Medicare Bulletin
Jurisdiction 15

Reaching Out to the Medicare Community

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Kentucky & Ohio Quarterly Provider Update

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

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

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

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

If you have any questions, please contact a CGS Customer Service Representative by calling the CGS Provider Contact Center at 1.866.276.9558 and choose Option 1.

Kentucky & Ohio

MM9859 Revised: Screening for Hepatitis B Virus (HBV) Infection

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: MM9859 Revised
Related CR Release Date: April 28, 2017
Related CR Transmittal #: R3761CP and R195NCD
Related Change Request (CR) #: CR 9859
Effective Date: September 28, 2016
Implementation Date: January 1, 2018

Note: This article was changed on May 17, 2017, to clarify language on page 3, under the “Professional Billing Requirements.” It now reads, only when services are ordered by the following provider specialties found on the provider’s enrollment record… All other information is unchanged.

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

Provider Action Needed
Change Request (CR) 9859 provides that the Centers for Medicare & Medicaid Services (CMS) has determined that, effective September 28, 2016, Medicare will cover screening for Hepatitis B Virus (HBV) infection when performed with the appropriate U.S. Food and Drug Administration (FDA) approved/cleared laboratory tests, used consistent with FDA-approved labeling and in compliance with the Clinical Laboratory Improvement Act (CLIA) regulations. **Medicare coinsurance and the Part B deductible are waived for this additional preventive service.** You should ensure that your billing staffs are aware of this coverage change.

Background
Pursuant to Section 1861(ddd) of the Social Security Act (the Act), CMS may add coverage of “additional preventive services” through the National Coverage Determination (NCD) process. The preventive services must meet all of the following criteria:

1. Reasonable and necessary for the prevention or early detection of illness or disability.
2. Recommended with a grade of A or B by the United States Preventive Services Task Force (USPSTF).
3. Appropriate for individuals entitled to benefits under Part A or enrolled under Part B.

The USPSTF has updated its recommendations for HBV screening, and CMS has reviewed these recommendations and supporting evidence; and has determined that the evidence is adequate to conclude that screening for HBV infection is reasonable and necessary for individuals entitled to benefits under Part A or enrolled under Part B, as described below.

Effective for services performed on or after September 28, 2016, Medicare will cover screening for HBV infection, when ordered by the beneficiary’s primary care physician or practitioner within the context of a primary care setting, and performed by an eligible Medicare provider for these services, within the context of a primary care setting with the appropriate U.S. Food and Drug Administration (FDA) approved/cleared laboratory tests, used consistent with FDA-approved labeling and in compliance with the Clinical Laboratory Improvement Act (CLIA) regulations, for beneficiaries who meet either of the following conditions:

1. Asymptomatic, non-pregnant adolescents and adults at high risk for HBV infection. “High risk” is defined as persons born in countries and regions with a high prevalence of HBV infection (that is, ≥ 2%), US-born persons not vaccinated as infants whose parents were born in regions with a very high prevalence of HBV infection (≥ 8%), HIV positive persons, men who have sex with men, injection drug users, household contacts or sexual partners of persons with HBV infection. In addition, CMS has determined that repeated screening would be appropriate annually for beneficiaries with continued high risk persons. Testing is covered annually only for persons who have continued high risk (men who have sex with men, injection drug users, household contacts or sexual partners of persons with HBV infection) who have not received hepatitis B vaccination.
2. A screening test at the first prenatal visit is covered for pregnant women and then rescreening at time of delivery for those with new or continuing risk factors. In addition, CMS has determined that screening during the first prenatal visit would be appropriate for each pregnancy, regardless of previous hepatitis B vaccination or previous negative hepatitis B surface antigen (HBsAg) test results.

For the purposes of CR9859:

- The determination of ‘high risk for HBV” is identified by the primary care physician or practitioner who assesses the patient’s history, which is part of any complete medical history, typically part of an annual wellness visit and considered in the development of a comprehensive prevention plan. The medical record should be a reflection of the service provided.

- A primary care setting is defined by the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Emergency departments, inpatient hospital settings, ambulatory surgical centers, skilled nursing facilities, inpatient rehabilitation facilities, clinics providing a limited focus of health care services, and hospice are examples of settings not considered primary care settings under this definition.

**Key Points of CR9859**

**Applicable Healthcare Common Procedure Coding System (HCPCS) Code**

Effective for claims with dates of service on or after September 28, 2016, the claims processing instructions for payment of screening for hepatitis B virus will apply to the following HCPCS and CPT codes:

- HBV screening for asymptomatic, non-pregnant adolescents and adults at high risk - code G0499
- HBV screening for pregnant women - CPT codes 86704, 86706, 87340, and 87341

**Types of Bills (TOB) for Institutional Claims**

Effective for claims with dates of service on or after September 28, 2016, you should use the following TOBs when submitting claims with G0499, 87340, 87341, 86704, or 86706 for HBV screening:

- Outpatient hospitals - TOB 13X (payment based on Outpatient Prospective Payment System)
- Non-patient laboratory specimen - TOB 14X (payment based on laboratory fee schedule)
- Critical Access Hospitals (CAHs) - TOB 85X, (payment based on reasonable cost when the revenue code is not 096X, 097X, and 098X)
- End Stage Renal Disease (ESRD) - TOB 72X (payment based on ESRD Prospective Payment System when submitting code G0499 with diagnosis code N18.6. HBV is not separately payable for ESRD TOB 72X.)

**Professional Billing Requirements**

For claims with dates of service on or after September 28, 2016, CMS will allow coverage for HBV screening only when services are ordered by the following provider specialties found on the provider’s enrollment record:

- 01 - General Practice
- 08 - Family Practice
- 11 - Internal Medicine
- 16 - Obstetrics/Gynecology
- 37 - Pediatric Medicine
- 38 - Geriatric Medicine
- 42 - Certified Nurse Midwife
- 50 - Nurse Practitioner
- 89 - Certified Clinical Nurse Specialist
- 97 - Physician Assistant
Claims submitted by providers other than the specialty types noted above will be denied.

Additionally, for claims with dates of service on or after September 28, 2016, CMS will allow coverage for HBV screening only when submitted with one of the following Place of Service (POS) codes:

- 11 - Physician’s Office
- 19 - Off Campus Outpatient Hospital
- 22 - On Campus Outpatient Hospital
- 49 - Independent Clinic
- 71 - State or Local Public Health Clinic
- 81 - Independent Laboratory

Claims submitted without one of the POS codes noted above will be denied.

### Diagnosis Code Reporting Requirements

For claims with dates of service on or after September 28, 2016, CMS will allow coverage for G0499 for HBV screening only when services are reported with both of the following diagnosis codes denoting high risk:

- Z11.59 - Encounter for screening for other viral disease
- Z72.89 - Other Problems related to lifestyle.

For claims with dates of service on or after September 28, 2016, CMS will allow coverage for G0499 for subsequent visits, only when services are reported with the following diagnosis codes:

- Z11.59 and one of the high risk codes below
  - F11.10-F11.99
  - F13.10-F13.99
  - F14.10-F14.99
  - F15.10-F15.99
  - Z20.2
  - Z20.5
  - Z72.52
  - Z72.53

For claims with dates of service on or after September 28, 2016, CMS will allow coverage for HBV screening (CPT codes 86704, 86706, 87340 and 87341) in pregnant women only when services are reported with one of the following diagnosis codes:

- Z11.59 - Encounter for screening for other viral diseases, and one of the following
  - Z34.00 - Encounter for supervision of normal first pregnancy, unspecified trimester
  - Z34.80 - Encounter for supervision of other normal pregnancy, unspecified trimester
  - Z34.90 - Encounter for supervision of normal pregnancy, unspecified trimester
  - O09.90 - Supervision of high risk pregnancy, unspecified trimester

For claims with dates of service on or after September 28, 2016, CMS will allow coverage for HBV screening (CPT codes 86704, 86706, 87340, and 87341) in pregnant women at high risk only when services are reported with one of the following diagnosis codes:

- Z11.59 - Encounter for screening for other viral diseases; and
- Z72.89 - Other problems related to lifestyle, and also one of the following:

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<tr>
<th>Code</th>
<th>Description</th>
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<td>Z34.02</td>
<td>Encounter for supervision of normal first pregnancy, second trimester</td>
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<td>Encounter for supervision of normal first pregnancy, third trimester</td>
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<td>Z34.83</td>
<td>Encounter for supervision of other normal pregnancy, third trimester</td>
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<tr>
<td>Code</td>
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<tr>
<td>Z34.90</td>
<td>Encounter for supervision of normal pregnancy, unspecified, unspecified trimester</td>
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<td>Encounter for supervision of normal pregnancy, unspecified, third trimester</td>
</tr>
<tr>
<td>O09.90</td>
<td>Supervision of high risk pregnancy, unspecified, unspecified trimester</td>
</tr>
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<td>O09.93</td>
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</table>

Claim/Service Denial

When denying payment for HBV screening use, your MAC will use the appropriate Claim Adjustment Reason Codes (CARCs), Remittance Advice Remark Codes (RARCs), or group codes.

When denying services submitted on a TOB other than 13X, 14X, or 85X, they will use:

- CARC 170 - Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present
- RARC N95 - This provider type/provider specialty may not bill this service
- Group Code CO (Contractual Obligation) - Assigning financial liability to the provider

When denying services when HCPCS G0499 is paid in history for claims with dates of service on and after September 28, 2016, or if the beneficiary’s claim history shows claim lines containing CPT codes 86704, 86706, 87340, and 87341 submitted in the previous 11 full months they will use the following messages:

- CARC 119 - “Benefit maximum for this time period or occurrence has been reached.”
- RARC N386 - “This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at [http://www.cms.gov/mcd/search.asp](http://www.cms.gov/mcd/search.asp). If you do not have Web access, you may contact the contractor to request a copy of the NCD.”
- Group Code PR (Patient Responsibility) - Assigning financial responsibility to the beneficiary (if a claim is received with occurrence code 32 with or without GA modifier or a claim line is received with a GA modifier indicating a signed ABN is on file).
- Group Code CO (Contractual Obligation) - Assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

When denying services for G0499, when ICD-10 diagnosis code Z72.89 and Z11.59 are not present on the claim, MACs will use:

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

Denying services for HBV screening, HCPCS G0499, when ICD-10 diagnosis code Z34.00, Z34.01, Z34.02, Z34.03, Z34.80, Z34.81, Z34.82, Z34.83, Z34.90, Z34.91, Z34.92, Z34.93, O09.90, O09.91, O09.92, or O09.93 is present on the claim:
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.

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

When denying services for G0499 for subsequent visits, when ICD-10 diagnosis code Z11.59 and one of the following high risk diagnosis codes: F11.10- F11.19, F13.10 - F13.99, F14.10 - F14.99, F15.10 - F15.99, Z20.2, Z20.5, Z72.52, or Z72.53 are not present on the claim, MACs will use:

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

When denying claim lines for G0499 without the appropriate POS code, MACs will use:

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

When denying claim lines for G0499 that are not submitted from the appropriate provider specialties, MACs will use:

- CARC 184 - The prescribing/ordering provider is not eligible to prescribe/order the service billed. NOTE: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- RARC N386 - “This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at http://www.cms.gov/mcd/search.asp. If you do not have Web access, you may contact the contractor to request a copy of the NCD.”
- Group Code PR (Patient Responsibility) - Assigning financial responsibility to the beneficiary (if a claim is received with a GA modifier indicating a signed ABN is on file).
- Group Code CO (Contractual Obligation) - Assigning financial liability to the provider (if a claim line-item is received with a GZ modifier indicating no signed ABN is on file).

When denying services where previous HBV screening, HCPCS 86704, 86706, 87340, or 87341, is paid during the same pregnancy period or more than two screenings are paid to women that are at high risk, they will use:

- CARC 119 - “Benefit maximum for this time period or occurrence has been reached.”
- RARC N362 - “The number of days or units of service exceeds our acceptable maximum.”
- RARC N386 - “This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is
covered. A copy of this policy is available at http://www.cms.gov/mcd/search.asp. If you do not have Web access, you may contact the contractor to request a copy of the NCD."

- Group Code PR (Patient Responsibility) - Assigning financial responsibility to the beneficiary (if a claim is received with a GA modifier indicating a signed ABN is on file).
- Group Code CO (Contractual Obligation) - Assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

When denying claim lines for HBV screening, HCPCS G0499 for a subsequent HBV screening test for non-pregnant, high risk beneficiary when a claim line for an initial HBV screening has not yet been posted in history, use the following messages:

- CARC B15 - This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- RARC N386 - This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at http://www.cms.gov/mcd/search.asp. If you do not have Web access, you may contact the contractor to request a copy of the NCD.
- Group Code - CO (Contractual Obligation).

When denying services for HBV screening, HCPCS 86704, 86706, 87340, and 87341 that are billed without the appropriate diagnosis code MACs will use:

- CARC 50 - These are non-covered services because this is not deemed a “medical necessity” by the payer. Note: Refer to the 835 Healthcare Policy identification Segment (loop 2110 Service Payment information REF), if present.
- RARC N386 - "This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at http://www.cms.gov/mcd/search.asp. If you do not have Web access, you may contact the contractor to request a copy of the NCD."
- Group Code PR (Patient Responsibility) - Assigning financial responsibility to the beneficiary (if a claim is received with a GA modifier indicating a signed ABN is on file).
- Group Code CO (Contractual Obligation) - Assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

Additional Notes

- HCPCS code G0499 will appear in the January 1, 2018, Clinical Laboratory Fee Schedule (CLFS), in the January 1, 2017, Integrated Outpatient Code Editor (IOCE), and in the January 1, 2017, Medicare Physician Fee Schedule (MPFS) with indicator ‘X’. HCPCS code G0499 will be effective retroactive to September 28, 2016, in the IOCE.
- Your MAC will not search for claims containing HCPCS G0499 with dates of service on or after September 28, 2016, but may adjust claims that you bring to their attention.
- You should be aware that the revision to the “Medicare National Coverage Determinations Manual” is a National Coverage Determination (NCD). NCDs are binding on all carriers, fiscal intermediaries, contractors with the Federal government that review and/or adjudicate claims, determinations, and/or decisions, quality improvement organizations, qualified independent contractors, the Medicare appeals council, and Administrative Law Judges (ALJs) (see 42 CFR Section 405.1060(a)(4) (2005)). An NCD that expands coverage is also binding on a Medicare advantage organization. In addition, an ALJ may not review an NCD. (See Section 1869(f)(1)(A)(i) of the Social Security Act.)
- MACs will apply contractor pricing to claim lines with G0499 with dates of service September 28, 2016, through December 31, 2017.
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.

Document History

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<td>May 4, 2017</td>
<td>Initial article released.</td>
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Kentucky & Ohio

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

The Centers for Medicare & Medicaid Services (CMS) has 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:** MM9893 Revised
- **Related Change Request (CR) #:** CR 9893
- **Related CR Release Date:** May 10, 2017
- **Effective Date:** October 1, 2017
- **Related CR Transmittal #:** R18450TN
- **Implementation Date:** October 2, 2017

**Note:** This article was revised on May 10, 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, http://www.gao.gov/products/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.

Deductible and coinsurance do not apply to G0499.
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/.

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**Kentucky & Ohio**

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

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

**MLN Matters® Number:** MM9911 *Revised*

**Related CR Release Date:** April 28, 2017

**Related CR Transmittal #:** R3764CP

**Related Change Request (CR) #:** CR 9911

**Effective Date:** For claims processed on or after October 2, 2017

**Implementation Date:** October 2, 2017

**Note:** The article was revised on May 1, 2017, to reflect a revised CR9911 issued on April 28, 2017. In the article, the CR release date, transmittal number, and the Web address of CR9911 are revised. 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.
Under federal law, Medicare providers may not bill individuals enrolled in the QMB program for Medicare deductibles, coinsurance, or copayments, under any circumstances. (See 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 reimbursement for Medicare cost-sharing under certain circumstances. Nonetheless, Medicare providers must accept the Medicare payment and Medicaid payment (if any, and including any permissible Medicaid cost sharing from the beneficiary) as payment in full for services rendered to an individual enrolled in the QMB program.

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 016x 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)).

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.cmsmedicare.com. © 2017 Copyright, CGS Administrators, LLC.
Finally, CR 9911 will modify the MSN to inform beneficiaries if they are enrolled in QMB and cannot be billed for Medicare cost-sharing for covered items and services.

Additional Information


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

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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Kentucky & Ohio

**MM9916 Rescinded: Episode Payment Model Operations**

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

**MLN Matters® Number:** MM9916 Rescinded  **Related Change Request (CR) #:** CR 9916

**Related CR Release Date:** February 17, 2017  **Effective Date:** July 1, 2017

**Related CR Transmittal #:** R169DEMO  **Implementation Date:** July 3, 2017

**Note:** This article has been rescinded as CR9916 was rescinded. The CR will be replaced at a later date.

Kentucky & Ohio

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

Since March 2017, CGS has sent regular listserv announcements informing myCGS Web portal Users about the mandate for CGS to implement Multi-Factor Authentication (MFA) by July 1, 2017. MFA meets the security requirements that are mandated by the Centers for Medicare & Medicaid Services (CMS) that helps ensure your myCGS account and your patient’s Medicare information is protected.

If you were not signed up by July 1, 2017, MFA will automatically set with the e-mail address associated with the user ID. Each time you access myCGS, you will receive an eight-digit verification code via the e-mail address. If you signed up prior to July 1, 2017, the verification code is sent via the option you selected (text, or e-mail). Once the verification code is entered, you will have access to the myCGS website portal.
Each time you log into 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. This added security will allow you to enjoy peace of mind that will make this extra step more than worth it!


Kentucky & Ohio

**MM9940 Revised: The Process of Prior Authorization**

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:** MM9940 Revised    **Related Change Request (CR) #:** CR 9940
**Related CR Release Date:** January 20, 2017    **Effective Date:** February 21, 2017
**Related CR Transmittal #:** R698PI    **Implementation Date:** February 21, 2017

**Note:** This article was revised on May 1, 2017, to include a new Web address for the Required Prior Authorization List. All other information remains the same.

**Provider Types Affected**

This MLN Matters® Article is intended for providers ordering certain DMEPOS items and suppliers submitting claims to Medicare Administrative Contractors (MACs) for items furnished to Medicare beneficiaries.

**What You Need to Know**

Change Request (CR) 9940 updates the Centers for Medicare & Medicaid Services (CMS) “Program Integrity Manual” to permit the MACs to conduct prior authorization processes, as so directed by CMS through individualized operational instructions. As of January 2017, Prior Authorization of Certain Durable Medical Equipment, Prosthetic, Orthotic, and Supply Items, frequently subject to unnecessary utilization, is the only permanent (non-demonstration) prior authorization program approved for implementation. Make sure your billing staff is aware of these changes.

**Background**

Prior authorization is a process through which a request for provisional affirmation of coverage is submitted to a medical review contractor for review before the item or service is furnished to the beneficiary and before the claim is submitted for processing. It is a process that permits the submitter/requester (for example, provider, supplier, beneficiary) to send in medical documentation, in advance of the item or service being rendered, and subsequently billed, in order to verify its eligibility for Medicare claim payment.

For any item or service to be covered by Medicare it must:

- Be eligible for a defined Medicare benefit category
- Be medically reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member
- Meet all other applicable Medicare coverage, coding and payment requirements

Contractors shall, at the direction of CMS or other authorizing entity, conduct prior authorizations and alert the requester/submitter of any potential issues with the information submitted.
A prior authorization request decision can be either a provisional affirmative or a non-affirmative decision.

- A provisional affirmative decision is a preliminary finding that a future claim submitted to Medicare for the item or service likely meets Medicare’s coverage, coding, and payment requirements.

- A non-affirmative decision is a finding that the submitted information/documentation does not meet Medicare’s coverage, coding, and payment requirements, and if a claim associated with the prior authorization is submitted for payment, it would not be paid. MACs shall provide notification of the reason for the non-affirmation, if a request is non-affirmative, to the submitter/requester. If a prior authorization request receives a non-affirmative decision, the prior authorization request can be resubmitted an unlimited number of times.

- Prior authorization may also be a condition of payment. This means that claims submitted without an indication that the submitter/requester received a prior authorization decision (that is, Unique Tracking Number (UTN)) will be denied payment.

Each prior authorization program will have an associated Operational Guide that will be available on the CMS website. In addition, MACs will educate stakeholders each time a new prior authorization program is launched. That education will include the requisite information and timeframes for prior authorization submissions and the vehicle to be used to submit such information to the MAC.

Prior Authorization Program for DME MACs

A prior authorization program for certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) items that are frequently subject to unnecessary utilization is described in 42 CFR 414.234. Among other things, this section establishes a Master List of certain DMEPOS items meeting inclusion criteria and potentially subject to prior authorization. CMS will select Healthcare Common Procedure Coding System (HCPCS) codes from the Prior Authorization Master List to be placed on the Required Prior Authorization List, and such codes will be subject to prior authorization as a condition of payment. In selecting HCPCS codes, CMS may consider factors such as geographic location, item utilization or cost, system capabilities, administrative burden, emerging trends, vulnerabilities identified in official agency reports, or other data analysis.

- The Prior Authorization Master List is the list of DMEPOS items that have been identified using the inclusion criteria described in 42 CFR 414.234.

- The List of Required DMEPOS Prior Authorization Items contains those items selected from the Prior Authorization Master List to be implemented in the Prior Authorization Program. The List of Required DMEPOS Prior Authorization Items will be updated as additional codes are selected for prior authorization.

- CMS may suspend prior authorization requirements generally or for a particular item or items at any time and without undertaking rulemaking. CMS provides notification of the suspension of the prior authorization requirements via Federal Register notice and posting on the CMS prior authorization website.

The items on the Required Prior Authorization List, a “CMS Final Rule 6050-F” subpage containing the Master List, as well as other pertinent information and supporting documents regarding this program, are available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/DMEPOS/Prior-Authorization-Process-for-Certain-Durable-Medical-Equipment-Prosthetic-Orthotics-Supplies-Items.html.
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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Kentucky & Ohio

MM9957: New Physician Specialty Code for Advanced Heart Failure and Transplant Cardiology, Medical Toxicology, and Hematopoietic Cell Transplantation and Cellular Therapy

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: MM9957
Related CR Release Date: April 28, 2017
Related CR Transmittal #: R283FM and R3762CP

Related Change Request (CR) #: CR 9957
Effective Date: October 1, 2017
Implementation Date: October 2, 2017

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

Provider Action Needed
Change Request (CR) 9957 establishes new physician specialty codes for Advanced Heart Failure and Transplant Cardiology (C7), Medical Toxicology (C8), and Hematopoietic Cell Transplantation and Cellular Therapy (C9). The new codes are effective on October 1, 2017. Make sure that your billing staffs are aware of these new specialty codes.

Background
Physicians self-designate their Medicare physician specialty on the Medicare enrollment application (CMS-855I or CMS-855O) or Internet-based Provider Enrollment, Chain and Ownership System (PECOS) when they enroll in the Medicare program. Medicare physician specialty codes describe the specific/unique types of medicine that physicians (and certain other suppliers) practice. The Centers for Medicare & Medicaid Services (CMS) uses specialty codes for programmatic and claims processing purposes.

The CMS-855I and CMS-855O paper applications will be updated to reflect the new specialties in the future. In the interim, providers shall select the ‘Undefined physician type’ option on the enrollment application and specify the applicable specialty in the space provided.
Existing enrolled providers who want to update their specialty to reflect one of the new specialties must submit a change of information application to their MAC. Providers may submit an enrollment application to initially enroll or update their specialty within 60 days of the implementation date of the new specialties.

**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/).

**Kentucky & Ohio**

**MM9988 Revised: April Quarterly Update for 2017 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule**

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:** MM9988 Revised  
**Related Change Request (CR) #:** CR 9988  
**Related CR Release Date:** AMay 5, 2017  
**Related CR Transmittal #:** R3768CP  
**Effective Date:** April 1, 2017  
**Implementation Date:** April 3, 2017

**Note:** This article was revised on May 5, 2017, to reflect a revised CR9988 issued that day. The CR was revised to delete an example that was in the original CR. That example has been removed from the article. Also, the CR release date, transmittal number, and the Web address of CR9988 are revised in the article. All other information remains 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.

**What You Need to Know**

Change Request (CR) 9988 provides the April 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” (Pub.100-04, Chapter 23, Section 60, [https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c23.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c23.pdf)).
Payment on a fee schedule basis is required for durable medical equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by the Social Security Act (§1834(a), (h), and (i)) (https://www.ssa.gov/OP_Home/ssact/title18/1834.htm). Also, payment on a fee schedule basis is a regulatory requirement at 42 Code of Federal Regulations (CFR) §414.102 (http://www.ecfr.gov/cgi-bin/text-idx?SID=becd20e512ac4c175ad81e37e4583f85&mc=true&node=p42.3.414&rgn=div5#se42.3.414_1102) for parenteral and enteral nutrition (PEN), splints and casts, and intraocular lenses (IOLs) inserted in a physician’s office.

Additionally, Section §1834(a)(1)(F)(ii) (https://www.ssa.gov/OP_Home/ssact/title18/1834.htm) 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, 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 April 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 http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched.

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

Section 16005 of the 21st Century Cures Act extends the effective date through June 30, 2017, to exclude adjustments to fees using information from CBPs for certain wheelchair accessories (including seating systems) and seat and back cushions furnished in connection with Group 3 complex rehabilitative power wheelchairs (codes K0848 through K0864). As a result, the KU modifier fees have been added back to the DMEPOS fee schedule file effective January 1, 2017, and are effective for dates of service through June 30, 2017. The fees for items denoted with the HCPCS modifier ‘KU’ represent the unadjusted fee schedule amounts (the CY 2015 fee schedule amount updated by the 2016 and 2017 DMEPOS covered item update factor of 0.7 percent). The applicable complex rehabilitative wheelchair accessory codes are listed in CR 9520 (Transmittal 3535, dated June 7, 2016).

**Note for Change Request 8822 Reclassification of Certain DME to the Capped Rental Payment Category**

For dates of service on or after January 1, 2017, payment for the following HCPCS codes in all geographic areas is made on a capped rental basis: E0197, E0140, E0149, E0985, E1020, E1028, E2228, E2368, E2369, E2370, E2375, K0015, K0070, and E0955.

For dates of service on or after July 1, 2016, through December 31, 2016, these HCPCS codes were reclassified from the payment category for inexpensive and routinely purchased DME to payment on a capped rental basis in all areas except the nine Round 1 Recompete (Round 1 2014) Competitive Bidding Areas (CBAs). Program instructions on these changes were issued in CR 8822 (Transmittal 1626, dated February 19, 2016) and CR 8566 (Transmittal 1332, dated January 2, 2014). Related MLN Matters articles are at https://www.cms.gov/Outreach-
When submitting claims, suppliers that submit claims with more than four modifiers including when the claim is being billed with both the RT (right) and the LT (left) modifiers will include the NU (Purchase of new equipment) or RR (Rental) modifier as appropriate, the RT and LT modifiers and then the 99 modifier to signify that there are additional modifiers in use. On the narrative line, the supplier will include all applicable modifiers including the NU or RR, RT and LT modifiers.

Payment for Oxygen Volume Adjustments and Portable Oxygen Equipment

CR 9848 (Transmittal 3679, dated December 16, 2016) titled Payment for Oxygen Volume Adjustments and Portable Oxygen Equipment, updated the “Medicare Claims Processing Manual” (Pub.100-04, chapter 20, section 130.6) to clarify billing when the prescribed amount of stationary oxygen exceeds 4 liters per minute (LPM) and portable oxygen is prescribed. The QF modifier is used to denote when the oxygen flow exceeds 4 LPM and portable oxygen is prescribed.

The Social Security Act (§ 1834(a)(5)(C) and (D)) requires that when there is an oxygen flow rate that exceeds 4 LPM that the Medicare payment amount be the higher of 50 percent of the stationary payment amount (codes E0424, E0439, E1390, or E1392) or the portable oxygen add-on amount (E0431, E0433, E0434, E1392, or K0738), and never both.

To facilitate this payment calculation, the QF modifier is added to the DMEPOS fee schedule file effective April 1, 2017, for both stationary and portable oxygen. The stationary oxygen QF modifier fee schedule amounts represent 100 percent of the stationary oxygen fee schedule amount. The portable oxygen QF fee schedule amounts represent the higher of 50 percent of the monthly stationary oxygen payment amount or the fee schedule amount for the portable oxygen add-on amount.

Effective April 1, 2017, the modifier “QF” should be used in conjunction with claims submitted for stationary oxygen (codes E0424, E0439, E1390, or E1391) and portable oxygen (codes E0431, E0433, E0434, E1392, or K0738) when the prescribed amount of oxygen is greater than 4 liters per minute (LPM).

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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MM10013: Two New "K" Codes for Therapeutic Continuous Glucose Monitors

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: MM10013 Related Change Request (CR) #: CR 10013
Related CR Release Date: April 28, 2017 Effective Date: July 1, 2017
Related CR Transmittal #: R3751CP Implementation Date: July 3, 2017

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

What You Need to Know
Change Request (CR) 10013 provides the two codes for therapeutic Continuous Glucose Monitors (CGM) that will be added to the Healthcare Common Procedure Coding System (HCPCS) code set, effective July 1, 2017. The addition of these codes (K0553 and K0554) will facilitate Durable Medical Equipment (DME) MAC claims processing for therapeutic CGMs. Make sure that your billing staffs are aware of these two new codes.

Background
On January 12, 2017, the Centers for Medicare & Medicaid Services (CMS) issued a Ruling (CMS-1682-R), concluding that certain CGM, referred to as therapeutic CGMs, are considered durable medical equipment (DME).

Continuous glucose monitoring systems are considered therapeutic CGMs (and therefore DME), if the equipment:

- Is approved by the Food and Drug Administration for use in place of a blood glucose monitor for making diabetes treatment decisions (for example, changes in diet and insulin dosage)
- Is generally not useful to the individual in the absence of an illness or injury
- Is appropriate for use in the home
- Includes a durable component (a component that CMS determines can withstand repeated use and has an expected lifetime of at least 3 years) that is capable of displaying the trending of the continuous glucose measurements

To facilitate implementation of this Ruling, the following two codes will be added to the HCPCS code set effective July 1, 2017:

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

The billing jurisdiction for both of these codes will be the DME 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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Kentucky & Ohio

MM10055: New Waived Tests

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: MM10055
Related CR Release Date: May 12, 2017
Related CR Transmittal #: R3771CP
Effective Date: January 1, 2017
Implementation Date: July 3, 2017

Provider Types Affected
Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed
Change Request (CR) 10055 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 Food and Drug Administration (FDA) as waived tests under CLIA. The Current Procedural Terminology (CPT) codes for the following new tests must have the modifier QW to be recognized as a waived test. However, the tests mentioned on the first page of the attached list (that is, CPT codes: 81002, 81025, 82270, 82272, 82962, 83026, 84830, 85013, and 85651) do not require a QW modifier to be recognized as a waived test.

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

- 82465QW, 83718QW, 82947QW, 82950QW, 82951QW, 82952QW, December 22, 2016, Polymer Technology Systems, Inc., CardioChek Home Test System (CardioChek Home Chol+HDL+Glu test strips)
The new waived complexity code G0475 [HIV antigen/antibody, combination assay, screening] describes the testing assigned to the waived CPT 87806QW when it is performed for screening purposes. Effective January 1, 2017, the use of G0475QW will be permitted for claims submitted by facilities with a valid, current CLIA certificate of waiver.

The new waived complexity code, 87801QW [Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; amplified probe(s) technique] is assigned to the testing performed by the Alere i System Respiratory Syncytial Virus test.

The attachment to CR1005 contains the test name, manufacturer, and use for each above listed CPT codes. You should be aware that MACs will not search their files to either retract payment or retroactively pay claims; however, they 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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<tr>
<td>May 15, 2017</td>
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</table>
**Kentucky & Ohio**

**MM10057: MCS Implementation of the Restructured Clinical Lab Fee Schedule**

The Centers for Medicare & Medicaid Services (CMS) has issued the following *Medicare Learning Network® (MLN) Matters* article. This MLN Matters article and other CMS articles can be found on the CMS website at: [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:** MM10057  \hspace{1cm} **Related Change Request (CR) #:** CR 10057  
**Related CR Release Date:** May 12, 2017  \hspace{1cm} **Effective Date:** January 1, 2018  
**Related CR Transmittal #:** R1846OTN  \hspace{1cm} **Implementation Date:** January 2, 2018

**Provider Types Affected**

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

**Provider Action Needed**

Change Request (CR) 10057 instructs Medicare's Multi-Carrier System (MCS) maintainer to incorporate into the shared system, the revised Clinical Lab Fee Schedule (CLFS) containing the National fee schedule rates. Make sure your billing staffs are aware of these changes.

**Background**

Section 216 of Public Law 113-93, the “Protecting Access to Medicare Act of 2014,” added section 1834A to the Social Security Act (the Act). This provision requires extensive revisions to the payment and coverage methodologies for clinical laboratory tests paid under the clinical laboratory fee schedule (CLFS). The Centers for Medicare & Medicaid Services (CMS) published Final Rule 81 FR 41035, pages 41035-41101 on June 23, 2016, which implemented the provisions of the new legislation.

The final rule set forth new policies for how CMS sets rates for tests on the CLFS and is effective for dates of service on and after January 1, 2018. Beginning on January 1, 2017, applicable laboratories were required to submit data to CMS which describes negotiated payment rates with private payers for any corresponding volumes of tests on the CLFS. In general, with certain designated exceptions, the payment amount for a test on the CLFS furnished on or after January 1, 2018, will be equal to the weighted median of private payer rates determined for the test, based on data collected from laboratories during a specified data collection period. In addition, a subset of tests on the CLFS, advanced diagnostic laboratory tests (ADLTs), will have different data, reporting, and payment policies associated with them. In particular, the final rule discusses CMS’ proposals regarding:

- Definition of “applicable laboratory” (who must report data under section 1834A of the Act)
- Definition of “applicable information” (what data will be reported)
- Data collection period
- Schedule for reporting data to CMS
- Definition of ADLT
- Data Integrity
- Confidentiality and public release of limited data
- Coding for new tests on the CLFS
- Phased in payment reduction

**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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**Kentucky & Ohio**

**MM10071: July Quarterly Update for 2017 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule**

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

**MLN Matters® Number:** MM10071  
**Related CR Release Date:** April 28, 2017  
**Related CR Transmittal #:** R3760CP  
**Related Change Request (CR) #:** CR 10071  
**Effective Date:** July 1, 2017  
**Implementation Date:** July 3, 2017

**Provider Types Affected**

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

**Provider Action Needed**

Change Request (CR) 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 (http://www.ecfr.gov/cgi-bin/text-idx?SID=beecd20e512ac4c175ad81e37e4583f85&mc=true&node=p42.3.414&rgn=div5#se42.3.414_1102) 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**

Effective July 1, 2017, the fee schedule amounts for wheelchair accessories and seat and back cushions denoted with the HCPCS modifier ‘KU’ are deleted from the DMEPOS fee schedule file. These unadjusted fee schedule amounts have applied to wheelchair accessories and seat and back cushions furnished in connection with Group 3 complex rehabilitative power wheelchairs (codes K0848 through K0864). The fee schedule amounts associated with the KU modifier were mandated by Section 2 of Patient Access and Medicare Protection Act (PAMPA) effective for dates of service January 1, 2016 through December 31, 2016. Additionally, section 16005 of the 21st Century Cures Act extended the effective date through June 30, 2017. The list of HCPCS codes to which this statutory section applied is available in Transmittal 3535, CR 9520 dated June 7, 2016.

**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**

Kentucky & Ohio

MM10075: Payment for Moderate Sedation Services Furnished with Colorectal Cancer Screening Tests

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:** MM10075  
**Related CR Release Date:** April 28, 2017  
**Related CR Transmittal #:** R3763CP  
**Related Change Request (CR) #:** CR 10075  
**Effective Date:** January 1, 2017  
**Implementation Date:** October 2, 2017

**Provider Types Affected**

This MLN Matters article is intended for physicians and other providers submitting claims to Part A and B Medicare Administrative Contractors (MACs) for sedation services furnished with colorectal cancer screening tests.

**Provider Action Needed**

Change Request (CR) 10075 ensures accurate program payment for moderate sedation services furnished in conjunction with screening colonoscopy services for which the beneficiary should not be charged the coinsurance or deductible. The coinsurance and deductible for these services are waived, but due to coding changes and additions to the Medicare Physician Fee Schedule (MPFS) Database the payments for Calendar Year (CY) 2017 would not be accurate without this CR. Please make your billing staff aware of these changes.

**Background**

Section 4104 of the Affordable Care Act defined the term “preventive services” to include “colorectal cancer screening tests” and, as a result, it waives any coinsurance that would otherwise apply under Section 1833(a)(1) of the Social Security Act for screening colonoscopies. In addition, the ACA amended Section 1833(b)(1) of the Act to waive the Part B deductible for screening colonoscopies, which includes moderate sedation services as an inherent part of the screening colonoscopy procedural service. These provisions are effective for services furnished on or after January 1, 2011.

In the CY 2017 PFS Final Rule, the Centers for Medicare & Medicaid Services (CMS) modified coding and reporting of procedural services that include moderate sedation as an inherent part of the service, including for screening colonoscopies. CR 10075 operationalizes the existing waiver of deductible and coinsurance for moderate sedation services furnished in conjunction with and in support of colorectal cancer screening tests. Effective January 1, 2017, beneficiary coinsurance and deductible continues to not apply to the following moderate sedation claim lines when furnished in conjunction with screening colonoscopy services and when billed with Modifier 33 or Modifier PT:
• HCPCS code G0500: Moderate sedation services provided by the same physician or other qualified health care professional performing a gastrointestinal endoscopic service that sedation supports, requiring the presence of an independent, trained observer to assist in the monitoring of the patient’s level of consciousness and physiological status; patient age 5 years or older (additional time may be reported with 99153, as appropriate).

• CPT code 99153: Moderate sedation services provided by the same physician or other qualified healthcare professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent, trained observer to assist in the monitoring of the patient’s level of consciousness and physiological status; each additional 15 minutes of intra-service time (List separately in addition to code for primary service).

MACs will not search their files to either retract payment for claim lines already paid or to retroactively pay claim lines with HCPCS code G0500 or CPT code 99153. However, MACs will adjust such 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/.

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Kentucky & Ohio

**MM10090: Changes to the Payment Policies for Reciprocal Billing Arrangements and Fee-For-Time Compensation Arrangements (formerly referred to as Locum Tenens Arrangements)**

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:** MM10090

**Related CR Release Date:** May 12, 2017

**Related CR Transmittal #:** R3774CP

**Related Change Request (CR) #:** CR 10075

**Effective Date:** June 13, 2017

**Implementation Date:** June 13, 2017

Provider Types Affected

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

What You Need to Know

This article is based on Change Request (CR) 10090, which implements the 21st Century Cures Act (Section 16006). Outpatient physical therapy services furnished by physical therapists in a
Health Professional Shortage Area (HPSA), a Medically Underserved Area (MUA), or in a rural area can be billed under reciprocal billing and fee-for-time compensation arrangements in the same manner as physicians bill effective June 13, 2017.

Background

Section 1842(b)(6)(D) (https://www.ssa.gov/OP_Home/ssact/title18/1842.htm) of the Social Security Act (the Act) allows payment to be made to a physician for physicians’ services (and services furnished incident to such services) furnished by a second physician to patients of the first physician if the first physician is unavailable to provide the services, and the services are furnished pursuant to an arrangement that is either

- Informal and reciprocal, or
- Involves per diem or other fee-for-time compensation for such services.

In addition, the services must not be provided by the second physician over a continuous period of more than 60 days unless the regular physician is called or ordered to active duty as a member of a reserve component of the Armed Forces.

Effective June 13, 2017, this same process will be available to Medicare-enrolled physical therapists that use substitute physical therapists to furnish outpatient physical therapy services in a HPSA, MUA, or a rural area.

The purpose of CR10090 is to:

1. Implement Section 16006 (https://www.govtrack.us/congress/bills/114/hr34/text) of the 21st Century Cures Act, which allows outpatient physical therapy services furnished by physical therapists in a HPSA, MUA, or in a rural area to be billed under reciprocal billing and fee-for-time compensation arrangements in the same manner as physicians bill; this is effective June 13, 2017. The term “locum tenens,” which has historically been used in the manual to mean fee-for-time compensation arrangements, is being discontinued because the title of section 16006 of the 21st Century Cures Act uses “locum tenens arrangements” to refer to both fee-for-time compensation arrangements and reciprocal billing arrangements. As a result, continuing to use the term “locum tenens” to refer solely to fee-for-time compensation arrangements is not consistent with the law and could be confusing to the public.

2. Update Chapter 1, Sections 30.2.1; 30.2.10; 30.2.11; 30.2.13; and 30.2.14 of the “Medicare Claims Processing Manual” by changing “Carriers” to “A/B MACs Part B” and removing all references to “UPIN” (since the terms carriers and UPIN are obsolete).

3. Update Chapter 1, Sections 30.2.10 and 30.2.11 of the “Medicare Claims Processing Manual” to clarify that when a regular physician or physical therapist is called or ordered to active duty as a member of a reserve component of the Armed Forces for a continuous period of longer than 60 days, payment may be made to that regular physician or physical therapist for services furnished by a substitute under reciprocal billing arrangements or fee-for-time compensation arrangements throughout that entire period. This policy is required by section 137 of the Medicare Improvements for Patients and Providers Act of 2008.

Note: The revised portions of Chapter 1, Section 30 of the “Medicare Claims Processing Manual” are included as an attachment to CR10090.

Q5 and Q6 Modifiers

MACs will accept claims from Physical Therapists, Provider Specialty 65 – Physical Therapist in Private Practice, for reciprocal billing arrangements, when submitted with the Q5 modifier.

MACs will accept claims from Physical Therapists, Provider Specialty 65 – Physical Therapist in Private Practice, for fee-for-time compensation arrangements, when submitted with the Q6 modifier. MACs will accept claims from physical therapists that are reported with a Q5 or Q6
modifier whose descriptor references only physicians. When the descriptors are updated to include physical therapists and physicians, MACs will accept the Q5 or Q6 modifier with the updated descriptor.

**Note:** The Q5 and Q6 modifiers’ descriptors will be amended to include physical therapists in addition to physicians in the near future in a HCPCS quarterly update.

**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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**Kentucky & Ohio**

**MM10104: Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - July CY 2017 Update**

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

- **MLN Matters® Number:** MM10104
- **Related CR Release Date:** May 12, 2017
- **Related CR Transmittal #:** R3772CP
- **Related Change Request (CR) #:** CR 10104
- **Effective Date:** January 1, 2017
- **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) 10104 informs MACs about the release of payment files based upon the calendar year (CY) 2017 Medicare Physician Fee Schedule (MPFS) Final Rule. Make sure that your billing staffs are aware of these changes.

**Background**

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

Following is a summary of the changes for the July update to the 2017 MPFSDB.

Effective for dates of service (DOS) on and after January 1, 2017, except as noted otherwise.
The following new codes have been added to the HCPCS file effective May 1, 2017. The HCPCS file coverage code is C (carrier judgment) for these new codes. Coverage and payment will be determined by the MAC (they are not part of the MPFS).

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>0004U</td>
<td>Nfct ds dna 27 resist genes</td>
<td>Infectious disease (bacterial), DNA, 27 resistance genes, PCR amplification and probe hybridization in microarray format (molecular detection and identification of AmpC, carbapenemase and ESBL coding genes), bacterial culture colonies, report of genes detected or not detected, per isolate</td>
</tr>
<tr>
<td>0005U</td>
<td>Onco prst8 3 gene ur alg</td>
<td>Oncology (prostate) gene expression profile by real-time RT-PCR of 3 genes (ERG, PCA3, and SPDEF), urine, algorithm reported as risk score</td>
</tr>
</tbody>
</table>

The following new codes from CR 10107 have also been added to the MPFSDB effective July 1, 2017 (see MLN Matters article MM10107 (when it is available) for code descriptions and additional information):

<table>
<thead>
<tr>
<th>Code</th>
<th>Action</th>
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</thead>
<tbody>
<tr>
<td>Q9984</td>
<td>Procedure Status = N; there are no RVUs, payment policy indicators do not apply.</td>
</tr>
<tr>
<td>Q9985</td>
<td>Procedure Status = E; there are no RVUs, payment policy indicators do not apply</td>
</tr>
<tr>
<td>Q9986</td>
<td>Procedure Status = E; there are no RVUs, payment policy indicators do not apply</td>
</tr>
<tr>
<td>Q9988</td>
<td>Procedure Status = X; there are no RVUs, payment policy indicators do not apply</td>
</tr>
<tr>
<td>Q9989</td>
<td>Procedure Status = E; there are no RVUs, payment policy indicators do not apply</td>
</tr>
</tbody>
</table>

The following new HCPCS and CPT Category III codes have been added effective July 1, 2017.

<table>
<thead>
<tr>
<th>Code</th>
<th>Modifier</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>MPFSDB Indicator Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q9987</td>
<td>Pathogen test for platelets</td>
<td>Pathogen(s) test for platelets</td>
<td>Procedure Status X; there are no RVUs, payment policy indicators do not apply.</td>
<td></td>
</tr>
<tr>
<td>0469T</td>
<td>Rta polarize scan oc scr bi</td>
<td>Retinal polarization scan, ocular screening with on-site automated results, bilateral</td>
<td>Procedure Status N; there are no RVUs, payment policy indicators do not apply.</td>
<td></td>
</tr>
<tr>
<td>0470T</td>
<td>TC, 26 Oct skn img acquisj i&amp;r 1st</td>
<td>Optical coherence tomography (OCT) for microstructural and morphological imaging of skin, image acquisition, interpretation, and report; first lesion</td>
<td>Procedure Status C; PC/TC indicator 1; there are no RVUs, no other payment policy indicators apply.</td>
<td></td>
</tr>
<tr>
<td>0471T</td>
<td>TC, 26 Oct skn img acquisj i&amp;r addl</td>
<td>Optical coherence tomography (OCT) for microstructural and morphological imaging of skin, image acquisition, interpretation, and report; each additional lesion (List separately in addition to code for primary procedure)</td>
<td>Procedure Status C; PC/TC indicator 1; there are no RVUs, no other payment policy indicators apply.</td>
<td></td>
</tr>
<tr>
<td>0472T</td>
<td>Prgrmg io rta eltrd ra</td>
<td>Device evaluation, interrogation, and initial programming of intra-ocular retinal electrode array (eg, retinal prosthesis), in person, with iterative adjustment of the implantable device to test functionality, select optimal permanent programmed values with analysis, including visual training, with review and report by a qualified health care professional</td>
<td>Procedure Status C; there are no RVUs, payment policy indicators do not apply.</td>
<td></td>
</tr>
<tr>
<td>Code</td>
<td>Modifier</td>
<td>Short Descriptor</td>
<td>Long Descriptor</td>
<td>MPFSDB Indicator Information</td>
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<td>---------------------------------------------------------------------</td>
</tr>
<tr>
<td>0473T</td>
<td></td>
<td>Reprgrmg io rta eltrd ra</td>
<td>Device evaluation and interrogation of intra-ocular retinal electrode array (eg, retinal prosthesis), in person, including reprogramming and visual training, when performed, with review and report by a qualified health care professional</td>
<td>Procedure Status C; there are no RVUs, payment policy indicators do not apply.</td>
</tr>
<tr>
<td>0474T</td>
<td></td>
<td>Insj aqueous drg dev io rsvr</td>
<td>Insertion of anterior segment aqueous drainage device, with creation of intraocular reservoir, internal approach, into the supraciliary space</td>
<td>Procedure Status C; there are no RVUs, payment policy indicators do not apply.</td>
</tr>
<tr>
<td>0475T</td>
<td></td>
<td>Rec ftl car sgl 3 ch &amp;r</td>
<td>Recording of fetal magnetic cardiac signal using at least 3 channels; patient recording and storage, data scanning with signal extraction, technical analysis and result, as well as supervision, review, and interpretation of report by a physician or other qualified health care professional</td>
<td>Procedure Status C; there are no RVUs, payment policy indicators do not apply.</td>
</tr>
<tr>
<td>0476T</td>
<td></td>
<td>Rec ftl car sgl elec tr data</td>
<td>Recording of fetal magnetic cardiac signal using at least 3 channels; patient recording, data scanning, with raw electronic signal transfer of data and storage</td>
<td>Procedure Status C; there are no RVUs, payment policy indicators do not apply.</td>
</tr>
<tr>
<td>0477T</td>
<td></td>
<td>Rec ftl car sgl xrtj alys</td>
<td>Recording of fetal magnetic cardiac signal using at least 3 channels; signal extraction, technical analysis, and result</td>
<td>Procedure Status C; there are no RVUs, payment policy indicators do not apply.</td>
</tr>
<tr>
<td>0478T</td>
<td></td>
<td>Rec ftl car 3 ch rev &amp;r</td>
<td>Recording of fetal magnetic cardiac signal using at least 3 channels; review, interpretation, report by physician or other qualified health care professional</td>
<td>Procedure Status C; there are no RVUs, payment policy indicators do not apply.</td>
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**Kentucky & Ohio**

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

The Centers for Medicare & Medicaid Services (CMS) has revised the following Special Edition Medicare Learning Network® (MLN) Matters article. This MLN Matters article and other CMS articles can be found on the CMS website at: [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: SE1128 Revised**

**Related Change Request (CR) #: N/A**

**Related CR Release Date: May 12, 2017**

**Effective Date: N/A**

**Related CR Transmittal #: N/A**

**Implementation Date: N/A**

**Note:** 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.
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.

What You Need to Know

STOP – Impact to You

This Special Edition MLN Matters® Article from the Centers for Medicare & Medicaid Services (CMS) reminds all Medicare providers that they may not bill beneficiaries enrolled in the QMB program for Medicare cost-sharing. QMB is a Medicare Savings Program (MSP) that exempts Medicare beneficiaries from Medicare cost-sharing liability.

CAUTION – What You Need to Know

The QMB program is a State Medicaid benefit that covers Medicare premiums and deductibles, coinsurance, and copayments, subject to State payment limits. (States may limit their liability to providers for Medicare deductibles, coinsurance, and copayments under certain circumstances.) Medicare providers may not bill QMB individuals for Medicare cost-sharing, regardless of whether the State reimburses providers for the full Medicare cost-sharing amounts. Further, all original Medicare and MA providers—not only those that accept Medicaid—must refrain from charging QMB individuals for Medicare cost-sharing. Providers who inappropriately bill QMB individuals are subject to sanctions.

GO – What You Need to Do

Refer to the Background and Additional Information Sections of this article for further details and resources about this guidance. Please ensure that you and your staff are aware of the Federal billing law and policies regarding QMB individuals. Contact the Medicaid Agency in the States in which you practice to learn about ways to identify QMB patients in your State and procedures applicable to Medicaid reimbursement for their Medicare cost-sharing. If you are a MA provider, you may also contact the MA plan for more information. Finally, all Medicare providers should ensure that their billing software and administrative staff exempt QMB individuals from Medicare cost-sharing billing and related collection efforts.

Background

This article provides CMS guidance to Medicare providers to help them avoid inappropriately billing QMBs for Medicare cost-sharing, including deductibles, coinsurance, and copayments.

Billing of QMBs Is Prohibited by Federal Law

Federal law bars Medicare providers from billing a QMB beneficiary under any circumstances. See Section 1902(n)(3)(B) of the Social Security Act (the Act) (http://www.ssa.gov/OP_Home/ssact/title19/1902.htm), as modified by Section 4714 of the Balanced Budget Act of 1997. QMB is a Medicaid program for Medicare beneficiaries that exempts them from liability for Medicare cost-sharing. State Medicaid programs may pay providers for Medicare deductibles, coinsurance, and copayments. However, as permitted by Federal law, States can limit provider reimbursement for Medicare cost-sharing under certain circumstances. See the chart at the end of this article for more information about the QMB benefit.

Medicare providers must accept the Medicare payment and Medicaid payment (if any) as payment in full for services rendered to a QMB beneficiary. 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.)

Inappropriate Billing of QMB Individuals Persists

Despite Federal law, improper billing of QMB individuals 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 (https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Access_to_Care_Issues_Among_Qualified_Medicare_Beneficiaries.pdf).

Important Clarifications Concerning the QMB Billing Law.
Be aware of the following policy clarifications to ensure compliance with QMB billing requirements.

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

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

3. Note that QMBs 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.

Ways to Improve Processes Related to QMBs
Proactive steps to identify QMB individuals you serve and to communicate with State Medicaid Agencies (and MA plans if applicable), can promote compliance with QMB billing prohibitions.

1. Determine effective means to identify QMB individuals among your patients, such as finding out the cards that are issued to QMB individuals, so you can in turn ask all your patients if they have them. Learn if you can query State systems to verify QMB enrollment among your patients. MA providers should contact the plan to determine how to identify the plan’s QMB enrollees. Beginning October 1, 2017, you will be able to readily identify the QMB status of your patients with new Medicare Fee-For-Services improvements. Refer to Qualified Medicare Beneficiary Indicator in the Medicare Fee-For-Service Claims Processing System for more information about these improvements.

2. Determine the billing processes that apply to seeking reimbursement for Medicare cost-sharing from the States in which you operate. Different processes may apply to Original Medicare and MA services provided to QMB beneficiaries. 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 Remittance Advice.

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

3. Ensure that your billing software and administrative staff exempt QMB individuals from Medicare cost-sharing billing and related collection efforts.
### Program Income Criteria* Resources Criteria* Medicare Part A and Part B Enrollment Other Criteria Benefits

**QMB Only**

≤100% of Federal Poverty Line (FPL) ≤3 times SSI resource limit, adjusted annually in accordance with increases in Consumer Price Index Part A*** Not Applicable • 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)

**QMB Plus**

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

* States can effectively raise these Federal income and resources criteria under Section 1902(r)(2) ([https://www.ssa.gov/OP_Home/ssact/title19/1902.htm](https://www.ssa.gov/OP_Home/ssact/title19/1902.htm)) 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 ([https://secure.ssa.gov/apps10/poms.nsf/lnx/0600801140](https://secure.ssa.gov/apps10/poms.nsf/lnx/0600801140)).

### Additional Information


### Document History

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<tr>
<td>March 28, 2014</td>
<td>The article was revised on to change the name of the Coordination of Benefits Contractor (COBC) to BCRC.</td>
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<tr>
<td>February 1, 2016</td>
<td>The article was revised to include updated information for 2016 and a clarifying note regarding eligibility criteria in the table on page 4.</td>
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<td>The article was revised on February 4, 2016, to include updated information for 2016 and a correction to the second sentence in paragraph 2 under Important Clarifications Concerning QMB Balance Billing Law on page 3.</td>
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<tr>
<td>January 12, 2017</td>
<td>This article was revised to add a reference to MLN Matters article MM9817 (<a href="https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9817.pdf">https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9817.pdf</a>), which instructs Medicare Administrative Contractors to issue a compliance letter instructing named providers to refund any erroneous charges and recall any existing billing to QMBs for Medicare cost sharing.</td>
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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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Kentucky & Ohio


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

MLN Matters® Number: SE1624 Revised Related Change Request (CR) #: N/A
Related CR Release Date: May 1, 2017 Effective Date: N/A
Related CR Transmittal #: N/A Implementation Date: N/A

Note: This article was revised on May 1, 2017, to make a number of clarifications and to delete the table that had been in the article.

Provider Types Affected
This article is intended for providers billing Medicare Administrative Contractors (MACs) for services related to stem cell transplantation.

Provider Action Needed
The Office of the Inspector General (OIG) recently completed a review of Medicare claims related to stem cell transplants. This article is intended to address issues of incorrect billing as a result of the February 2016 OIG report (https://oig.hhs.gov/oas/reports/region9/91402037.pdf) and to clarify coverage of stem cell transplantation. This article does not introduce any new policies. It is intended to clarify the billing for stem cell services.

Background
The Centers for Medicare & Medicaid Services (CMS) has a coverage policy for stem cell transplantation, and the “Medicare National Coverage Determination (NCD) Manual” (Publication 100-03, Section 110.8, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part2.pdf) states that stem cell transplantation is a process in which stem cells are harvested from either a patient’s or donor’s bone marrow or peripheral blood for intravenous infusion.

Types of Stem Cell Transplants that are covered:
Medicare covers allogeneic and autologous transplants. Allogeneic and autologous stem cell transplants are covered under Medicare for specific diagnoses.

1. Allogeneic Hematopoietic Stem Cell Transplantation (HSCT)
   Allogeneic stem cell transplantation is a procedure in which a portion of a healthy donor’s stem cells is obtained and prepared for intravenous infusion to restore normal hematopoietic function in recipients having an inherited or acquired hematopoietic deficiency or defect.

   Expenses incurred by a donor are a covered benefit to the recipient/beneficiary but, except for physician services, are not paid separately. Services to the donor include physician services, hospital care in connection with screening the stem cell, and ordinary follow-up care.

2. Autologous Stem Cell Transplantation (AuSCT)
   Autologous stem cell transplantation is a technique for restoring stem cells using the patient’s own previously stored cells. Autologous stem cell transplants (AuSCT) must be used to effect hematopoietic reconstitution following severely myelotoxic doses of
In their February 2016 OIG report ([https://oig.hhs.gov/oas/reports/region9/91402037.pdf](https://oig.hhs.gov/oas/reports/region9/91402037.pdf)), the OIG determined that Medicare paid for many stem cell transplant procedures incorrectly. The main finding was that providers billed these procedures as inpatient when they should have been submitted as outpatient or outpatient with observation services. The key points in the report include:

- According to an independent medical review contractor contracted by OIG for this report, stem cell transplants are routinely performed in the outpatient setting.
- Hospitals may have incorrectly thought that stem cell transplantation was on CMS’s list of inpatient-only procedures.

**The Two-Midnight Rule**

To assist providers in determining whether inpatient admission is appropriate for payment under Medicare Part A, CMS adopted the Two-Midnight rule for admissions beginning on or after October 1, 2013. This rule established Medicare payment policy regarding the benchmark criteria to use when determining whether an inpatient admission is reasonable and necessary for purposes of payment under Medicare Part A.

In general, the Two-Midnight rule states that:

- Inpatient admissions will generally be payable under Part A if the admitting practitioner expects the patient to require a hospital stay that crosses two midnights and the medical record supports that reasonable expectation.
- Medicare Part A payment is generally not appropriate for hospital stays not expected to span at least two midnights.

The Two-Midnight rule also specifies that all treatment decisions for beneficiaries are based on the medical judgment of physicians and other qualified practitioners. The Two-Midnight rule does not prevent the physician or other qualified practitioner from providing any service at any hospital, regardless of the expected duration of the service.

As of CY 2016, for stays for which the physician or other qualified practitioner expects the patient to need less than two midnights of hospital care (and the procedure is not on the inpatient-only list or otherwise listed as a national exception), an inpatient admission may be payable under Medicare Part A on a case-by-case basis based on the judgment of the admitting physician or other qualified practitioner. The documentation in the medical record must support that an inpatient admission is necessary, and is subject to medical review.

**Additional Information**


You may want to review the following MLN Matters articles for further information:


Additional information is in a transcript of an MLN Connects® conference call discussing the Two-Midnight rule, which is available at https://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/2-27-14MidnightRuleTranscript.pdf.

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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<td>The article was revised to make a number of clarifications and to delete the table that had been in the article.</td>
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**Kentucky & Ohio**


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:** SE17012  
**Related CR Release Date:** May 16, 2017  
**Effective Date:** May 15, 2017

**Related Change Request (CR) #:** CR 9953  
**Implementation Date:** May 15, 2017

**Provider Types Affected**

This MLN Matters Article is intended for providers involved in a Change of Ownership (CHOW) submitting claims to Part A & B Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

**Provider Action Needed**

Special Edition article SE17012 clarifies language in Chapter 15, Section 15.7.7.1.5 of the “Medicare Program Integrity Manual” related to Electronic Funds Transfer (EFT) Payments and Changes of Ownership (CHOWs). Please make sure your staffs are aware of this update.
Background

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 9953 (effective May 15, 2017), for the purpose of making revisions to Chapter 15, Section 15.7.7.1.5 (Electric Funds Transfer (EFT) Payments and CHOWs) of the “Medicare Program Integrity Manual.” The revisions explain that after a Change of Ownership (CHOW) has been processed, only the Buyer is permitted to submit claims.

Change of Ownership (CHOW) is defined in 42 CFR 489.18 (a) and generally means, in the case of a partnership, the removal, addition, or substitution of a partner, unless the partners expressly agree otherwise, as permitted by applicable State law. In the case of a corporation, the term generally means the merger of the provider corporation into another corporation, or the consolidation of two or more corporations, resulting in the creation of a new corporation. The transfer of corporate stock or the merger of another corporation into the provider corporation does not constitute change of ownership.

The most common example of a CHOW occurs when a provider’s CMS Certification Number (CCN) and provider agreement are transferred to another entity as a result of the latter’s purchase of the provider. To illustrate, suppose Entity A is enrolled in Medicare, but Entity B is not. B acquires A. Assuming all regulatory requirements are met, A’s provider agreement and CCN number will transfer to B.

Upon accepting the provider agreement, the new owner accepts the terms and conditions under which it was originally issued. Once the CHOW processes and the MAC: 1) receives the tie-in notice from the CMS Regional Office; and 2) updates the Provider Enrollment Chain and Ownership System (PECOS), claims will only be paid under the new owner’s tax identification number, National Provider Identifier and CCN, or provider transaction number.

MACs will no longer have the ability to update the crosswalk in order for the Seller to complete their billing. Therefore, the old and new owners are responsible for working together on payment arrangements for claims for services furnished during and before the CHOW is processed.

The updated manual language follows:

**PIM Language Update**

In a CHOW, the existing provider agreement is automatically assigned to the Buyer/Transferee. If the Buyer/Transferee does not explicitly reject automatic assignment before the transfer date, the provider agreement is automatically assigned, along with the CCN, effective on the transfer date. The assigned agreement is subject to all applicable statutes and regulations and to the terms and conditions under which it was originally issued. Among other things, this means that the contractor will continue to adjust payments to the provider to account for prior overpayments and underpayments, even if they relate to services provided before the sale/transfer.

If the Buyer rejects assignment of the provider agreement, the Buyer must file an initial application to participate in the Medicare program. In this situation, Medicare will never pay the applicant for services the prospective provides before the date on which the provider qualifies for Medicare participation as an initial applicant.

Depending on the terms of the sale, the Buyer/Transferee may obtain a new NPI or maintain the existing NPI. After CHOW processing is complete, the Seller/Transferor will no longer be allowed to bill for services (i.e., services furnished after CHOW processing is complete) and only the Buyer is permitted to submit claims using the existing CCN. It is ultimately the responsibility of the old and new owners to work out between themselves any payment arrangements for claims for services furnished during the CHOW processing period.
STAY INFORMED AND JOIN THE CGS LISTSERV NOTIFICATION SERVICE

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

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

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

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

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/.