and you should print it for your records. CMS strongly recommends that you include this receipt with your uploaded documents on PECOS or mail it to the MAC along with the Certification Statement for the enrollment application. CMS will notify the MAC that the application fee has been paid. Revalidations are processed only when fees have cleared.

**Summary**

- CMS will post the revalidation due dates for the upcoming revalidation cycle on [http://go.cms.gov/MedicareRevalidation](http://go.cms.gov/MedicareRevalidation) for all providers/suppliers. This list will be refreshed periodically. Check this list regularly for updates.
- MACs will continue to send revalidation notices (either by e-mail or mail) within 2-3 months prior to your revalidation due date. When responding to revalidation requests, be sure to revalidate your entire Medicare enrollment record, including all reassignment and practice locations. If you have multiple reassignments/billing structures, you must coordinate the revalidation application submission with all parties.
- If a revalidation application is received but incomplete, the MACs will develop for the missing information. If the missing information is not received within 30 days of the request, the MACs will deactivate the provider/supplier's billing privileges.
- If a revalidation application is not received by the due date, the MAC may place a hold on your Medicare payments and deactivate your Medicare billing privileges.
• If the provider/supplier has not billed Medicare for the previous 12 consecutive months, the MAC will deactivate their Medicare billing privileges.
• If billing privileges are deactivated, a reactivation will result in the same PTAN but an interruption in billing during the period of deactivation. This will result in a gap in coverage.
• If the revalidation application is approved, the provider/supplier will be revalidated and no further action is needed.

Additional Information
To find out whether a provider/supplier has been mailed a revalidation notice go to http://go.cms.gov/MedicareRevalidation on the CMS website.


For more information about the enrollment process and required fees, refer to MLN Matters® Article MM7350, which is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7350.pdf on the CMS website.

For more information about the application fee payment process, refer to MLN Matters Article SE1130, which is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1130.pdf on the CMS website.

The MLN fact sheet titled “The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Provider and Supplier Organizations” is designed to provide education to provider and supplier organizations on how to use Internet-based PECOS to enroll in the Medicare Program and is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_PECOS_ProviderSup_FactSheet_ICN903767.pdf on the CMS website.

To access PECOS, your Authorized Official must register with the PECOS Identification and Authentication system. To register for the first time go to https://pecos.cms.hhs.gov/pecos/PecosiAConfirm.do?transferReason=CreateLogin to create an account.

For additional information about the enrollment process and Internet-based PECOS, please visit the Medicare Provider-Supplier Enrollment webpage at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html.

If you have questions, contact your MAC. Medicare provider enrollment contact information for each State can be found at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/contact_list.pdf.

Document History

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<td>April 10, 2017</td>
<td>The article was revised to correct the table on page 6. The last row should have stated the date as &quot;November 29 – December 14, 2017.&quot;</td>
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<td>Initial article released.</td>
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SE17011: Next Generation Accountable Care Organization (NG ACO) – All Inclusive Population Based Payment (AIPBP) Implementation

The Centers for Medicare & Medicaid Services (CMS) has issued the following Special Edition Medicare Learning Network® (MLN) Matters article. This MLN Matters article and other CMS articles can be found on the CMS website at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2016-MLN-Matters-Articles.html

MLN Matters® Number: SE17011
Related CR Release Date: April 20, 2017
Related CR Transmittal #: N/A

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Provider Types Affected

This MLN Matters Article is intended for physicians, hospitals, and other providers who are participating in Next Generation Accountable Care Organization (NGACOs) Model and submitting claims to Medicare Administrative Contractors (MACs) under the All-Inclusive Population Based Payment (AIPBP) alternate payment mechanism for certain services for Medicare beneficiaries.

Provider Action Needed

Special Edition (SE) article SE17011 reminds providers of the implementation of the AIPBP payment mechanism for participating ACOs.

Background

The NGACO Model offers ACOs the option to participate in a payment mechanism called AIPBP under which the ACO takes on responsibility for entering into payment arrangements with its providers and paying claims, in place of claims being paid by Medicare’s Fee-For-Service (FFS) systems. The goal of AIPBP is to establish a monthly cash flow for AIPBP-participating ACOs and a mechanism for ACOs to enter payment arrangements with Next Generation Participants and Preferred Providers. Conceptually, AIPBP builds on population-based payments (PBP) in the Pioneer ACO Model and available in the NGACO Model, but enables even greater flexibility in establishing payment relationships between the ACO and its providers.

Under AIPBP, participating ACOs will receive a monthly lump-sum payment outside of the FFS system and be responsible for paying Next Generation Participants and Preferred Providers with whom they have entered into written AIPBP Payment Arrangement agreements. The monthly payment will be based on an estimation of the care that will be provided to aligned beneficiaries in the performance year by AIPBP-participating providers.

Reconciliation will occur following the performance year to true up the monthly payments (based on estimation) versus what AIPBP-participating providers would have been paid under FFS.

All participating providers will continue to submit FFS claims to CMS, which will fully adjudicate the claims, but will not make payment to providers who have agreed to participate in AIPBP except for add-on payments for inpatient hospitals (specifically operating outlier payments, operating disproportionate share hospital [DSH] payments, operating indirect medical education [IME] payments, Medicare new technology payments, and Islet isolation cell transplantation payments.).
ACOs had an annual election to participate in AIPBP from among three alternate payment mechanisms in 2017; the ACO’s Providers/Suppliers and Preferred Providers will agree to participate on a provider-by-provider basis (that is, not all Providers/Suppliers, or Preferred Providers will have claims reduced up to 100 percent). All AIPBP-participating providers will receive a 100-percent reduction to their claims if they see an aligned beneficiary, unless that aligned beneficiary has opted out of medical claims data sharing with the ACO or if the claim is for substance abuse-related services. If an AIPBP-participating provider sees a beneficiary not aligned to an ACO, they would not receive the reduction.

Providers who do not have an AIPBP Payment Arrangement with an ACO, whether in the ACO or not, will continue to receive normal FFS reimbursements for all the beneficiaries they treat, including aligned beneficiaries. Medicare systems will continue to view providers and beneficiaries as being FFS.

As mentioned, providers continue to submit all FFS claims to CMS, which will make coverage and liability determinations and assess beneficiary liability. Beneficiary liabilities will be calculated based on what Medicare would have paid in absence of AIPBP, and Medicare Summary Notices (MSNs) should reflect the amount that would have been paid (as is currently done for PBP). Similarly, Medicare will continue to send remittance notices to AIPBP-participating providers (just as they would receive remittance notices if not participating in AIPBP).

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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<td>Initial article release.</td>
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</tbody>
</table>