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Articles contained in this edition are current as of August 29, 2018.

Bold, italicized material is excerpted from the American Medical Association Current Procedural Terminology CPT codes. Descriptions and other data only are copyrighted 2018 American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Kentucky & Ohio

myCGS Video Education Now Available

CGS now offers Part B providers educational videos to learn more about myCGS, the CGS Web portal. Learn what myCGS is, what information is available via myCGS and how to register and more. The myCGS videos currently available include:

- Intro to myCGS
- Financial Tools
- Eligibility
- Messages and Greenmail


Kentucky & Ohio

Provider Contact Center (PCC) Training

Medicare is a continuously changing program, and it is important that we provide correct and accurate answers to your questions. To better serve the provider community, the Centers for Medicare & Medicaid Services (CMS) allows the provider contact centers the opportunity to offer training to our customer service representatives (CSRs). The list below indicates when the CGS Part B PCC (1.866.276.9558) will be closed for CSR training and staff development.

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<thead>
<tr>
<th>Date</th>
<th>PCC Training/Closures</th>
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<tr>
<td>Monday, October 8, 2018</td>
<td>PCC Closed</td>
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The Interactive Voice Response (IVR) (1.866.290.9481) is available for assistance in obtaining patient eligibility information, claim and deductible information, and general information. For information about the IVR, access the IVR User Guide at https://www.cgsmedicare.com/partb/cs/partb_ivr_user_guide.pdf on the CGS website. In addition, CGS’ Internet portal, myCGS, is available to access eligibility information through the Internet. For Additional Information, go to https://www.cgsmedicare.com/partb/index.html and click the “myCGS” button on the left side of the Web page.

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**Contact Information for CGS Medicare Part B**

To contact a CGS Customer Service Representative, call the CGS Provider Contact Center at 1.866.276.9558 and choose Option 1. For additional contact information, please access the Kentucky & Ohio Part B “Contact Information” Web page at [https://www.cgsmedicare.com/partb/cs/index.html](https://www.cgsmedicare.com/partb/cs/index.html) for information about the myCGS Web portal, the Interactive Voice Response (IVR) system, as well as telephone numbers, fax numbers, and mailing addresses for other CGS departments.

**Kentucky & Ohio**

**New Policy Magnetic Resonance Image Guided High Intensity Ultrasound (MRgFUS) for Essential Tumor**

CGS Administrators, LLC has one new policy that will take effect on October 1, 2018, Magnetic Resonance Image Guided High Intensity Focused Ultrasound (MRgFUS) for Essential Tumor L37790. We did not receive any comments during the open comment period June 20, 2018-August 6, 2018 for this policy.

Please see links below to view the policy.


**Kentucky & Ohio**

**Quarterly Provider Update**

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

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

Kentucky & Ohio

Stay Informed and Join the CGS ListServ Notification Service

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

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

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

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

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MM10559: Update to Medicare Claims Processing Manual, Chapter 24, Section 90

The Centers for Medicare & Medicaid Services (CMS) 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: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/

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<td>Related CR Release Date: August 3, 2018</td>
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<td>Related CR Transmittal #: R4096CP</td>
<td>Implementation Date: November 5, 2018</td>
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Provider Types Affected

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

What You Need to Know

This article is based on Change Request (CR) 10559 which reduces confusion and clarifies the Administrative Simplification Compliance Act (ASCA) waiver process guideline in the Medicare Claims Processing Manual, Chapter 24, Section 90. CR10559 combines two sections (90.3.2 and 90.3.3) into one new Section 90.3.2 with a new title and description.

Background

Section 3 of the ASCA, Pub. L. 107-105, and the implementing regulation at 42 CFR 424.32 (see https://www.ecfr.gov/cgi-bin/text-idx?SID=c41b2cb8b72f75bd58ae2a26094f4cfe&mc=true&node=p42.3.424&rgn=div5#se42.3.4.24_132), require providers to submit all initial claims for reimbursement under Medicare, (except for small providers), electronically as of October 16, 2003, with limited exceptions.

This newsletter should be shared with all health care practitioners and managerial members of the provider/supplier staff. Newsletters issued after February 1997 are available at no cost from our website at http://www.cgsmedicare.com. © 2018 Copyright, CGS Administrators, LLC.
Medicare is prohibited from paying claims submitted in a non-electronic manner that do not meet the limited exception criteria. The issuance of waivers under this limited exception criteria to is discussed in Chapter 24, Section 90 of the Medicare Claims Processing Manual.

A provider may submit a waiver request to their MAC claiming other types of “unusual circumstances” outside of their control prevent submission of electronic claims. It is the responsibility of the provider to submit appropriate documentation including request application with Provider name, address, email, and phone number to establish the validity of a waiver request in this situation. Requests received without documentation and above stated information to fully explain and justify why enforcement of the requirement would be against equity and good conscience in these cases will be denied. If the MAC agrees that the waiver request has merit, the MAC sends the request to the Centers for Medicare & Medicaid Services (CMS) for review and issuance of the CMS decision.

If the MAC does not consider an “unusual circumstance” to be met, and does not recommend CMS approval, the MAC must issue a form letter to the provider. As required by the Privacy Act of 1974, letters issued to a provider to announce a waiver decision must be addressed to the organizational name of a provider and not to an individual (whether a sole practitioner, employee, or an owner of the provider organization). The organizational name is generally a corporate name under which the provider is registered as a Medicare provider or that is used to obtain an Employer Identification Number (EIN).

Additional Information
The official instruction, CR10559, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4096CP.pdf. The revised manual chapter is attached to the CR.

If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

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**Kentucky & Ohio**

**MM10824: Next Generation Accountable Care Organization (ACO) Model 2019 Benefit Enhancement**

The Centers for Medicare & Medicaid Services (CMS) 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: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/

**MLN Matters® Number:** MM10824  
**Related CR Release Date:** August 10, 2018  
**Related CR Transmittal #:** R203DEMO  
**Related Change Request (CR) #:** 10824  
**Effective Date:** January 1, 2019  
**Implementation Date:** January 7, 2019

**Provider Types Affected**
This MLN Matters® Article is intended for providers who are participating in Next Generation Accountable Care Organizations (NGACOs) and submitting claims to Medicare Administrative Contractors (MACs) for certain care management home visit services to Medicare beneficiaries that would not otherwise be covered by Original Fee-For-Service (FFS) Medicare.

**Provider Action Needed**
Change Request (CR) 10824 provides instruction on implementing one new Benefit Enhancement for program year three of the NGACO Model.
Background
The goal of the NGACO Model is to improve the quality of care, population health outcomes, and patient experience for the beneficiaries who choose traditional FFS Medicare. The Model provides greater alignment of financial incentives and greater access to tools that may aid beneficiaries and providers in achieving better health at lower costs. Some of the tools that are available to beneficiaries and providers are conditional waivers of certain Medicare payment requirements, called Benefit Enhancements. These Benefit Enhancements currently include the Three-Day Skilled Nursing Facility Rule Waiver, the Post-Discharge Home Visits Waiver, and the Telehealth Expansion Waiver. There are Medicare Learning Network articles available describing each of these and the links for them are available in the Additional Information section.

New Benefit Enhancement for 2019
Care Management Home Visits
Building upon the NGACOs’ experience in offering the Post-Discharge Home Visits Benefit Enhancement, the Model will offer a new Care Management Home Visits Benefit Enhancement to equip the NGACOs with a new tool to provide home visits proactively and in advance of a potential hospitalization. Next Generation Participants and Preferred Providers who have initiated a care treatment plan for aligned beneficiaries will be eligible to receive up to two Care Management Home Visits within 90 days of seeing that Next Generation Participant or Preferred Provider.

CMS will extend the conditional Medicare payment rule waiver issued under the Post-Discharge Home Visits Benefit Enhancement to establish the Care Management Home Visits Benefit Enhancement. Specifically, the scope of covered items and services under this Benefit Enhancement include those services and supplies that would be covered under Medicare Part B and are furnished “incident to” the professional services of a physician or other practitioner.

With the exception that CMS will waive the direct supervision requirement such that the services and supplies may be furnished by auxiliary personnel under the billing physician’s or other billing practitioner’s general supervision, this new Care Management Home Visits Benefit Enhancement will provide NGACO Participants and Preferred Providers greater flexibility to furnish these services within a beneficiary’s home or place of residence.

The items and services provided as part of these care management home visits are intended to supplement, rather than substitute for, visits to a primary care provider or specialist in a traditional health care setting. As such, these home visits are not intended to be performed on an ongoing basis, nor to serve as a substitute for the Medicare home health benefit, nor as the primary mechanism to meet beneficiaries’ care needs. Also, note that this is not a home health benefit, and beneficiaries eligible to receive home health services will not be eligible for this Benefit Enhancement.

The Healthcare Common Procedure Coding System (HCPCS) codes for the Care Management Home Visit services are:

- G0076: Brief (20 minutes) care management home visit for a new patient. For use only in a Medicare-approved Center for Medicare & Medicaid Innovation (CMMI) model. (Services must be furnished within a beneficiary’s home, domiciliary, rest home, assisted living and/or nursing facility.)
- G0077: Limited (30 minutes) care management home visit for a new patient. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary’s home, domiciliary, rest home, assisted living and/or nursing facility.)
- G0078: Moderate (45 minutes) care management home visit for a new patient. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary’s home, domiciliary, rest home, assisted living and/or nursing facility.)
• G0079: Comprehensive (60 minutes) care management home visit for a new patient. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary’s home, domiciliary, rest home, assisted living and/or nursing facility.)

• G0080: Extensive (75 minutes) care management home visit for a new patient. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary’s home, domiciliary, rest home, assisted living and/or nursing facility.)

• G0081: Brief (20 minutes) care management home visit for an existing patient. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary’s home, domiciliary, rest home, assisted living and/or nursing facility.)

• G0082: Limited (30 minutes) care management home visit for an existing patient. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary’s home, domiciliary, rest home, assisted living and/or nursing facility.)

• G0083: Moderate (45 minutes) care management home visit for an existing patient. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary’s home, domiciliary, rest home, assisted living and/or nursing facility.)

• G0084: Comprehensive (60 minutes) care management home visit for an existing patient. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary’s home, domiciliary, rest home, assisted living and/or nursing facility.)

• G0085: Extensive (75 minutes) care management home visit for an existing patient. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary’s home, domiciliary, rest home, assisted living and/or nursing facility.)

• G0086: Limited (30 minutes) care management home care plan oversight. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary’s home, domiciliary, rest home, assisted living and/or nursing facility.)

• G0087: Comprehensive (60 minutes) care management home care plan oversight. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary’s home, domiciliary, rest home, assisted living and/or nursing facility.)

These codes should be submitted on Type of Bill: 85X, with Revenue Codes 96X, 97X, or 98X. The payment rates will be in the Medicare Physician Fee Schedule (MPFS). However, Medicare will reimburse the lesser of the billed charge or MPFS rate for Critical Access Hospital Method II providers billing on Type of Bill 85X, with Revenue Codes 96X, 97X, or 98X.

**Additional Information**


Information on the CRs previously implemented for the Next Generation ACO Model are available at:


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The Centers for Medicare & Medicaid Services (CMS) 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: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/

MLN Matters® Number: MM10834
Related Change Request (CR) #: 10834
Related CR Release Date: August 10, 2018
Related CR Transmittal #: R4114CP
Effective Date: July 12, 2018
Implementation Date: October 1, 2018

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.

What You Need to Know
The HCPCS code set is updated on a quarterly basis. Change Request (CR) 10834 informs MACs of the October 2018 addition of one new HCPCS code. Effective with dates of service on or after July 12, 2018, the Q5108 is payable by Medicare. The short descriptor for Q5108 is Injection, fulphila and the long descriptor is Injection, pegfilgrastim-jmdb, biosimilar, (fulphila), 0.5 mg. The Type of Service (TOS) Codes for Q5108 are 1, P and the Medicare Physician Fee Schedule Database (MPFSDB) Status Indicator is E. Note that MACs should hold claims for Q5108 until CR10834 is implemented.

Additional Information

If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

Document History

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<tr>
<td>August 10, 2018</td>
<td>Initial article released.</td>
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MM10858: Updates to the Medicare Claims Processing Manual, Chapter 24, ASCA Waiver Review Form of Letters, Exhibits A-H

The Centers for Medicare & Medicaid Services (CMS) 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: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/

MLN Matters® Number: MM10858  Related Change Request (CR) #: 10858
Related CR Release Date: August 3, 2018  Effective Date: January 1, 2019
Related CR Transmittal #: R4102CP  Implementation Date: January 7, 2019

Provider Type 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) 10858 provides an update to the language contained in the Form Letters the MACs use to inform certain providers of Administrative Simplification Compliance Act (ASCA) waiver reviews. The CR gives you clear directions for communicating with your MACs regarding ASCA waiver review-related questions when you receive a review Form Letter. Make sure your billing staffs are aware of these directions.

Background
Section 3 of the ASCA, PL107-105, and the implementing regulation at 42 CFR 424.32, requires that you, on or after October 16, 2003, submit electronically (with limited exceptions); all of your initial claims for reimbursement under Medicare. You should be aware that Medicare cannot pay for claims: 1) That do not meet the limited exception criteria; and 2) Which you submit non-electronically. The issuance of waivers under this limited exception criteria to providers has been delegated to the MACs by the Centers for Medicare & Medicaid Services (CMS). Refer to https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm3440.pdf for Additional Information about this requirement, including a list of these exception criteria.

Based on discussions with MACs to streamline the communication process with your MACs, CMS has made minor modifications to the ASCA waiver review letters that will improve this communication. CR10858 provides these modifications; specifically, the addition of the statement: “If you have questions, please contact your MAC Customer Service.”

You will find the updated Claims Processing Manual, Chapter 24 (General EDI and EDI Support Requirements, Electronic Claims, and Mandatory Electronic Filing of Medicare Claims), as an attachment to CR10858. It documents the changes mentioned above for the waiver review Exhibits of Form Letters (A-H).

Additional Information

If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

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MM10859: International Classification of Diseases, Tenth Revision (ICD-10) and Other Coding Revisions to National Coverage Determinations (NCDs)

The Centers for Medicare & Medicaid Services (CMS) 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: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/

MLN Matters® Number: MM10859
Related CR Release Date: August 10, 2018
Related CR Transmittal #: R2122OTN

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

Provider Action Needed
Change Request (CR) 10859 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 follow the link below for the NCD spreadsheets included with this CR: https://www.cms.gov/Medicare/Coverage/DeterminationProcess/downloads/CR10859.zip.

Make sure that your billing staffs are aware of these changes.

Background
Previous NCD coding changes appear in ICD-10 quarterly updates that are available at https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html, along with other CRs implementing new NCD policy. Edits to ICD-10, and other coding updates specific to NCDs, will be included in subsequent quarterly releases as needed. No policy-related changes are included with these updates. Any policy-related changes to NCDs continue to be implemented via the current, long-standing NCD process.

Coding (as well as payment) are separate and distinct areas of the Medicare Program from coverage policy/criteria. Revisions to codes within an NCD are carefully and thoroughly reviewed and vetted by the Centers for Medicare & Medicaid Services and are not intended to change the original intent of the NCD. The exception to this is when coding revisions are released as official implementation of new or reconsidered NCD policy following a formal national coverage analysis.

Note: The translations from ICD-9 to ICD-10 are not consistent one-to-one 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.

CR10859 makes coding and clarifying adjustments to the following NCDs:

- NCD80.11 Vitrectomy
- NCD110.21 Erythropoiesis-Stimulating Agents (ESAs) for Cancer
- NCD190.3 Cytogenetics
- NCD190.11 Home Prothrombin Time (PT)/International Normalized Ratio (INR)
- NCD220.6.17 Positron Emission Tomography (PET) for Oncologic Conditions
• NCD270.3 Blood-Derived Products for Chronic, Non-Healing Wounds
• NCD260.1 Adult Liver Transplantation
• NCD110.18 Aprepitant for Chemo-Induced Emesis
• NCD270.1 Electrical Stimulation, Electromagnetic Therapy for Wounds

Note/Clarification: A/B MACs shall use default Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) messages where appropriate: Remittance Advice Remark Codes (RARC) N386 with Claim Adjustment Reason Code (CARC) 50, 96, and/or 119. See latest CAQH CORE update. When denying claims associated with the NCDs referenced in CR10859, except where otherwise indicated, A/B MACs shall use:

• Group Code PR (Patient Responsibility) assigning financial responsibility to the beneficiary (if a claim is received with occurrence code 32, or with occurrence code 32 and a GA modifier, indicating a signed Advance Beneficiary Notice (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). For modifier GZ, use CARC 50 and Medicare Summary Notice (MSN) 8.81 per instructions in CR 7228/TR 2148.

Additional Information

If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

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Kentucky & Ohio

MM10871: Quarterly Influenza Virus Vaccine Code Update - January 2019

The Centers for Medicare & Medicaid Services (CMS) 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: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/

MLN Matters® Number: MM10871
Related CR Release Date: August 3, 2018
Related CR Transmittal #: R4100CP
Effective Date: January 1, 2019
Implementation Date: January 7, 2019

Provider Type 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) 10871 provides instructions for payment and edits for Medicare’s Common Working File (CWF) and Fiscal Intermediary Shared System (FISS) to include and update new or existing influenza virus vaccine codes. This update includes one new influenza virus vaccine code: 90689. Please make certain your billing staffs are aware of this update.

Background
Effective for claims processed with Dates of Service (DOS) on or after January 1, 2019, influenza virus vaccine code 90689 (Influenza virus vaccine quadrivalent (IIV4), inactivated, adjuvanted, preservative free, 0.25mL dosage, for intramuscular use) will be payable by Medicare. The short descriptor is VACC IIV4 NO PRSVR 0.25ML IM. This new code will be
included on the 2019 Medicare Physician Fee Schedule Database file update and the annual Healthcare Common Procedure Coding System (HCPCS) update.

Except as noted below, MACs will use the Centers for Medicare & Medicaid Services (CMS) Seasonal Influenza Vaccines Pricing Web page: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html to obtain the payment rate for 90689. The new influenza virus vaccine code 90689 is not retroactive to August 1, 2018. No claims should be accepted for influenza virus vaccine code 90689 between the DOS August 1, 2018, and December 31, 2018. If claims are received in January 2019 with code 90689 for DOS between August 1, 2018, and December 31, 2018, MACs will follow their normal course of action for codes billed prior to their effective date.

Payment Basis for Institutional Claims
MACs will pay for influenza virus vaccine code 90689 with a Type of Service (TOS) of V based on reasonable cost to

- Hospitals (Type of Bill 12X and 13X)
- Skilled Nursing Facilities (22X and 23X)
- Home Health Agencies (34X)
- Hospital-based renal dialysis facilities (72X)
- Critical Access Hospitals (85X)

MACs will pay for influenza virus vaccine code 90689 with a TOS of V based on the lower of the actual charge or 95 percent of the Average Wholesale Price (AWP), to:

- Indian Service Hospitals (IHS) (12X and 13X)
- Hospices (81X and 82X)
- IHS Critical Access Hospitals (85X)
- Comprehensive Outpatient Rehabilitation Facilities (CORFs) (75X)
- Independent Renal Dialysis Facilities (72X)

Note: In all cases, coinsurance and deductible do not apply.

Additional Information

If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

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**MM10881: October Quarterly Update for 2018**

**Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule**

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The Centers for Medicare & Medicaid Services (CMS) 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: [https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/)

**MLN Matters® Number:** MM10881
**Related Change Request (CR) #:** 10881
**Related CR Release Date:** August 10, 2018
**Effective Date:** October 1, 2018
**Related CR Transmittal #:** R4108CP
**Implementation Date:** October 1, 2018

**Provider Type Affected**

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

**Provider Action Needed**

Change Request (CR) 10881 informs DME MACs about the changes to the DMEPOS fee schedule which is updated on a quarterly basis, when necessary, to implement fee schedule amounts for new codes and correct any fee schedule amounts for existing codes. Make sure that your billing staffs are aware of these changes.

**Background**

The DMEPOS fee schedules are updated on a quarterly basis, when necessary, in order to implement fee schedule amounts for new and existing codes, as applicable, and apply changes in payment policies. The update process for the DMEPOS fee schedule is located in the Medicare Claims Processing Manual, Chapter 23, Section 60.

Payment on a fee schedule basis is required for Durable Medical Equipment (DME), prosthetic devices, orthotics, prosthetics and surgical dressings by Section 1834(a), (h), and (i) of the Social Security Act (the Act). Additionally, payment on a fee schedule basis is a regulatory requirement at 42 Code of Federal Regulations (CFR) 414.102 for Parenteral and Enteral Nutrition (PEN), splints, casts and Intraocular Lenses (IOLs) inserted in a physician's office.

Additionally, Section 1834(a)(1)(F)(ii) of the Act mandates adjustments to the fee schedule amounts for certain items furnished on or after January 1, 2016, in areas that are not competitive bid areas, based on information from Competitive Bidding Programs (CBPs) for DME. Section 1842(s)(3)(B) of the Act provides authority for making adjustments to the fee schedule amount for enteral nutrients, equipment and supplies (enteral nutrition) based on information from CBPs.

The methodologies for adjusting DMEPOS fee schedule amounts under this authority are established at 42 CFR, Section 414.210(g).The DMEPOS and PEN fee schedule files contain Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the adjustments, as well as codes that are not subject to the fee schedule CBP adjustments.

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

October quarterly updates are only required for the DMEPOS Rural Zip code file containing the Quarter 4 2018 Rural ZIP code changes. An October update to the 2018 DMEPOS and PEN fee schedule files is not required.
The October 2018 DMEPOS Rural Zip file (PUF) will be available for State Medicaid Agencies, managed care organizations, and other interested parties shortly after the release of the data files at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html.

Additional Information

If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

Document History

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**Kentucky & Ohio**

**MM10898: Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - October 2018 Update**

The Centers for Medicare & Medicaid Services (CMS) 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: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/

**MLN Matters® Number:** MM10898  
**Related CR Number:** 10898  
**Related CR Release Date:** August 10, 2018  
**Related CR Transmittal #:** R4109CP  
**Effective Date:** January 1, 2018  
**Implementation Date:** October 1, 2018

**Provider Type 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) 10898 amends payment files issued to MACs based upon the 2018 Medicare Physician Fee Schedule (MPFS) Final Rule. Make sure your billings staffs are aware of these changes.

**Background**
The Centers for Medicare & Medicaid Services (CMS) issued payment files to the MACs based upon the 2018 MPFS Final Rule, published in the Federal Register on November 15, 2017, to be effective for services furnished from January 1, 2018, through December 31, 2018.

CR 10898 presents a summary of the changes for the October update to the 2018 MPFS. Section 1848(c)(4) of the Social Security Act authorizes the Secretary to establish ancillary policies necessary to implement relative value units (RVU) for physicians’ services. Unless otherwise stated, these changes are effective for dates of service on and after January 1, 2018.

The HCPCS codes listed below have been added to the Medicare Physician Fee Schedule Database (MPFSDB) effective for dates of service on and after October 1, 2018.

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>ACTION</th>
</tr>
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<tbody>
<tr>
<td>G9978</td>
<td>Non-Facility &amp; Facility PE RVU = 0.23. All other MPFS indicators &amp; RVUs = 99201</td>
</tr>
<tr>
<td>G9979</td>
<td>Non-Facility &amp; Facility PE RVU = 0.42. All other MPFS indicators &amp; RVUs = 99202</td>
</tr>
<tr>
<td>G9980</td>
<td>Non-Facility &amp; Facility PE RVU = 0.60. All other MPFS indicators &amp; RVUs = 99203</td>
</tr>
<tr>
<td>G9981</td>
<td>Non-Facility &amp; Facility PE RVU = 1.01. All other MPFS indicators &amp; RVUs = 99204</td>
</tr>
</tbody>
</table>
The following “Q” codes are effective on or after July 1, 2018 (see CR 10626 for Additional Information on HCPCS code Q9994 and CR 10624 on HCPCS codes Q5105 and Q5106). HCPCS code Q5108 is effective July 12, 2018. See CR 10834 for more information on HCPCS Q5108:

<table>
<thead>
<tr>
<th>CODE</th>
<th>ACTION</th>
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<tbody>
<tr>
<td>Q9994</td>
<td>Procedure Status = X; there are no RVUs, payment policy indicators do not apply.</td>
</tr>
<tr>
<td>Q5105</td>
<td>Procedure Status = E; there are no RVUs, payment policy indicators do not apply.</td>
</tr>
<tr>
<td>Q5106</td>
<td>Procedure Status = E; there are no RVUs, payment policy indicators do not apply.</td>
</tr>
<tr>
<td>Q5108</td>
<td>Procedure Status = E; there are no RVUs, payment policy indicators do not apply.</td>
</tr>
</tbody>
</table>

Note: MACs will not search their files to retract payment for claims already paid or to retroactively pay claims. However, MACs will adjust claims brought to their attention.

Additional Information

If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

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Kentucky & Ohio

MM10899: October 2018 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) 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: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/

MLN Matters® Number: MM10899
Related CR Release Date: August 3, 2018
Related CR Transmittal #: R4107CP
Related Change Request (CR) #: 10899
Effective Date: October 1, 2018
Implementation Date: October 1, 2018

Provider Type Affected
This MLN Matters Article is intended for physicians, providers and suppliers billing Medicare Administrative Contractors (MACs) for Medicare Part B drugs provided to Medicare beneficiaries.

Provider Action Needed
Change Request (CR) 10899 provides the quarterly update for Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to the prior quarterly pricing files. CR 10899
instructs MACs to download and implement the October 2018 and, if released, the revised July 2018, April 2018, January 2018, and October 2017 ASP drug pricing files for Medicare Part B drugs. Medicare shall use the October 2018 ASP and Not Otherwise Classified (NOC) drug pricing files to determine the payment limit for claims for separately payable Medicare Part B drugs processed on or after October 1, 2018, through December 31, 2018. Make sure your billing staffs are aware of these updates.

**Background**

The ASP methodology is based on quarterly data that manufacturers submit to the Centers for Medicare & Medicaid Services (CMS). CMS supplies MACs with the ASP and NOC drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the Outpatient Prospective Payment System (OPPS) are incorporated into the Outpatient Code Editor (OCE) through separate instructions available in Chapter 4, Section 50 of the Medicare Claims Processing Manual at [https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf).

- File: October 2018 ASP and ASP NOC – effective dates of service: October 1, 2018, through December 31, 2018;
- File: July 2018 ASP and ASP NOC – effective dates of service: July 1, 2018, through September 30, 2018;
- File: April 2018 ASP and ASP NOC – effective dates of April 1, 2018, through June 30, 2018;
- File: January 2018 ASP and ASP NOC – effective dates of service: January 1, 2018, through March 31, 2018; and

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 Chapter 17, Section 20.1.3 of the Medicare Claims Processing Manual at [https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c17.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c17.pdf).

For any drug or biological not listed in the ASP or NOC drug pricing files that is billed with the KD modifier, MACs will 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 on or after January 1, 2017, associated with the passage of the 21st Century Cures Act which is available at [https://www.gpo.gov/fdsys/pkg/PLAW-114publ255/pdf/PLAW-114publ255.pdf](https://www.gpo.gov/fdsys/pkg/PLAW-114publ255/pdf/PLAW-114publ255.pdf).

MACs will not search and adjust claims that have already been processed unless you bring such claims to your MAC’s attention.

**Additional Information**


If you have questions, your MACs may have more information. Find their website at [http://go.cms.gov/MAC-website-list](http://go.cms.gov/MAC-website-list).

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Kentucky & Ohio

SE1434 Rescinded: Provider Enrollment Requirements for Writing Prescriptions for Medicare Part D Drugs

The Centers for Medicare & Medicaid Services (CMS) 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: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/

MLN Matters® Number: SE1434 Rescinded
Related CR Release Date: August 2, 2018
Related CR Transmittal #: N/A

Note: This article was rescinded on August 2, 2018.