KENTUCKY & OHIO

Administration
MM9911 Revised: Qualified Medicare Beneficiary Indicator in the Medicare Fee-For-Service Claims Processing System ......................................................... 10
MM10143: Internet Only Manual Update to Pub. 100-04, Chapter 15 .................................................. 14

Coding
MM10183: Quarterly Update to the National Correct Coding Initiative (NCCI) Procedure to Procedure (PTP) Edits, Version 23.3, Effective October 1, 2017 ......................... 15

Coverage, LCDs, and NCDs
MM10089 Revised: Percutaneous Image-guided Lumbar Decompression (PILD) for Lumbar Spinal Stenosis (LSS) ........................................ 12

Credentialing & Enrollment
Revised CMS-588: Electronic Funds Transfer Authorization Agreement ........................................... 3
SE17016: Modernized National Plan and Provider Enumeration System ........................................... 19

Drugs & Biologicals
MM10187: October 2017 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions To Prior Quarterly Pricing Files ........................................ 16

Laboratory
MM10198: New Waived Tests .................................................. 17

Preventive Services
MM9859 Revised: Screening for Hepatitis B Virus (HBV) Infection .................................................. 3

Responding to Medical Review Additional Documentation Requests through myCGS
myCGS, our secure online Web portal, allows you to submit documentation in response to additional documentation requests (ADRs) received from our medical review (MR) department. It is important that ADR responses are submitted to the correct line of business (LOB). Refer to Chapter 7: Forms Tab, of the myCGS User Guide at https://www.cgsmedicare.com/pdf/mycgs/chapter7_partb.pdf

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

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

Revised CMS-588: Electronic Funds Transfer Authorization Agreement

Providers and suppliers must use the revised CMS-588 form (Electronic Funds Transfer Authorization Agreement) beginning January 1, 2018. The revised form has been posted on the CMS Forms List (https://go.usa.gov/xX3Sa). Medicare Administrative Contractors will accept both the current and revised versions of the CMS-588 through December 31, 2017. Visit the Medicare Provider-Supplier Enrollment Web page (https://go.usa.gov/xXCWk) for more information about Medicare enrollment and the Electronic Funds Transfer (EFT) requirements.

Changes to the form include:

- New indicator shows if the EFT is for an individual or a group/organization/corporation in Parts 1 and 2 (Reason for Submission and Account Holder Information)
- Now optional to list the financial institution’s contact person
- Four digits added to the “Provider’s/Supplier’s/Indirect Payment Procedure Entity’s Account Number with Financial Institution,” making it consistent with the industry standard

Kentucky & Ohio

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

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

MLN Matters® Number: MM9859 Revised Related Change Request (CR) #: CR 9859
Related CR Release Date: June 29, 2017 Effective Date: September 28, 2016
Related CR Transmittal #: R3804CP and R198NCD Implementation Date: January 2, 2018

Note: This article was revised on June 30, 2017, to reflect an updated Change Request (CR) 9859.

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

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 submitted 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 life style.

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
  - Z34.01 - Encounter for supervision of normal first pregnancy, first trimester
  - Z34.02 - Encounter for supervision of normal first pregnancy, second trimester
  - Z34.03 - Encounter for supervision of normal first pregnancy, third trimester
  - Z34.08 - Encounter for supervision of other normal pregnancy, unspecified trimester
  - Z34.09 - Encounter for supervision of other 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:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z34.00</td>
<td>Encounter for supervision of normal first pregnancy, unspecified trimester</td>
</tr>
<tr>
<td>Z34.01</td>
<td>Encounter for supervision of normal first pregnancy, first trimester</td>
</tr>
<tr>
<td>Z34.02</td>
<td>Encounter for supervision of normal first pregnancy, second trimester</td>
</tr>
<tr>
<td>Z34.03</td>
<td>Encounter for supervision of normal first pregnancy, third trimester</td>
</tr>
<tr>
<td>Z34.08</td>
<td>Encounter for supervision of other normal pregnancy, unspecified trimester</td>
</tr>
<tr>
<td>Z34.09</td>
<td>Encounter for supervision of other normal pregnancy, unspecified, unspecified trimester</td>
</tr>
<tr>
<td>Z34.90</td>
<td>Encounter for supervision of normal pregnancy, unspecified, unspecified trimester</td>
</tr>
<tr>
<td>Z34.91</td>
<td>Encounter for supervision of normal pregnancy, unspecified, first trimester</td>
</tr>
<tr>
<td>Z34.92</td>
<td>Encounter for supervision of normal pregnancy, unspecified, second trimester</td>
</tr>
<tr>
<td>Z34.93</td>
<td>Encounter for supervision of normal pregnancy, unspecified, third trimester</td>
</tr>
<tr>
<td>O09.90</td>
<td>Supervision of high risk pregnancy, unspecified, unspecified trimester</td>
</tr>
<tr>
<td>O09.91</td>
<td>Supervision of high risk pregnancy, unspecified, first trimester</td>
</tr>
<tr>
<td>O09.92</td>
<td>Supervision of high risk pregnancy, unspecified, second trimester</td>
</tr>
<tr>
<td>O09.93</td>
<td>Supervision of high risk pregnancy, unspecified, third trimester</td>
</tr>
</tbody>
</table>
Claim/Service Denial

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

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

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

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

- CARC 119 - “Benefit maximum for this time period or occurrence has been reached.”
- RARC N386 - “This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at http://www.cms.gov/mcd/search.asp. 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 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](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](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 https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/.

### Document History

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 30, 2017</td>
<td>This article was revised to reflect an updated CR9859. In the article, the CR release date, transmittal numbers, and the Web address of the CR are revised. All other information is unchanged.</td>
</tr>
<tr>
<td>June 9, 2017</td>
<td>The article was revised to reflect an updated CR that changed the implementation date from January 1, 2018, to January 2, 2018.</td>
</tr>
<tr>
<td>May 4, 2017</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>

#### Kentucky & Ohio

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

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

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

**Note:** The article was revised on June 29, 2017, to reflect a revised CR9911 issued on June 28, 2017. In the article, the CR release date, transmittal number, and the Web address of CR9911 are revised. Clarifications are also made to the second paragraph of the Background section. All other information remains the same.

**Provider Types Affected**

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

**Provider Action Needed**

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

**Background**

QMB is a Medicaid program that assists low-income beneficiaries with Medicare premiums and cost-sharing. In 2015, 7.2 million persons (more than one out of every ten Medicare beneficiaries) were enrolled in the QMB program.
Federal law bars Medicare providers from billing a QMB individual for Medicare Part A and B deductibles, coinsurance, or copayments, under any circumstances. Sections 1902(n)(3)(B); 1902(n)(3)(C); 1905(p)(3); 1866(a)(1)(A); 1848(g)(3)(A) of the Social Security Act. State Medicaid programs may pay providers for Medicare deductibles, coinsurance, and copayments. However, as permitted by Federal law, states can limit provider payment for Medicare cost-sharing, under certain circumstances. Regardless, QMB individuals have no legal liability to pay Medicare providers for Medicare Part A or Part B cost-sharing. Providers may seek reimbursement for unpaid Medicare deductible and coinsurance amounts as a Medicare bad debt related to dual eligible beneficiaries under CMS Pub. 15-1, Chapter 3 of the Provider Reimbursement Manual (PRM).

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

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

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

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

CWF will provide the claims processing systems the QMB indicator if the "through date" falls within a QMB coverage period (one of the occurrences) for inpatient hospital claims (TOB 011x) and religious non-medical health care institution claims (TOB 041x).

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

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

In addition, the MACs will include a Claim Adjustment Reason Code of 209 ("Per regulatory or other agreement. The provider cannot collect this amount from the patient. However, this..."
Finally, CR 9911 will modify the MSN to inform beneficiaries if they are enrolled in QMB and cannot be billed for Medicare cost-sharing for covered items and services.

Additional Information


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

If you have any questions, please contact 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>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 29, 2017</td>
<td>The article was revised to reflect a revised CR9911 issued on June 28, 2017. In the article, the CR release date, transmittal number, and the Web address of CR9911 are revised. Clarifications were also made to the second paragraph of the Background section. All other information remains the same.</td>
</tr>
<tr>
<td>May 1, 2017</td>
<td>The article was revised to reflect a revised CR9911 issued on April 28, 2017. In the article, the CR release date, transmittal number, and the Web address of CR9911 are revised. All other information remains the same.</td>
</tr>
<tr>
<td>February 3, 2017</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>

Kentucky & Ohio

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

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:** MM10089 Revised  **Related Change Request (CR) #:** CR 10089

**Related CR Release Date:** July 25, 2017  **Effective Date:** December 7, 2016

**Related CR Transmittal #:** R3811CP and R200NCD  **Implementation Date:** June 27, 2017

**Note:** This article was revised on July 26, 2017, to reflect the revised CR10089 issued on July 25. In the article, the transmittal numbers, CR release date, implementation date, and the Web addresses for accessing the transmittals are revised. All other information remains the same.

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

You can review the list of approved clinical studies related to PILD for LSS at http://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/PILD.html on the CMS website.


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

MM10143: Internet Only Manual Update to Pub. 100-04, Chapter 15

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: MM10143
Related CR Release Date: June 23, 2017
Related CR Transmittal #: R3800CP
Related Change Request (CR) #: CR 10143
Effective Date: July 25, 2017
Implementation Date: July 25, 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) 10143 corrects errors in Chapter 15, Section 20.1.4 of the Medicare Claims Processing Manual.

Background
CR10143 corrects errors in Chapter 15, Section 20.1.4 of the Medicare Claims Processing Manual. These changes are being made to correct minor typographical errors. No policy, processing, or system changes are anticipated. The change specifies that the year that is associated with the Medicare Modernization Act 2003

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>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 5, 2017</td>
<td>Initial article released.</td>
</tr>
<tr>
<td>July 26, 2017</td>
<td>The article was revised on July 26, 2017, to reflect the revised CR10089 issued on July 25. In the article, the transmittal numbers, CR release date, implementation date, and the Web addresses for accessing the transmittals are revised. All other information remains the same.</td>
</tr>
</tbody>
</table>

July 18, 2017 | Initial article released. |
Kentucky & Ohio

MM10183: Quarterly Update to the National Correct Coding Initiative (NCCI) Procedure to Procedure (PTP) Edits, Version 23.3, Effective October 1, 2017

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

MLN Matters® Number: MM10183  Related Change Request (CR) #: CR10183
Related CR Release Date: July 14, 2017  Effective Date: October 1, 2017
Related CR Transmittal #: R3807CP  Implementation Date: October 2, 2017

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 10183 informs the MACs about the update to the National Correct Coding Initiative (NCCI) procedure to procedure edits (PTP). This notice applies to Chapter 23, Section 20.9 of the Medicare Claims Processing Manual. Make sure your billing staffs are aware of these changes.

Background

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

Version 23.3 will include all previous versions and updates from January 1, 1996, to the present. In the past, CCI was organized in two tables: Column 1/Column 2 Correct Coding Edits and Mutually Exclusive Code (MEC) Edits. In order to simplify the use of NCCI edit files (two tables), on April 1, 2012, CMS consolidated these two edit files into the Column One/Column Two Correct Coding edit file. Separate consolidations have occurred for the two practitioner NCCI edit files and the two NCCI edit files used for the Outpatient Code Editor (OCE). It will only be necessary to search the Column One/Column Two Correct Coding edit file for active or previously deleted edits. CMS no longer publishes a Mutually Exclusive edit file on its website for either practitioner or outpatient services, since all active and deleted edits will appear in the single Column One/Column Two Correct Coding edit file on each website. The edits previously contained in the Mutually Exclusive edit file are NOT being deleted but are being moved to the Column One/Column Two Correct Coding edit file. Refer to the CMS NCCI Web page for additional information at http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html.

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

Additional Information

Kentucky & Ohio

MM10187: October 2017 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions To Prior Quarterly Pricing Files

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

MLN Matters® Number: MM10187 Related Change Request (CR) #: CR10187
Related CR Release Date: July 21, 2017 Effective Date: October 1, 2017
Related CR Transmittal #: R3809CP Implementation Date: October 2, 2017

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

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

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

- File: October 2017 ASP and ASP NOC — Effective Dates of Service: October 1, 2017, through December 31, 2017
- File: July 2017 ASP and ASP NOC — Effective Dates of Service: July 1, 2017, through September 30, 2017
- File: April 2017 ASP and ASP NOC — Effective Dates of Service: April 1, 2017, through June 30, 2017
- File: January 2017 ASP and ASP NOC — Effective Dates of Service: January 1, 2017, through March 31, 2017
For any drug or biological not listed in the ASP or NOC drug-pricing files, MACs will determine the payment allowance limits in accordance with the policy described in the “Medicare Claims Processing Manual,” Chapter 17, Section 20.1.3, which is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c17.pdf. For any drug or biological not listed in the ASP or NOC drug-pricing files that is billed with the KD modifier, contractors shall determine the payment allowance limits in accordance with instructions for pricing and payment changes for infusion drugs furnished through an item of Durable Medical Equipment (DME) on or after January 1, 2017, associated with the passage of the 21st Century Cures Act.

Additional Information

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

Document History

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 21, 2017</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>

Kentucky & Ohio

**MM10198: New Waived Tests**

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

**MLN Matters® Number:** MM10198
**Related Change Request (CR) #:** CR10198
**Related CR Release Date:** July 27, 2017  
**Effective Date:** October 1, 2017
**Related CR Transmittal #:** R3812CP  
**Implementation Date:** October 2, 2017

**Provider Types Affected**
This MLN Matters® Article is intended for clinical diagnostic laboratories submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

**Provider Action Needed**
Change Request (CR) 10198 informs MACs of new Clinical Laboratory Improvement Amendments of 1988 (CLIA) waived tests approved by the Food and Drug Administration (FDA). Since these tests are marketed immediately following approval, the Centers for Medicare & Medicaid Services (CMS) must notify the MACs of the new tests so that they can accurately process claims. CR10198 lists 17 newly added waived complexity tests.

**Background**
The CLIA regulations require a facility to be appropriately certified for each test performed. To ensure that Medicare and Medicaid only pay for laboratory tests categorized as waived complexity under CLIA in facilities with a CLIA certificate or waiver, laboratory claims are currently edited at the CLIA certificate level.
This article includes the latest tests approved by the FDA as waived tests under CLIA. The Current Procedural Terminology (CPT) codes for the following new tests must have the modifier QW to be recognized as a waived test. However, the tests mentioned on the first page of the attached list (that is, CPT codes 81002, 81025, 82270, 82272, 82962, 83026, 84830, 85013, and 85651) do not require a QW modifier to be recognized as a waived test.

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

- 87880QW, December 8, 2016, Quidel Sofia Strep A+ FIA (from throat swab only);
- 80305QW, April 28, 2017, Alere Toxicology Services Alere iCup Rx Multi-Drug Urine Test Cup;
- 87804QW, May 30, 2017, Quidel Sofia 2 {Sofia Influenza A+B FIA}; and

**Note:** MACs will not search their files to either retract payment or retroactively pay claims; however, MACs should adjust claims if they are brought to their attention.

**Additional Information**


**Document History**

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 28, 2017</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>
**SE17016: Modernized National Plan and Provider Enumeration System**

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

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

**Provider Types Affected**

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

**PROVIDER ACTION NEEDED**

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

**Background**

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

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


**New NPPES Impact on Type 1 Providers**

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

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

New NPPES Impact on Type 2 Providers

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

Key Features of the Modernized NPPES

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

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

Electronic File Interchange (EFI) Features

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

Data Dissemination File (DDS) Enhancements

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

New Optional Fields in NPPES 3.0

The following new fields will allow the user to give more information about the provider and the practice location:
• Primary languages
• Secondary languages
• Race and ethnicity
• Accessibility of the location to users with mobility disabilities
• Provider’s office hours of operation
• Provider’s direct email address

Frequently Asked Questions
Feel free to visit the NPPES Web help guide to see solutions to frequently asked questions. That guide is available at https://nppes.cms.hhs.gov/webhelp/nppeshelp/NPPES%20FAQS.html.

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

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

If you have any questions, please contact the NPI enumerator by phone at 1.800.465.3203 (NPI Toll-Free) or 1.800.692.2326 (NPI TTY), by email at customerservice@npienumerator.com or by regular mail at:

NPI Enumerator
PO Box 6059
Fargo, ND 58108-6059

Document History

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 27, 2017</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>