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Expanding Possibilities with myCGS
Are you missing out on a fast and secure system that provides Medicare information with a click of a mouse? Visit the myCGS website at https://www.cgsmedicare.com/partb/mycgs/index.html to check out the many portal features and learn how to register if you are a new user. Save time and resources - take advantage of this Web-based resource today!

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

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Kentucky & Ohio

Update to the Interest Paid on Clean Non-PIP Claims Not Paid Timely

According to the Medicare Claims Processing Manual, (Pub 100-04, Ch. 1., §80.2.2), interest is paid on clean claims, not paid under the periodic interim payment (PIP) method, if payment is not made within 30 days after the date of receipt. The interest rate is determined by the Treasury Department on a 6-month basis, effective every January and July 1. Effective, July 1, 2017, the interest amount is 2.375%.

For additional information about when interest is paid on a claim, and how to calculate the interest, refer to the Medicare Claims Processing Manual, (Pub 100-04, Ch. 1., §80.2.2) at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf on the Centers for Medicare & Medicaid Services (CMS) website. Current and past interest rate amounts can be viewed at http://fms.treas.gov/prompt/rates.html on the Treasury Department website.

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New Medicare Cards Offer Greater Protection to More than 57.7 Million Americans

The following is a news release issued by the Centers for Medicare & Medicaid Services (CMS). Refer to the CMS Newsroom (https://www.cms.gov/Newsroom/Newsroom-Center.html) Web page for this and other news.

New cards will no longer contain Social Security numbers, to combat fraud and illegal use.

The Centers for Medicare & Medicaid Services (CMS) is readying a fraud prevention initiative that removes Social Security numbers from Medicare cards to help combat identity theft, and safeguard taxpayer dollars. The new cards will use a unique, randomly-assigned number called a Medicare Beneficiary Identifier (MBI), to replace the Social Security-based Health Insurance Claim Number (HICN) currently used on the Medicare card. CMS will begin mailing new cards in April 2018 and will meet the congressional deadline for replacing all Medicare cards by April 2019. Today, CMS kicks-off a multi-faceted outreach campaign to help providers get ready for the new MBI.

“We're taking this step to protect our seniors from fraudulent use of Social Security numbers which can lead to identity theft and illegal use of Medicare benefits,” said CMS
Administrator Seema Verma. "We want to be sure that Medicare beneficiaries and healthcare providers know about these changes well in advance and have the information they need to make a seamless transition."

Providers and beneficiaries will both be able to use secure look up tools that will support quick access to MBIs when they need them. There will also be a 21-month transition period where providers will be able to use either the MBI or the HICN further easing the transition.

CMS testified on Tuesday, May 23rd before the U.S. House Committee on Ways & Means Subcommittee on Social Security and U.S. House Committee on Oversight & Government Reform Subcommittee on Information Technology, addressing CMS's comprehensive plan for the removal of Social Security numbers and transition to MBIs.

Personal identity theft affects a large and growing number of seniors. People age 65 or older are increasingly the victims of this type of crime. Incidents among seniors increased to 2.6 million from 2.1 million between 2012 and 2014, according to the most current statistics from the Department of Justice. Identity theft can take not only an emotional toll on those who experience it, but also a financial one: two-thirds of all identity theft victims reported a direct financial loss. It can also disrupt lives, damage credit ratings and result in inaccuracies in medical records and costly false claims.

Work on this important initiative began many years ago, and was accelerated following passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). CMS will assign all Medicare beneficiaries a new, unique MBI number which will contain a combination of numbers and uppercase letters. Beneficiaries will be instructed to safely and securely destroy their current Medicare cards and keep the new MBI confidential. Issuance of the new MBI will not change the benefits a Medicare beneficiary receives.

CMS is committed to a successful transition to the MBI for people with Medicare and for the health care provider community. CMS has a website (https://www.cms.gov/medicare/ssnri/index.html) dedicated to the Social Security Removal Initiative (SSNRI) where providers can find the latest information and sign-up for newsletters. CMS is also planning regular calls as a way to share updates and answer provider questions before and after new cards are mailed beginning in April 2018.

For more information, please visit: https://www.cms.gov/medicare/ssnri/index.html

Kentucky & Ohio

MM9246 Revised: Medicare Coverage of Screening for Lung Cancer with Low Dose Computed Tomography (LDCT)

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: MM9246 Revised  Related Change Request (CR) #: CR 9246
Related CR Release Date: October 15, 2015  Effective Date: February 5, 2015
Related CR Transmittal #: R3374CP and R185NCD  Implementation Date: January 4, 2016

Note: This article was revised on June 12, 2017, to add a paragraph on page 3 to clarify that Independent Diagnostic Testing Facilities (IDTFs) may be eligible facilities. All other information is unchanged.
Provider Types Affected
This MLN Matters® Article is intended for physicians, other providers, and suppliers who submit claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed
Change Request (CR) 9246 informs MACs that Medicare covers lung cancer screening with LDCT if all eligibility requirements listed in the National Coverage Determination (NCD) are met. Make sure that your billing staffs are aware of these changes.

Background
Section 1861(ddd)(1) of the Social Security Act (the Act) (http://www.socialsecurity.gov/OP_Home/ssact/title18/1861.htm) authorizes the Centers for Medicare & Medicaid Services (CMS) to add coverage of “additional preventive services” through the NCD process. The “additional preventive services” must meet all of the following criteria:

- Be reasonable and necessary for the prevention or early detection of illness or disability;
- Be recommended with a grade of A or B by the United States Preventive Services Task Force (USPSTF); and
- Be appropriate for individuals entitled to benefits under Part A or enrolled under Part B.

CMS reviewed the evidence for lung cancer screening with low dose computed tomography (LDCT) and determined that the criteria listed above were met, enabling CMS to cover this “additional preventive service” under Medicare Part B.

CMS issued NCD 210.14 on August 21, 2015, that provides for Medicare coverage of screening for lung cancer with LDCT. Effective for claims with dates of service on and after February 5, 2015, Medicare beneficiaries must meet all of the following criteria:

- Be 55–77 years of age;
- Be asymptomatic (no signs or symptoms of lung cancer);
- Have a tobacco smoking history of at least 30 pack-years (one pack-year = smoking one pack per day for one year; 1 pack = 20 cigarettes);
- Be a current smoker or one who has quit smoking within the last 15 years; and,
- Receive a written order for lung cancer screening with LDCT that meets the requirements described in the NCD.

Written orders for lung cancer LDCT screenings must be appropriately documented in the beneficiary’s medical record, and must contain the following information:

- Date of birth;
- Actual pack–year smoking history (number);
- Current smoking status, and for former smokers, the number of years since quitting smoking;
- A statement that the beneficiary is asymptomatic (no signs or symptoms of lung cancer); and,
- The National Provider Identifier (NPI) of the ordering practitioner.

Counseling and Shared Decision-Making Visit
Before the first lung cancer LDCT screening occurs, the beneficiary must receive a written order for LDCT lung cancer screening during a lung cancer screening counseling and shared decision-making visit that includes the following elements and is appropriately documented in the beneficiary’s medical records:
• Must be furnished by a physician (as defined in section 1861(r)(1) of the Act) or qualified non-physician practitioner (meaning a Physician Assistant (PA), Nurse Practitioner (NP), or Clinical Nurse Specialist (CNS) as defined in section1861(aa)(5) of the Act); and

• Must include all of the following elements:
  ▪ Determination of beneficiary eligibility including age, absence of signs or symptoms of lung cancer, a specific calculation of cigarette smoking pack-years; and if a former smoker, the number of years since quitting;
  ▪ Shared decision-making, including the use of one or more decision aids, to include benefits and harms of screening, follow-up diagnostic testing, over-diagnosis, false positive rate, and total radiation exposure;
  ▪ Counseling on the importance of adherence to annual lung cancer LDCT screening, impact of co-morbidities, and ability or willingness to undergo diagnosis and treatment;
  ▪ Counseling on the importance of maintaining cigarette smoking abstinence if former smoker; or the importance of smoking cessation if current smoker and, if appropriate, furnishing of information about tobacco cessation interventions; and,
  ▪ If appropriate, the furnishing of a written order for lung cancer screening with LDCT.

Written orders for subsequent annual LDCT screens may be furnished during any appropriate visit with a physician or qualified non-physician practitioner (PA, NP, or CNS).

As part of the NCD, all criteria listed in the NCD must be met to include requirements for reading radiologists and radiology imaging facilities. In addition to collecting and submitting data to a CMS-approved registry, all facilities that would like to be eligible to perform the lung cancer screening, including Independent Diagnostic Testing Facilities (IDTFs), must meet all criteria stated in the Decision Memo for Lung Cancer Screening with LDCT, which is available at https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=274. Information regarding CMS-approved registries is posted at: http://www.cms.gov/Medicare/Medicare-General-Information/MedicareApprovedFacilities/Lung-Cancer-Screening-Registries.html on the CMS website.

Coinsurance and Deductibles
Medicare coinsurance and Part B deductible are waived for this preventive service.

Health Care Common Procedure Coding System (HCPCS) Codes
Effective for claims with dates of service on and after February 5, 2015, the following HCPCS codes are used for lung cancer screening with LDCT:

• G0296 – Counseling visit to discuss need for lung cancer screening (LDCT) using low dose CT scan (service is for eligibility determination and shared decision making)
• G0297 – Low dose CT scan (LDCT) for lung cancer screening

In addition to the HCPCS code, these services must be billed with ICD-10 diagnosis code Z87.891 (personal history of tobacco use/personal history of nicotine dependence), ICD-9 diagnosis code V15.82.

NOTE: Contractors shall apply contractor-pricing to claims containing HCPCS G0296 and G0297 with dates of service February 5, 2015, through December 31, 2015.

Institutional Billing Requirements
Effective for claims with dates of service on and after February 5, 2015, providers may use the following Types of Bill (TOBs) when submitting claims for lung cancer screening, HCPCS codes G0296 and G0297: 12X, 13X, 22X, 23X, 71X (G0296 only), 77X (G0296 only), and 85X.

Medicare will pay for these services as follows:
• Outpatient hospital departments: TOBs 12X and 13X - based on Outpatient Prospective Payment System (OPPS);
• Skilled nursing facilities (SNFs): TOBs 22X and 23X – based on the Medicare Physician Fee Schedule (MPFS);
• Critical Access Hospitals (CAHs): TOB 85X – based on reasonable cost;
• CAH Method II: TOB 85X with revenue code 096X, 097X, or 098X based on the lesser of the actual charge or the MPFS (115% of the lesser of the fee schedule amount and submitted charge) for HCPCS G0296 only;
• Rural Health Clinics (RHCs): TOB 71X - based on the all-inclusive rate for HCPCS G0296 only; and
• Federally Qualified Health Centers (FQHCs): TOB 77X - based on the PPS rate for HCPCS G0296 only.

**NOTE:** For outpatient hospital settings, as in any other setting, services covered under this NCD must be ordered by a primary care provider within the context of a primary care setting and performed by an eligible Medicare provider for these services.

### Claim Adjustment Reason Codes (CARCs), Remittance Advice Remark Codes (RARCs), Group Codes

MACs will use the following CARCs, RARCs, and Group Codes when denying payment for LDCT lung cancer screening, HCPCS G0296 and G0297:

#### Submitted on a TOB other than 12X, 13X, 22X, 23X, 71X, 77X, or 85X:

- 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 (if a claim is received with a GZ modifier indicating no signed ABN is on file).

**NOTE:** For modifier GZ, MACs will use CARC 50.

#### For TOBs 71X and 77X when HCPCS G0296 is billed on the same date of service with another visit (this does not apply to initial preventive physical exams for 71X TOBs):

- CARC 97: The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- RARC M15: Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.

**NOTE:** 77X TOBs will be processed through the Integrated Outpatient Code Editor under the current process.
- Group Code CO assigning financial liability to the provider.

#### Where a previous HCPCS G0297 is paid in history in a 12-month period (at least 11 full months must elapse from the date of the last screening):

- 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 CO assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).
NOTE: For modifier GZ, MACs will use CARC 50.

Because the beneficiary is not between the ages of 55 and 77 at the time the service was rendered (line-level):

- CARC 6: "The procedure/revenue code is inconsistent with the patient’s age. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."
- 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).

NOTE: For modifier GZ, MACs will use CARC 50.

Because the claim line was not billed with ICD-10 diagnosis Z87.891:

- 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 assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

NOTE: For modifier GZ, MACs will use CARC 50.

Additional Information

The official instruction, CR9246, consists of two transmittals:


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

Document History

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<th>Date of Change</th>
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<tr>
<td>June 12, 2017</td>
<td>The article was revised on June 9, 2017, to include a paragraph on page 3 to show that IDTFs may be eligible facilities.</td>
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<tr>
<td>June 24, 2016</td>
<td>The article was revised to add a link to a related article MM9540 (<a href="https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9540.pdf">https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9540.pdf</a>). That article provides an ICD-10 code that has been added for Lung Cancer Screening with Low Dose Computed Tomography (LDCT).</td>
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<td>November 16, 2015</td>
<td>Initial article posted.</td>
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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 Change Request (CR) #: CR 9859
Related CR Release Date: April 28, 2017  Effective Date: September 28, 2016
Related CR Transmittal #: R3761CP and R195NCD  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, unspecified trimester
  - O09.90 - Supervision of high risk pregnancy, unspecified, 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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<th>Code</th>
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<td>Z34.02</td>
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**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. 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:

• 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.

• Deductible and coinsurance do not apply to G0499.

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 17, 2017</td>
<td>The article was changed to clarify language on page 3, under “Professional Billing Requirements.” It now reads, only when services are ordered by the following provider specialties found on the provider’s enrollment record…</td>
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<td>May 4, 2017</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:** June 8, 2017

**Effective Date:** October 1, 2017

**Related CR Transmittal #:** R1857OTN

**Implementation Date:** October 2, 2017

**Note:** This article was revised on June 9, 2017, due to the release of an updated Change Request (CR). The CR date, transmittal number and the link to the transmittal changed. All other information remains the same.
Provider Types Affected
This MLN Matters® Article is intended for physicians, providers and suppliers submitting claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries.

What You Need to Know
This article is based on CR 9893. To comply with the Government Accountability Office (GAO) final report entitled Medicare Secondary Payer (MSP): Additional Steps Are Needed to Improve Program Effectiveness for Non-Group Health Plans (GAO 12-333, 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.

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/.

Document History

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<tr>
<td>June 9, 2017</td>
<td>The article was revised due to the release of an updated Change Request (CR). The CR date, transmittal number and the link to the transmittal changed.</td>
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<tr>
<td>May 10, 2017</td>
<td>The article was revised due to the release of an updated Change Request (CR). The CR date, transmittal number and the link to the transmittal changed.</td>
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<td>February 17, 2017</td>
<td>Initial article released.</td>
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Kentucky & Ohio

MM9980: Screening for the Human Immunodeficiency Virus (HIV) Infection

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: MM9980
Related CR Release Date: June 8, 2017
Related CR Transmittal #: R1857OTN
Related Change Request (CR) #: CR 9893
Effective Date: October 1, 2017
Implementation Date: October 2, 2017

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9980 informs MACs that they shall recognize the specified HCPCS codes for services related to the Screening for the Human Immunodeficiency Virus (HIV) Infection. Make sure that your billing staffs are aware of these codes.
Background
The Centers for Medicare & Medicaid Services (CMS) issued CR9403 (transmittal 3461), effective April 13, 2015, for screening for HIV infection. The guidelines are based on strong recommendations by the U.S. Preventive Services Task Force published in April 2013. The recommendations provide guidelines for screening various age groups based on risk of infection as well as for pregnant women.

Effective for claims with dates of service on or after April 13, 2015, MACs will recognize the following Healthcare Common Procedure Coding System (HCPCS) codes for claims processed on or after October 2, 2017: G0432, G0433, and G0435. Testing frequency and other functions for these codes is the same as for those listed in CR9403. A related MLN Matters article is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9403.pdf.

<table>
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<tr>
<th>HCPCS Code</th>
<th>Descriptor</th>
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<tr>
<td>G0432</td>
<td>Infectious agent antibody detection by enzyme Immune assay (EIA) technique, qualitative or semi-quantitative, multiple-step method, HIV-1 or HIV-2, screening.</td>
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<tr>
<td>G0433</td>
<td>Infectious agent antibody detection by enzyme-linked immunosorbent assay (ELISA) technique, antibody, HIV-1 or HIV-2, screening.</td>
</tr>
<tr>
<td>G0435</td>
<td>Infectious agent antibody detection by rapid antibody test of oral mucosa transudate, HIV-1 or HIV-2, screening.</td>
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Billing Requirements
Your MAC will calculate the next eligible date for HIV Screening to include HCPCS codes G0432, G0433, and G0435 to be included with G0475 and based on effective date of April 13, 2015.

The next eligible date will be displayed on all of Medicare's Common Working File (CWF) provider query screens (HUQA, HIQA, HIQH, ELGA, ELGH, and PRVN). This includes MBD and NGD extract records.

When there is no next eligible date, the CWF provider query screens will display this information in the date field to indicate why there is not a next eligible date.

When the incoming HUOP or HUBC claim line having the HIV screening HCPCS code G0475, G0432, G0433, or G0435 is submitted without the required HIV Primary Diagnosis Codes of Z11.4, OR

When the incoming HUOP or HUBC claim line having the HIV screening HCPCS 80081 is submitted with one of the following secondary diagnosis codes denoting pregnancy, but the required HIV primary diagnosis code of Z11.4 is not present:

- 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, O09.93

The claim line item will be denied. In denying the line, MACs will use either:

- Claim Adjustment Reason Code (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. or
- CARC 11 - This diagnosis is inconsistent with the procedure. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- Remittance Advice Remarks Code (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.
Medicare will create a new consistency edit to deny when the incoming HUOP or HUBC claim line having either the HIV HCPCS codes G0475, G0432, G0433, G0435, or the CPT HCPCS code 80081 is submitted with one of the pregnancy secondary diagnosis codes, but the Sex Code on the claim indicates ‘Male.’ The secondary diagnosis codes indicating pregnancy are:

- 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, O09.93

In denying a line for this reason, MACs will use:

- CARC 7 - The procedure/revenue code is inconsistent with the patient’s gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- Group Code CO

Medicare systems will create a consistency edit to not allow Place of Service (POS) other than 11 (Office) or 81 (Independent Lab for the HIV screenings HCPCS G0475, G0432, G0433, and ‘G0435’ effective with dates of service on or after April 13, 2015. If a POS other than 11 or 81 is on the claim, the MAC will deny the line item, using:

- CARC 171 - Payment is denied when performed/billed by this type of provider in 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 this place of service.
- Group Code CO

Medicare systems will create a consistency edit to not allow Type of Bill (TOB) other than 12X, 13X, 14X, 22X, 23X, and 85x for the HIV screening HCPCS G0475, G0432, G0433, and G0435.

**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/.

**Kentucky & Ohio**

**MM10013 Revised: Two New “K” Codes for Therapeutic Continuous Glucose Monitors**

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:** MM10013 Revised
**Related Change Request (CR) #:** CR 10013
**Related CR Release Date:** May 18, 2017
**Effective Date:** July 1, 2017
**Related CR Transmittal #:** R3775CP
**Implementation Date:** July 3, 2017

This newsletter should be shared with all health care practitioners and managerial members of the provider/supplier staff. Newsletters issued after January 1997 are available at no cost from our website at http://www.cgsmedicare.com. © 2017 Copyright, CGS Administrators, LLC.
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/.
Kentucky & Ohio

MM10040: Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP), and PC Print Update

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

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

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

Provider Action Needed
Change Request (CR) 100040 updates the remittance advice remark code (RARC) and claims adjustment reason code (CARC) lists and also instruct ViPS Medicare System (VMS) and Fiscal Intermediary Shared System (FISS) maintainers to update Medicare Remit Easy Print (MREP) and PC Print. Make sure that your billing staffs are aware of these changes and obtain the updated MREP and PC Print software if they use that software.

Background
The Health Insurance Portability and Accountability Act (HIPAA) of 1996 instructs health plans to be able to conduct standard electronic transactions adopted under HIPAA using valid standard codes. Medicare policy states that CARCs and RARCs, as appropriate, which provide either supplemental explanation for a monetary adjustment or policy information that generally applies to the monetary adjustment, are required in the remittance advice and coordination of benefits transactions.

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

CMS provides a CR as a code update notification indicating when updates to CARC and RARC lists are made available on the Washington Publishing Company (WPC) website. Shared System Maintainers (SSMs) have the responsibility to implement code deactivation, making sure that any deactivated code is not used in original business messages and allowing the deactivated code in derivative messages. SSMs must make sure that Medicare does not report any deactivated code on or after the effective date for deactivation as posted on the WPC website. If any new or modified code has an effective date past the implementation date specified in the CR, MACs must implement those updates on the date specified on the WPC website, which is at http://wpc-edi.com/Reference/.
A discrepancy between the dates may arise as the WPC website is only updated three times per year and may not match the CMS release schedule. For CR10040, the MACs and the SSMs must get the complete list for both CARCs and RARCs from the WPC website to obtain the comprehensive lists for both code sets and determine the changes included on the code list since the last code update CR (CR 9878).

**Additional Information**


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

**Document History**

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**Kentucky & Ohio**

**MM10041: Implement Operating Rules - Phase III Electronic Remittance Advice (ERA) Electronic Funds Transfer (EFT): CORE 360 Uniform Use of Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC) and Claim Adjustment Group Code (CAGC) Rule - Update from Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE)**

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

**MLN Matters® Number:** MM10041  
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**Related CR Transmittal #:** R3781CP  
**Implementation Date:** October 2, 2017

**Provider Types Affected**

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

**Provider Action Needed**

This article is based on Change Request (CR) 10041 which instructs MACs and Medicare’s Shared System Maintainers (SSMs) to update systems based on the CORE 360 Uniform Use of Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC) and Claim Adjustment Group Code (CAGC) Rule publication. These system updates reflect the Committee on Operating Rules for Information Exchange (CORE) Code Combination List for June 2017. Make sure that your billing staff is aware of these changes.
In addition, if you use the PC Print or Medicare Remit Easy Print (MREP) software supplied by your MAC, be sure to obtain the updated version of that software when it is available.

**Background**

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

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

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

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

CAQH CORE will publish the next version of the Code Combination List on or about June 10, 2017. This update is based on the CARC and RARC updates as posted at the Washington Publishing Company (WPC) website on or about March 1, 2017. This will also include updates based on Market Based Review (MBR) that CAQH CORE conducts once a year to accommodate code combinations that are currently being used by Health Plans including Medicare as the industry needs them.


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

**Additional Information**


**Document History**

<table>
<thead>
<tr>
<th>Date of Change</th>
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<tbody>
<tr>
<td>May 26, 2017</td>
<td>Initial article released.</td>
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**MM10043: Claim Status Category and Claim Status Codes Update**

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

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<th>MLN Matters® Number: MM10043</th>
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<tr>
<td>Related CR Release Date: May 26, 2017</td>
<td>Effective Date: October 1, 2017</td>
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<tr>
<td>Related CR Transmittal #: R3782CP</td>
<td>Implementation Date: October 2, 2017</td>
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</table>

**Provider Types Affected**

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

**Provider Action Needed**

Change Request (CR) 10043 informs MACs about system changes to update, as needed, the Claim Status and Claim Status Category Codes used for the Accredited Standards Committee (ASC) X12 276/277 Health Care Claim Status Request and Response and ASC X12 277 Health Care Claim Acknowledgment transactions. Make sure that your billing staffs are aware of these changes.

**Background**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires all covered entities to use only Claim Status Category Codes and Claim Status Codes approved by the National Code Maintenance Committee in the ASC X12 276/277 Health Care Claim Status Request and Response transaction standards adopted under HIPAA for electronically submitting health care claims status requests and responses. These codes explain the status of submitted claim(s). Proprietary codes may not be used in the ASC X12 276/277 transactions to report claim status. This Recurring Update Notification (RUN) can be found in Chapter 31, Section 20.7. The National Code Maintenance Committee meets at the beginning of each ASC X12 trimester meeting (January/February, June, and September/October) and makes decisions about additions, modifications, and retirement of existing codes. The Committee has decided to allow the industry 6 months for implementation of newly added or changed codes.


Included in the code lists are specific details, including the date when a code was added, changed, or deleted. All code changes approved during the June 2017 committee meeting will be posted on these sites on or about July 1, 2017. MACs must complete entry of all applicable code text changes and new codes, and terminate use of deactivated codes by the implementation date of CR 10043.

The Centers for Medicare & Medicaid Services (CMS) will issue RUNs regarding the need for future updates to these codes. When instructed, Medicare contractors must update their claims systems to ensure that the current version of these codes is used in their claim status responses. Contractor and shared systems changes will be made as necessary as part of a routine release to reflect applicable changes such as retirement of previously used codes or newly created codes.
These code changes are to be used in editing of all ASC X12 276 transactions processed on or after the date of implementation and to be reflected in the ASC X12 277 transactions issued on and after the date of implementation of this CR 10043.

Additional Information


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

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Kentucky & Ohio

MM10086: ICD-10 Coding Revisions to National Coverage Determinations (NCDs)

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: MM10086
Related CR Release Date: May 26, 2017
Related CR Transmittal #: R1854OTN
Related Change Request (CR) #: CR 10086
Effective Date: October 1, 2017
Implementation Date: October 2, 2017, shared system edits, July 14, 2017, local edits

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 10086 constitutes a maintenance update of International Classification of Diseases, Tenth Revision (ICD-10) conversions and other coding updates specific to National Coverage Determinations (NCDs). These NCD coding changes are the result of newly available codes, coding revisions to NCDs released separately, or coding feedback received. Please make sure your billing staffs are aware of these changes.

Background

The translations from International Classification of Diseases, Ninth Revision (ICD-9) to ICD-10 are not consistent 1:1 matches, nor are all ICD-10 codes appearing in a complete General Equivalence Mappings (GEMs) mapping guide or other mapping guides appropriate when reviewed against individual NCD policies. In addition, for those policies that expressly allow MAC discretion, there may be changes to those NCDs based on current review of those NCDs against ICD-10 coding. For these reasons, there may be certain ICD-9 codes that were once considered appropriate prior to ICD-10 implementation that are no longer considered acceptable.
Previous NCD coding changes appear in ICD-10 quarterly updates that can be found at https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html, along with other CRs implementing new policy NCDs. Edits to ICD-10 and other coding updates specific to NCDs will be included in subsequent, quarterly releases and individual CRs as appropriate. No policy related changes are included with the ICD-10 quarterly updates. Any policy related changes to NCDs continue to be implemented via the current, long-standing NCD process.

CR10086 makes coding and clarifying adjustments to the following NCDs:

- NCD20.29 - Hyperbaric Oxygen (HBO)
- NCD40.7 - Outpatient Intravenous Insulin Therapy
- NCD80.2 - Photodynamic Therapy
- NCD80.2.1 - Ocular Photodynamic Therapy
- NCD80.3 - Photosensitive Drugs
- NCD80.3.1 - Verteporfin
- NCD80.11 - Vitrectomy
- NCD100.1 - Bariatric Surgery
- NCD110.4 - Extracorporeal Photopheresis
- NCD110.23 - Stem Cell Transplantation
- NCD190.3 - Cytogenetic Studies
- NCD190.11 - Home Prothrombin Time/International Normalized Ratio (PT/INR)
- NCD210.13 - Screening for Hepatitis C Virus
- NCD220.4 - Mammograms
- NCD220.6.17 - PET for Solid Tumors
- NCD270.1 - Electrical Stimulation Electromagnetic Therapy for Treatment of Wounds
- NCD20.31, 20.31.1, 20.31.2, 20.31.3 - Intensive Cardiac Rehabilitation


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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<td>June 13, 2017</td>
<td>Initial article released.</td>
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Kentucky & Ohio

MM10089: Percutaneous Image-guided Lumbar Decompression (PILD) for Lumbar Spinal Stenosis (LSS)

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: MM10089
Related CR Release Date: May 26, 2017
Related CR Transmittal #: R3787CP and R196NCD

Related Change Request (CR) #: CR 10089
Effective Date: December 7, 2016
Implementation Date: June 27, 2017

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

Provider Action Needed
Change Request (CR) 10089 announces that effective for dates of service on or after December 7, 2016, Medicare will cover Percutaneous Image-guided Lumbar Decompression (PILD) under Coverage with Evidence Development (CED) for beneficiaries with Lumbar Spinal Stenosis (LSS) who are enrolled in a Centers for Medicare & Medicaid Services (CMS)-approved prospective longitudinal study. PILD procedures using an FDA-approved/cleared device that completed a CMS-approved prospective, randomized, controlled clinical trial (RCT) that met the criteria are listed in the January 2014 NCD (CR8757, see related MLN Matters article at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8757.pdf).

Background
CMS currently covers PILD under the CED paradigm. PILD is a posterior decompression of the lumbar spine performed under indirect image guidance without any direct visualization of the surgical area. This is a procedure proposed as a treatment for symptomatic LSS unresponsive to conservative therapy. This procedure is generally described as a non-invasive procedure using specially designed instruments to percutaneously remove a portion of the lamina and debulk the ligamentum flavum. The procedure is performed under x-ray guidance (for example, fluoroscopic, CT) with the assistance of contrast media to identify and monitor the compressed area via epiduragram.

Section 1862(a)(1)(E) of the Social Security Act (the Act) authorizes coverage for PILD for beneficiaries with LSS under CED. On January 9, 2014, CMS posted its first NCD (150.13) covering PILD for beneficiaries with LSS when provided in a RCT meeting certain conditions under CED. Clinical studies must be designed using current validated and reliable measurement instruments and clinically appropriate comparator treatments for patients randomized to the non-PILD group.

On April 13, 2016, CMS accepted a complete formal request for a reconsideration of the NCD that limited coverage of PILD for LSS to a CMS-approved prospective RCT. After considering the related published literature and public comments as required by Section 1862(l) of the Act, CMS will expand the January 2014 NCD to cover PILD for LSS under CED through a prospective longitudinal study that meets certain criteria listed in Chapter 1, Section 150.13 of the NCD manual (Pub. 100-03). You should refer to Chapter 1, Section 310 of the NCD Manual, as well as Chapter 32, Sections 69 and 330, of the “Medicare Claims Processing Manual” (Pub. 100-04) for more information.
NOTE: As mentioned in MM8954, there are 2 distinct procedure codes that are to be used: G0276 only for clinical trials that are blinded, randomized, and controlled, and contain a placebo procedure control arm (use CR 8954 for claims processing instructions), and 0275T for all other approved clinical trials (use CR 8757 for claims processing instructions).

CR 10089 does not replace but rather is in addition to CR 8757 and CR 8954.

Additional Information


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

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<td>June 5, 2017</td>
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Kentucky & Ohio


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:** MM10107  
**Related Change Request (CR) #:** CR 10107  
**Related CR Release Date:** May 18, 2017  
**Effective Date:** July 1, 2017  
**Related CR Transmittal #:** R3776CP  
**Implementation Date:** July 3, 2017

**Provider Types Affected**

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

**What You Need to Know**

The HCPCS code set is updated on a quarterly basis. Change Request (CR) 10107 informs MACs of updating specific drug/biological HCPCS codes. Beginning on July 1, 2017, the HCPCS file will include the following new codes:
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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MEDICARE BULLETIN GR 2017-08

KENTUCKY & OHIO PART B

Also, beginning on July 1, 2017, HCPCS code J1725 (Injection, hydroxyprogesterone caproate, 1 mg) is no longer payable for Medicare.

Make sure your billing staffs are aware of these changes.

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


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: MM10110 Related CR Release Date: June 16, 2017
Related CR Transmittal #: R236BP Related Change Request (CR) #: CR 10110 Effective Date: September 18, 2017
Implementation Date: September 18, 2017

Provider Types Affected

This MLN Matters® Article is intended for ambulance providers and suppliers submitting Medicare Part B claims to the Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.
What You Need to Know

Change Request (CR) 10110 which revises the “Medicare Benefit Policy Manual” (Chapter 10, Sections 10.3.5 and 30.1.1) to clarify the definitions for locality and ground ambulance services for ALS assessment. The term “locality” with respect to ambulance service means the service area surrounding the institution to which individuals normally travel or are expected to travel to receive hospital or skilled nursing services. Your MACs have the discretion to define “locality” in their service areas.

Background

CR10110 provides clarifications of the definitions for locality and ground ambulance services for Advanced Life Support (ALS) assessment, and it revises the “Medicare Benefit Policy Manual” to clarify that:

- MACs have the discretion to define “locality” in their service areas.
- If an ALS assessment is performed, the services will be covered at the ALS emergency level if medically necessary and all other coverage requirements are met.

The Centers for Medicare & Medicaid Services (CMS) defines the term “locality” (with respect to ambulance service) as the service area surrounding the institution to which individuals normally travel (or are expected to travel) to receive hospital or skilled nursing services.

EXAMPLE: Mr. A becomes ill at home and requires ambulance service to the hospital. The small community in which he lives has a 35-bed hospital. Two large metropolitan hospitals are located some distance from Mr. A’s community and both regularly provide hospital services to the community’s residents. The community is within the “locality” of both metropolitan hospitals and direct ambulance service to either of these (as well as to the local community hospital) is covered.

ALS assessment is defined in 42 CFR 414.605 (https://www.ecfr.gov/cgi-bin/text-idx?SID=c9a41dd27ec978a13d4e3d3b51c88f19&mc=true&node=se42.3.414_1605&rgn=div8) as an assessment performed by an ALS crew as part of an emergency response that was necessary because the patient’s reported condition at the time of dispatch was such that only an ALS crew was qualified to perform the assessment.

Note that an ALS assessment does not necessarily result in a determination that the patient requires an ALS level of service.

In the “Medicare Benefit Policy Manual” (Chapter 10, Section 30.1.1), CMS states that in the case of an appropriately dispatched ALS Emergency service, if the ALS crew completes an ALS Assessment, then the services provided by the ambulance transportation service provider or supplier may be covered at the ALS emergency level. This is regardless of whether the patient required ALS intervention services during the transport, provided that ambulance transportation itself was medically reasonable and necessary.

Additional Information


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

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<td>June 16, 2017</td>
<td>Initial article released.</td>
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MM10138: July 2017 Update of the Ambulatory Surgical Center (ASC) Payment System

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: MM10138
Related CR Release Date: June 9, 2017
Related CR Transmittal #: R3792CP

CR 10138 informs MACs about changes to the ASC payment center and billing instructions for various payment policies implemented in the July 2017 ASC payment system update. The CR also includes HCPCS updates. Make sure your billing staffs are aware of these changes.

BACKGROUND
This article notifies the MACs about updates to the ASC payment center and billing instructions for various payment policies implemented in the July 2017 ASC payment system update, as well as HCPCS changes.

CR10138 also includes updates to payment rates for separately payable drugs and biologicals, including descriptors for newly created Level II HCPCS codes for drugs and biologicals (ASC DRUG files). CR10138 includes Calendar Year (CY) 2017 ASC payment rates for covered surgical and ancillary services (ASCFS file).

1. **Category III CPT Code, Effective July 1, 2017**
   The American Medical Association (AMA) releases Category III Current Procedural Terminology (CPT) codes twice per year: in January, for implementation beginning the following July, and in July, for implementation beginning the following January.

   For the July 2017 update, the Centers for Medicare & Medicaid Services (CMS) is implementing one (1) Category III CPT code that AMA released in January 2017 for implementation on July 1, 2017. The ASC payment rate and ASC payment indicator (ASC PI) for this code is listed in Table 1.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>July 2017 ASC PI</th>
</tr>
</thead>
<tbody>
<tr>
<td>0474T</td>
<td>Insj aqueous drg dev io rsrv</td>
<td>Insertion of anterior segment aqueous drainage device, with creation of intraocular reservoir, internal approach, into the supraciliary space</td>
<td>J8</td>
</tr>
</tbody>
</table>

2. **New Separately Payable Procedure Codes**
   Effective July 1, 2017, three new HCPCS codes, C9745, C9746, and C9747, have been created. These codes, along with their descriptors and ASC PI, are listed in Table 2.
3. Drugs, Biologicals, and Radiopharmaceuticals
   a. ASC Drugs and Biologicals with OPPS Pass-Through Status, Effective July 1, 2017

For CY 2017, two new HCPCS codes, with OPPS Pass-Through Status, have been created for reporting drugs and biologicals in the ASC payment system, where there have not previously been specific codes available. These new codes are listed in Table 3.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>ASC PI</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9489</td>
<td>Injection, nusinersen</td>
<td>Injection, nusinersen, 0.1 mg</td>
<td>K2</td>
</tr>
<tr>
<td>C9490</td>
<td>Injection, bezlotoxumab</td>
<td>Injection, bezlotoxumab, 10 mg</td>
<td>K2</td>
</tr>
</tbody>
</table>

b. Drugs and Biologicals with Payments Based on Average Sales Price (ASP), Effective July 1, 2017

For CY 2017, payment for non-pass-through drugs, biologicals and therapeutic radiopharmaceuticals continues to be made at a single rate of ASP + 6 percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical. In addition, in CY 2017, a single payment of ASP + 6 percent continues to be made for pass-through drugs, biologicals and radiopharmaceuticals to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items. Payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. Updated payment rates effective July 1, 2017, and drug price restatements are in the July 2017 ASC Addendum BB, available at [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html).

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

Some drugs and biologicals based on ASP methodology may have payment rates that are corrected retroactively. These retroactive corrections typically occur on a quarterly basis. The list of drugs and biologicals with corrected payments rates will be accessible on the first date of the quarter at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/ASC-Restated-Payment-Rates.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/ASC-Restated-Payment-Rates.html). Suppliers who think they may have received an incorrect payment for drugs and biologicals impacted by these corrections may request contractor adjustment of the previously processed claims.

d. New Drug HCPCS Codes Effective July 1, 2017
Effective July 1, 2017, one new HCPCS code has been created for reporting drugs and biologicals in the ASC payment system, where there have not previously been specific codes available. This new code is listed in Table 4.

Table 4 — New Drug HCPCS Codes Effective July 1, 2017

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>ASC PI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q9986</td>
<td>Inj, Makena</td>
<td>Injection, hydroxyprogesterone caproate (Makena), 10 mg</td>
<td>K2</td>
</tr>
</tbody>
</table>

e. Change to ASC Payment Indicator for CPT Code 90682

The influenza vaccine associated with CPT code 90682 (Influenza virus vaccine, quadrivalent (riv4), derived from recombinant dna, hemagglutinin (ha) protein only, preservative and antibiotic free, for intramuscular use) is approved for use in the 2017-2018 flu season (see MLN Matters article MM9876 at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9876.pdf). CPT code 90682 was added to the January 2017 ASCFS with an effective date of January 1, 2017, and assigned an ASC PI of “L1” (Influenza vaccine; pneumococcal vaccine. Packaged item/service; no separate payment made). Because this code is not a payable code until the start of the 2017 flu season, the payment indicator will be retroactively corrected from ASC PI=L1 to ASC PI=Y5 (Nonsurgical procedure/item not valid for Medicare purposes because of coverage, regulation and/or statute; no payment made) effective January 1, 2017, through June 30, 2017. Effective July 1, 2017, CPT code 90682 is assigned SI=L1. ASCs are reminded that ordinarily packaged codes are not billed in the ASC payment system. This change is described in Table 5.

Table 5 — Change to ASC Payment Indicator for CPT Code 90682

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>ASC PI</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>90682</td>
<td>Riv4 vacc recombinant dna im</td>
<td>Influenza virus vaccine, quadrivalent (riv4), derived from recombinant dna, hemagglutinin (ha) protein only, preservative and antibiotic free, for intramuscular use</td>
<td>Y5</td>
<td>January 1, 2017 – June 30, 2017</td>
</tr>
<tr>
<td>90682</td>
<td>Riv4 vacc recombinant dna im</td>
<td>Influenza virus vaccine, quadrivalent (riv4), derived from recombinant dna, hemagglutinin (ha) protein only, preservative and antibiotic free, for intramuscular use</td>
<td>L1</td>
<td>July 1, 2017</td>
</tr>
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</table>

f. Revised Status Indicator for HCPCS Code J1725

For the July 2017 update, the HCPCS Workgroup inactivated HCPCS code J1725 for Medicare reporting and replaced it with HCPCS code Q9986 (see table 4 above for Q9986 descriptors and ASC PI). Therefore, effective July 1, 2017, the ASC PI for HCPCS code J1725 (Injection, hydroxyprogesterone caproate, 1 mg) will change from ASC PI=K2 (Drugs and biologicals paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate) to ASC PI= Y5 (Nonsurgical procedure/item not valid for Medicare purposes because of coverage, regulation and/or statute; no payment made). Table 6 describes the status indicator change and effective date for HCPCS code J1725. The payment rate for HCPCS codes Q9986 is included in the July 2017 ASC Addendum BB, available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html.

Table 6 — Revised Status Indicator for HCPCS Code J1725

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>ASC PI</th>
<th>Effective Date</th>
<th>Termination Date</th>
</tr>
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<tr>
<td>J1725</td>
<td>Hydroxyprogesterone caproate</td>
<td>Injection hydroxyprogesterone caproate, 1 mg</td>
<td>K2</td>
<td>01/01/2012</td>
<td>06/30/2017</td>
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<tr>
<td>J1725</td>
<td>Hydroxyprogesterone caproate</td>
<td>Injection hydroxyprogesterone caproate, 1 mg</td>
<td>Y5</td>
<td>07/01/2017</td>
<td></td>
</tr>
</tbody>
</table>
g. **Other Changes to CY 2017 HCPCS Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals**

Effective July 1, 2017, HCPCS code Q9989 (Ustekinumab, for Intravenous Injection, 1 mg) will replace HCPCS code C9487 (Ustekinumab, for Intravenous Injection, 1 mg). The payment indicator will remain K2, “Drugs and biologicals paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate.” The HCPCS code change and effective date are described in Table 7.

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>ASC PI</th>
<th>Effective Date</th>
<th>Termination Date</th>
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<tbody>
<tr>
<td>C9487</td>
<td>Ustekinumab IV inj, 1 mg</td>
<td>Ustekinumab, for Intravenous Injection, 1 mg</td>
<td>K2</td>
<td>04/01/2017</td>
<td>06/30/2017</td>
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<tr>
<td>Q9989</td>
<td>Ustekinumab IV Inj, 1 mg</td>
<td>Ustekinumab, for Intravenous Injection, 1 mg</td>
<td>K2</td>
<td>07/01/2017</td>
<td></td>
</tr>
</tbody>
</table>

4. **Coverage Determinations**

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

**Additional Information**


If you have any questions, please contact 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**

<table>
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<th>Date of Change</th>
<th>Description</th>
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<tr>
<td>June 9, 2017</td>
<td>The article was revised on due to the release of an updated CR that corrected an error to the ASC Payment Indicator for C9747 in Table 2 (changed from J8 to G2).</td>
</tr>
<tr>
<td>June 2, 2017</td>
<td>Initial Article Released.</td>
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</table>
MM10156: Changes to the Laboratory National Coverage Determination (NCD) Edit Software for October 2017

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

MLN Matters® Number: MM10156 Related Change Request (CR) #: CR 10156
Related CR Release Date: June 16, 2017 Effective Date: October 1, 2017
Related CR Transmittal #: R3797CP Implementation Date: October 2, 2017

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

What You Need to Know
Change Request (CR) 10156 informs MACs about the changes that will be included in the October 2017 quarterly release of the edit module for clinical diagnostic laboratory services. Make sure your billing staffs are aware of these changes.

Background
CR 10156 announces the changes that will be included in the October 2017 quarterly release of the edit module for clinical diagnostic laboratory services.

CR 10156 revises several laboratory NCD code lists as follows:

- Add ICD-10-CM code E034, effective 10/1/2016, to the list of ICD-10-CM codes that are covered by Medicare for the Lipids Testing (190.23A) NCD.
- Add ICD-10-CM code E034, effective 10/1/2016, to the list of ICD-10-CM codes that are covered by Medicare for the Lipids Testing (190.23B) NCD.
- Add ICD-10-CM codes D4959 and R9349, effective 10/1/2016, to the list of ICD-10-CM codes that are covered by Medicare for the Human Chorionic Gonadotropin (190.27) NCD.
- Delete ICD-10-CM code Z8482 from the list of ICD-10-CM codes that are covered by Medicare for the Glycated Hemoglobin/Glycated Protein (190.21) NCD.

Additional Information
MACs will not search their files to either retract payment for claims already paid or retroactively pay claims, but they will adjust such claims that you bring to their attention.

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: SE1605 Revised   Related Change Request (CR) #: N/A
Related CR Release Date: N/A   Effective Date: N/A
Related CR Transmittal #: N/A   Implementation Date: N/A

Note: This article was revised on June 15, 2017, to change the effective date of deactivations due to non-billings from 5 days from the date of the deactivation letter to 10 days. (See page 6.) All other information is unchanged.

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

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

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

GO – What You Need to Do
1. Check http://go.cms.gov/MedicareRevalidation for the provider/suppliers due for revalidation;
2. If the provider/supplier has a due date listed, CMS encourages you to submit your revalidation within six months of your due date or when you receive notification from your MAC to revalidate. When either of these occur:
Submit a revalidation application through Internet-based PECOS located at https://pecos.cms.hhs.gov/pecos/login.do, the fastest and most efficient way to submit your revalidation information. Electronically sign the revalidation application and upload your supporting documentation or sign the paper certification statement and mail it along with your supporting documentation to your MAC; or

- Complete the appropriate CMS-855 application available at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html;

- If applicable, pay your fee by going to https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do; and

- Respond to all development requests from your MAC timely to avoid a hold on your Medicare payments and possible deactivation of your Medicare billing privileges.

Background

Section 6401 (a) of the Affordable Care Act established a requirement for all enrolled providers/suppliers to revalidate their Medicare enrollment information under new enrollment screening criteria. CMS has completed its initial round of revalidations and will be resuming regular revalidation cycles in accordance with 42 CFR §424.515. This cycle of revalidation applies to those providers/suppliers that are currently and actively enrolled.

What’s ahead for your next Medicare enrollment revalidation?

Established Due Dates for Revalidation

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

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

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

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

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

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

This newsletter should be shared with all health care practitioners and managerial members of the provider/supplier staff. Newsletters issued after January 1997 are available at no cost from our website at http://www.cgsmedicare.com. © 2017 Copyright, CGS Administrators, LLC.
Note: Providers/suppliers who are within 2 months of their listed due dates on [http://go.cms.gov/MedicareRevalidation](http://go.cms.gov/MedicareRevalidation) but have not received a notice from their MAC to revalidate, are encouraged to submit their revalidation application.

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

### Large Group Coordination

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

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

### Unsolicited Revalidation Submissions

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

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

### Submitting Your Revalidation Application

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

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

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

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

To revalidate via the Internet-based PECOS, go to [https://pecos.cms.hhs.gov/pecos/login.do](https://pecos.cms.hhs.gov/pecos/login.do). PECOS allows you to review information currently on file and update and submit your
revalidation via the Internet. Once completed, YOU MUST electronically sign the revalidation application and upload any supporting documents or print, sign, date, and mail the paper certification statement along with all required supporting documentation to your appropriate MAC IMMEDIATELY.

PECOS ensures accurate and timelier processing of all types of enrollment applications, including revalidation applications. It provides a far superior alternative to the antiquated paper application process.

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

**Getting Access to PECOS:**

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

To learn more about establishing an I&A account or to verify your ability to submit applications using PECOS, please refer to https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedEnroll_PECOS_PhyNonPhys_FactSheet_ICN903764.pdf.

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

For questions about accessing PECOS (such as login, forgot username/password) or I&A, contact the External User Services (EUS) help desk at 1.866.464.8049 or at EUSSupport@cgi.com.

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

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

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

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

**Revalidation Timeline and Example**

Providers/suppliers may use the following table/chart as a guide for the sequence of events through the revalidation progression.
### Deactivations Due to Non-Billing

Providers/suppliers that have not billed Medicare for the previous 12 consecutive months will have their Medicare billing privileges deactivated in accordance with 42 CFR §424.540. The effective date of deactivation will be 10 days from the date of the corresponding deactivation letter issued by the MACs notifying the providers/suppliers of the deactivation action.

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

#### Application Fees

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

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

### SUMMARY:

- CMS will post the revalidation due dates for the upcoming revalidation cycle on [http://go.cms.gov/MedicareRevalidation](http://go.cms.gov/MedicareRevalidation) for all providers/suppliers. This list will be refreshed periodically. Check this list regularly for updates.
- MACs will continue to send revalidation notices (either by email or mail) within 2-3 months prior to your revalidation due date. When responding to revalidation requests, be sure to revalidate your entire Medicare enrollment record, including all reassignment and practice locations. If you have multiple reassignments/billing structures, you must coordinate the revalidation application submission with all parties.
- If a revalidation application is received but incomplete, the MACs will develop for the missing information. If the missing information is not received within 30 days of the request, the MACs will deactivate the provider/supplier’s billing privileges.
- If a revalidation application is not received by the due date, the MAC may place a hold on your Medicare payments and deactivate your Medicare billing privileges.
If the provider/supplier has not billed Medicare for the previous 12 consecutive months, the MAC will deactivate their Medicare billing privileges.

If billing privileges are deactivated, a reactivation will result in the same PTAN but an interruption in billing during the period of deactivation. This will result in a gap in coverage.

If the revalidation application is approved, the provider/supplier will be revalidated and no further action is needed.

**Additional Information**

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


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

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

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

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

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<tr>
<td>March 15, 2017</td>
<td>The updated article revised the table on page 6 and added additional information after that table.</td>
</tr>
<tr>
<td>February 22, 2016</td>
<td>Initial Article Released.</td>
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